PRESCRIPTION DRUG PRICE INFLATION: ARE PRICES RISING TOO FAST?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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PRESCRIPTION DRUG PRICE INFLATION: ARE PRICES RISING TOO FAST?

TUESDAY, DECEMBER 8, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:39 a.m., in Room 2123, Rayburn House Office Building, Hon. Frank Pallone, Jr., [chairman of the subcommittee] presiding.

Present: Representatives Pallone, Dingell, Eshoo, Green, Capps, Schakowsky, Matheson, Harman, Barrow, Christensen, Castor, Sarbanes, Space, Sutton, Waxman (ex officio), Deal, Shimkus, Buyer, Pitts, Murphy of Pennsylvania, Burgess, and Gingrey.

Also Present: Representative Welch.

Staff Present: Brian Cohen, Senior Investigator and Policy Advisor; Jack Ebeler, Senior Advisor on Health Policy; Karen Lightfoot, Communications Director and Senior Policy Advisor; Earley Green, Chief Clerk; Bruce Wolpe, Senior Advisor; Bobby Clark, Policy Advisor; Virgil Miller, Professional Staff; Jeff Wease, Deputy Information Officer; Erika Smith, Professional Staff; Katie Campbell, Professional Staff; Sharon Davis, Chief Legislative Clerk; Allison Lorr, Special Assistant; Lindsay Vidal, Press Assistant; Elizabeth Letter, Special Assistant; Mitchell Smiley, Special Assistant; Justine Italiano, Staff Assistant; Matt Eisenberg, Staff Assistant; Ryan Long, Minority Chief Health Counsel; Clay Alspach, Minority Counsel; Brandon Clark, Minority Professional Staff; Melissa Bartlett, Minority Counsel; and Chad Grant, Minority Legislative Analyst.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. The meeting of the subcommittee is called to order. And today we are having a hearing on "Prescription Drug Price Inflation: Are Drug Prices Rising Too Fast?" And I will first recognize myself for an opening statement.

Every day in America, a life is saved, an illness is averted, or the effects of a disabling condition are mitigated thanks to the innovative medicines produced by the pharmaceutical industry.

And I also think that it is important to mention the constructive role that the pharmaceutical industry and individual companies have played over the past few years amid various health care debates. The industry was an early and active proponent for the re-

authorization and strengthening of SCHIP, which we were finally able to achieve earlier this year. In addition, I want to recognize their efforts to ensure comprehensive health reform is enacted this year. While I know that we all have not seen eye to eye on every issue, I appreciate the fact that the industry acknowledged very early on that they have a stake in making sure health-care reform succeeds and they are willing to make a contribution towards paying for it.

Unfortunately, for all the good the pharmaceutical and biotech industry do, it is often overlooked or eclipsed by reports of behavior designed to maximize profits at the expense of individual patients, employers, and American taxpayers.

Indeed, according to a 2008 public opinion poll conducted by the Kaiser Family Foundation, negative views of the pharmaceutical industry appear to be driven by perceptions about the cost of prescription drugs and pharmaceutical company profits. The Kaiser poll shows that seven in 10 adults say pharmaceutical companies are too focused on profits and not enough on helping people. And nearly eight in 10, 79 percent, believe that high profits are a major factor in the price of prescription drugs, and the same proportion feels that drug prices are unreasonable.

The poll further suggests that these opinions about prescription drug prices are driven by people's real-life struggles paying for drugs. Four in 10 adults report some serious problem paying for medication, either that it is a serious problem for their family to pay for drugs they need or not filling a prescription or skipping doses because of cost.

And new evidence suggests that prescription drug prices are increasing rapidly. Most recently, the New York Times reported on November 15th that drug prices had increased by approximately 9 percent over the last year. And, by at least one analysis, it is the highest annual rate of inflation for drug prices since 1992.

At the same time, general inflation, as measured by the Consumer Price Index, has fallen over the past year, which means that, while people are paying less for other types of goods and services, they are paying more for brand-name prescription drugs at a time when they are least able to afford to do so. And, as you know, millions of Americans are out of work, millions are losing their homes, millions are without health care coverage. So it should come as little surprise that Members of Congress would be alarmed about the idea of drug companies raising prices at a time when so many of our constituents are already unable to afford the medical care they need.

Now, some researchers, including Dr. Schondelmeyer, who we are going to hear from today, has suggested there is a link between spikes in prescription drug prices and when there is legislation pending that impacts the pharmaceutical industry's bottom line, such as the various health-care reform bills currently moving through Congress.

I know that the pharmaceutical industry disagrees with this claim and has suggested that any increases in drug prices are a result of investments in research and developments that are necessary to keep new and innovative drugs moving through the pipeline. And I would be unfair if I didn't point out the industry—you

know, that this is not, you know—how should I say it—one broad stroke. I mean, there are companies that are increasing prices, and there are others that are not. But, according to Dr. Schondelmeyer's research, some drugs saw no increase, some increases were below the average, but other drug prices increased by almost 20 percent, such as Flomax, which appears excessive, in my opinion.

Furthermore, these surveys on drug prices are unable to account for discounts and rebates provided by manufacturers to wholesalers or purchasers. Hence, there is a level of uncertainty that is inherent in these numbers, and that is why we are basically supportive of better price transparency. And when it comes to prescription drugs, I think that that is something that we really need, more transparency. And I have been advocating that for a long time.

I think that better reporting and more transparency will help us make sure that drug prices are not rising arbitrarily or to maximize profits and that every American has access to affordable prescription drugs. And that is a goal that we all share.

So we are here today to try to get to the bottom of this latest price increase. And we obviously have people that will be talking about some of the reports that have come out, and also from the industry. And so I want to thank our panel of witnesses in advance for being here today.

I do have to mention, though, that I know there is some issue with regard to Dr. Schondelmeyer because we just received his testimony this morning at 9:30. And I am very upset by that because the rules actually provide that we have to have the testimony much sooner. I think it is 2 days' notice. When we get it at the last minute—you know, it literally is the last minute—I know there are some Members here that are going to suggest that he shouldn't testify at all.

I was sort of inclined initially to say that, as well, because I haven't had anybody that submitted their testimony so late. But I would ask—I guess it is my prerogative to make the decision, and I am going to ask him to speak this morning, only because a lot of this hearing came about because of his initial survey. And I think if we don't have the opportunity to hear from him, the panel and the hearing this morning won't be as productive.

But I don't want to sound like a teacher chastising a student or something, but it is a problem when we get the testimony this late.

Mr. SHIMKUS. Would the chairman yield for 1 second?

Mr. PALLONE. Yes.

Mr. SHIMKUS. Just trying to understand the historical aspect of this, did this happen last year with another health care briefing from Dr. Schondelmeyer, where we didn't get the briefing but all we got was a PowerPoint?

Mr. PALLONE. You know, I am not sure. I know that—look, let's be honest—and I don't want to get into an argument with anybody, because I agree with you. Unfortunately, we are getting testimony late. Like, I know that one of your witnesses, I think we got it yesterday, which, you know, is not as bad as getting it at the last minute. But it is getting to be a pattern that, you know, we are getting some of this testimony a day earlier rather than 2 days. And so I think we need to be a little more—I don't know what the

word is—tough on the witnesses and remind them that we need it, you know, 48 hours in advance.

Mr. SHIMKUS. If the chairman would yield just for 1 more second.

Mr. PALLONE. Sure.

Mr. SHIMKUS. It is my understanding that last year in the Government Reform Committee the same thing happened.

Mr. PALLONE. I am just told he hasn't testified before.

Mr. SHIMKUS. And so my issue is, it is a pattern now. It is not a one-time mistake.

Mr. PALLONE. Well, not in his case.

Mr. SHIMKUS. I am just making a point that it might be a pattern, and we ought to be a little bit more——

Mr. PALLONE. Well, he has not testified before so I don't want to say that it is a pattern on his behalf.

But I do want to mention that it is important for both Democrat and Republican witnesses to try to get the testimony in, not just even 24, but 48 hours. The rules provide for the 48.

But, anyway, let me yield to our ranking member, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Chairman Pallone. Thank you for holding this hearing on the cost of prescription drugs.

If the subcommittee is intent on addressing the high cost of pharmaceuticals, I believe that approval of the follow-on biologic legislation, which fairly balances consumer access with strong incentives to innovate, is essential to achieving this goal.

In 2007, global sales of these drugs reached $75 billion. Current estimates suggest that half of all drugs, both small- and large-molecule-based, will be biopharmaceutical's best year, while statistics further indicate that spending on biologic drugs is expected to grow 20 percent annually.

It is very disappointing that this committee, during markup of health reform legislation earlier, fell short on its commitment to achieve this goal. Unfortunately, provisions which aim to truly encourage competition, reduce cost, and, most importantly, increase access to critical drugs that currently fall out of the reach of countless Americans every day were not included as a part of the bill, as Chairman Waxman and I both tried to get done.

Instead of government price controls, which have a proven track record of declining research-and-development spending among those nations who have adopted it, appropriate incentives which spur research and development and enhance access to cutting-edge drugs is essential. As we all know, incentives to invest in R&D projects are highly dependent upon legislation this Congress puts into place. We must ensure appropriate provisions are put in place which continue to promote world-class pharmaceutical research and development in the fight for new cures here at home and abroad while ensuring continued access to these drugs by the American people. It is, indeed, a delicate balance.

I also look forward to AARP's testimony and appreciate the opportunity to discuss their decision to support H.R. 3962, particularly in light of significant cuts which are prescribed by the legislation within the Medicare program. I look forward to learning more

about the reasons that led them to endorse this health care bill, which, as Chairman Waxman and I would probably say, did not embrace some of the cost savings in the pharmaceutical area that perhaps it should have included.

Again, thank you, Chairman Pallone, for holding the hearing today. I yield back my time.

Mr. PALLONE. Thank you, Mr. Deal.

Chairman Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman, for holding this hearing.

This is an important hearing. We are in the process of reforming health care, and one of our goals in doing so should be to hold down costs.

Well, our economy is in a slump. The Consumer Price Index has actually gone down. Yet, for pharmaceutical prices in the last year, there has been a 9 percent increase. I must say that, when it comes to prescription drugs and the drug industry, nothing surprises me anymore, but increases of this magnitude is really pretty shocking.

Our Nation sees that when drug prices are raised by 9 percent or more over a year, that increases the out-of-pocket cost for drugs, it drives up insurance premiums, it increases the cost of the Medicare D program, means more and more citizens—some with insurance, some without—are forced to go without the drugs they need to remain healthy.

And reports indicate that this problem is getting worse, not better. The drug price increases over the last year are the biggest we have seen in a very, very long time. It is hard to escape the conclusion that the industry is positioning itself—positioning its pricing for enactment of the new health reform legislation. They were met with great acclaim when they announced with the White House and the Senate that they were going to take an 80-percent reduction in their profits over the next 10 years, $80 billion. Well, a 9 percent increase in prices over this last year comes to $20 billion that they are getting in just 1 year. So let us keep this in perspective.

When Americans hear about these soaring drug prices, they are absolutely right to demand to know what Congress is doing about it. In the House, led by members of our committee, we are trying to tackle this problem. Last month, the House passed historic health-care reform legislation, and I am confident the Senate is going to follow our example in a very short period of time.

In our legislation, we provided that health insurance, including drug coverage for 36 million citizens who would be otherwise without it, and we closed the Part D donut hole, meaning that seniors would no longer have to stop taking drugs when their coverage runs out. What we did in the pharmaceutical area is that these companies will not just get a blank check as we form our health care system. We tried to strike an important balance that put consumers and taxpayers first.

We require the drug industry to provide additional discounts for the Medicaid program. We end the multi-billion-dollar windfall that the industry received when dual-eligible enrollees were switched from Medicaid to Medicare Part D drug coverage. We are requiring that discounts be provided when the government pays for low-income people to get health care coverage.

The House bill uses this money that would otherwise go to the drug companies to help millions of Americans afford health care coverage and to close the Part D donut hole. That is a good policy outcome. It is good for America, and it is the right prescription for PhRMA.

The drug industry made over $50 billion in profits in 2008—$50 billion in profits. Some of that went to increase their research and development. Most of it—or let's put it this way—more of it went to marketing drugs than into R&D.

So when we look at a drug price increase of 9 percent over the last year, it is the highest increase in recent memory. And as we try to climb out of our massive recession, as more and more Americans struggle with the loss of health care coverage and high insurance costs, everyone has to pay more costs for drugs. This is not right. We can't afford it.

The drug companies are playing a shell game when they tell us they are going to take reductions in government expenditure, yet they are going to get millions of new customers paying for drugs, and yet what we see is, at the same time, they are increasing their drug prices at a record rate. I hope this hearing will help us inform the people who are working on health care reform so that we don't let them get away with this blank check.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Waxman follows:]

Chairman Henry A. Waxman
Opening Statement
Hearing on "Prescription Drug Price Inflation: Are Prices Rising Too Fast?"
December 8, 2009

I thank Chairman Pallone for holding this hearing, and look forward to hearing from our witnesses.

I've been working on health and drug-related issues for 35 years. I helped pass the Waxman-Hatch generic drug legislation and have now been involved for years in oversight work on Medicare Part D.

I'd like to think that when it comes to prescription drugs and the drug industry, nothing surprises me anymore.

But the recent increases in prescription drug prices shocked everyone.

Our nation is trying to recover from the largest economic downturn since the Great Depression. The Consumer Price Index has actually dropped over the last year. Social Security checks will remain stagnant. Millions of Americans have lost their jobs and their health insurance.

Yet the brand-name prescription drug industry raised prices by more than 9% over the last year.

These price increases ripple through our health care system with devastating implications. They increase out of pocket costs for drugs and drive up insurance premiums. They increase the cost of the Medicare Part D program. And they mean that more and more citizens — some with insurance, some without — are forced to go without the drugs they need to remain healthy.

And reports indicate that this problem may be getting worse, not better. The drug price increases over the last year are the biggest in years. This past weekend, the New York Times reported that Allos, the manufacturer of a new cancer drug called Folotyn, will be selling this drug for $30,000 a month. $30,000 per month. And the drug hasn't even been shown to increase the life expectancy of those who take it.

It is hard to escape the conclusion that the industry is positioning the pricing of its products for enactment of the new health reform legislation.

When Americans hear about these soaring drug prices, they are absolutely right to demand to know what Congress is doing about it.

In the House, led by members of our Committee, we are trying to tackle this problem. Last month, the House passed historic health care reform legislation, and I am confident that the Senate will soon follow.

The House legislation provides health insurance, including drug coverage, for 36 million citizens who would otherwise be without it. And it closes the Part D donut hole, meaning that seniors will no longer have to stop taking drugs when their coverage runs out.

These changes will mean billions of dollars in new market opportunities for pharmaceutical manufacturers. That's appropriate. We need a profitable brand-name drug industry in this country. The industry's scientific breakthroughs improve healthcare and quality of life for millions.

But we cannot write the pharmaceutical industry a blank check as we reform the health care system.

The House health care reform bill strikes an important balance that puts consumers and taxpayers first. In return for the billions of dollars in new market opportunities, we require that the drug industry provide additional discounts for the Medicaid program. And we end the multi-billion dollar windfall that the industry received when dual eligible enrollees were switched from Medicaid to Medicare Part D drug coverage.

The House bill uses the money raised from these industry concessions to help millions of Americans afford health care coverage and to close the Part D donut hole. This is a policy outcome that is good for America and the right prescription for PhRMA.

To date, the Senate has so far not gone as far as the House with their drug related provisions. When we do sit down with the Senate, I think the pharmaceutical industry's recent price increases will be exhibit A on why we need new provisions to protect taxpayers, Part D enrollees, and others with and without insurance from exorbitant prescription drug costs.

Thank you Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Waxman.
The gentleman from Illinois, Mr. Shimkus.

OPENING STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. SHIMKUS. Thank you, Mr. Chairman.

And I do appreciate the chairman of the full committee's letter requesting a CBO analysis. I just wish we had that in hand prior to having this hearing, which bespeaks of the timing of this hearing for the purposes of whatever the majority wants to deem without having a proper analysis.

Having said that, Medicare D has been one of the most successful Federal health care programs. Originally scored in first-year costs at $49 billion; it came in at $41 billion. Overall, since its inception, it is 40 percent under projected cost. Seniors have more choices.

And it is a distinct difference in the direction that we are heading in 3962, where Medicare D incentivizes private insurers to provide access to prescription drugs so people can choose, and you let the market work, which is just the opposite of what we plan to do when we eventually move to a government takeover of health care in 3962.

Every health care hearing that we are going to have is going to be, as the chairman of the full committee says, in the parameters of the health care bill that is moving through both chambers. And rightly it should be. So there will be a lot of great questions because of the calling of this hearing, and we look forward to discussing those.

Let me end on just talking about comments made last week which was disparaged but has been proved correct by a paper called The Californian. Last week we had the breast cancer decision from 40 to 49. And a lot of us said, this will start the road down to the government making determinations based upon cost. And the headline here, "State Ends Subsidy for Mammograms to Low-Income Women Under 50." And they also say, "The State's decision, announced December 1st and effective January 1st, follows a controversial Federal recommendation last month that mammograms before the age of 50 are generally not needed. However, the private health care system has rejected the Federal task force recommendations."

So here you have the public health agency say, we are going to accept these to save costs; the private insurers are going to keep them, which is an incentive for us to stop disparaging private insurance and really be concerned about government-run.

Here is what Dr. Klausen says. "What makes me really worried is that the California Department of Public Health wants to save money by taking away a cancer detection program," Klausen said. "That discriminates against a gender, also discriminates against an income level, and it also discriminates against how community clinics can practice medicine."

That is the road we are heading. I reject this path. It will be harmful to public health. And we will get a chance to ask questions of those people who are in the room, the closed-door meetings with the White House and other leaderships, on their role in H.R. 3962.

And I yield back my time.

Mr. PALLONE. The gentlewoman from California, Ms. Eshoo.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. ESHOO. Thank you, Mr. Chairman, for holding this very important and timely hearing today.

Like most of my colleagues, I, too, am very concerned to see reports of artificially increased drug prices on the heels of a promise made by the drug manufacturers to decrease prices for consumers.

Last month, the AARP released a study which found brand-name drugs increased by 9.3 percent, the highest drug inflation since 2002. Just a few months earlier, a much-touted announcement by the White House and PhRMA promised $80 billion in savings on drug costs, most notably to help seniors who are struggling to pay for medications in the donut hole.

At a time when everyone in the health care industry is being asked to put something on the table to contribute something to the reform effort, the drug companies were some of the most vocal in touting the, quote, "sacrifice" they were making for the cause of health-care reform.

Last April, IMS predicted that drug sales might actually go down. But IMS Health, a consulting firm paid for by the drug companies to advise them, reported a significant increase in prices.

I certainly understand the need to couple profits with innovation in order to promote science and encourage new therapies and treatments. I think that that is essential, not only to advance what we want to advance but that we retain an American position where we are first in the world, because our people benefit from it. But, as I understand it, the House PhRMA agreement called for reduced drug costs to support comprehensive health-care reform and not discounts from jacked-up prices.

I know that we are going to be hearing from PhRMA, who I understand will testify that reports of rapidly increasing drug prices are false and that the increase was based solely on the listed price of drugs, not the discounted prices most Americans or the government pay. I am eager to hear their explanation and be able to report these explanations back to my constituents, if they are worthy of being reported, if they really hold something.

I am also eager to hear from AARP, which fueled much of the drug pricing debate with their recently released report. As both an interest group for seniors and an insurance company, their report may have different implications.

I would just like to add, too, that the gentleman from Georgia made some comments about biologics. And I know that he is not pleased with the outcome of what is in the bill. I do believe very, very firmly that by treating biologics in a new way, bringing them into biosimilars, that this will make biologics—move them into generics. And, thereby, more and more Americans will be able to not only afford them, but that that pathway is a very robust one, a smart way to go.

I don't want to lose this to other countries. I think that America is in a position today where it can ill-afford that. And, most frank-

ly, we have two major biologics companies today. We have to do this the right way so that this can reach patients. And it really represents, I think, the most hope in medicine. Because, as good as pharmaceutical drugs may be, they only treat symptoms, they don't go to the cause of a disease. So biologics are really where the most hope lies.

So I thank you again, Mr. Chairman, for holding this hearing. I look forward to the testimony, the important testimony of the witnesses. And I yield back.

[The prepared statement of Ms. Eshoo follows:]

Statement of the Honorable Anna G. Eshoo
House Committee on Energy and Commerce, Subcommittee on Health
Hearing on "*Prescription Drug Price Inflation: Are Prices Rising Too Fast?*"
December 8, 2009

Thank you, Mr. Chairman, for holding this timely and important hearing today. Like most of my colleagues, I'm very concerned to see reports of artificially increased drug prices on the heels of a promise made by drug manufacturers to *decrease* prices for consumers. This has a very real impact on my constituents daily, as well as seniors and others across our country.

Last month AARP released a study which found brand name drug prices increased by 9.3%, the highest drug inflation rate since 2002. Just a few months earlier, a much touted announcement by the White House and PhRMA, promised $80 billion in savings on drug costs, most notably to help seniors who are struggling to pay for medications in the "donut hole." At a time when everyone in the healthcare industry is being asked to contribute to the reform effort, it can be said that the drug companies were some of the most vocal in touting the "sacrifice" they were making to the cause of health reform.

But last month, IMS Health, a consulting firm paid by the drug companies to advise them, predicted that drug sales might actually go *down*, but IMS actually reported a significant increase in prices. In fact, IMS made an unusual change in the middle of its forecasting cycle, saying it now believed that U.S. sales would grow 4.5% in 2009—or $21 billion more than expected six months earlier.

I understand the need to couple profits with innovation in order to promote science and encourage new therapies and treatments. But as I understand it, the House-PhRMA agreement called for reduced drug costs to support comprehensive healthcare reform, not for phony discounts from jacked-up prices.

We will hear from PhRMA, who I understand will testify that reports of rapidly increasing drug prices are false and the increase was based solely on the listed prices of drugs, not the discounted prices most Americans, or the government, pay. I'm eager to hear their explanation.

I'm also eager to hear from AARP, which fueled much of the drug-pricing debate with their recently released report. As both an interest group for seniors *and* an insurance company, their report may have many different implications.

Mr. PALLONE. I thank the gentlewoman.
The gentleman from Indiana, Mr. Buyer.

OPENING STATEMENT OF HON. STEVE BUYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. BUYER. I thank the chairman for the hearing today.

And I don't mind receiving input from anyone, at this point, because there is such great uncertainty out there, especially regarding your very aggressive health agenda. And it is an agenda that I think is on the verge to hurt the industry and which we are going to discuss here today, and there, in turn, hurting the health of America and to the world.

I think it is important to look at what we know about drug prices and their relationship with regulations, such as price controls, which are supported by the majority. It is what is included in their health reform legislation that was passed by the House and is being debated by the Senate.

What we ought to be doing is we ought to be looking at the effect of price controls. And we can look at the model that is by European countries between 1986 and 2004. During this time, these countries strengthened their price controls, and the controls had a devastating impact upon research-and-development spending. And all of that investment then began to shift to America.

Before the strident price controls were implemented in the mid-1980s, spending in Europe for research and development of the new life-saving drugs exceeded that of the United States by 24 percent. By 2004, spending in Europe on research and development of drugs trailed the United States by 15 percent. So what did this dramatic decline in research-and-development investment in Europe amount to? Well, they have 50 fewer new drugs approved in Europe and about 1,700 fewer scientists employed in Europe.

Europe's pharmaceutical industry research and development grew at merely one-half of the rate of that here in the United States. As economists John Vernon and Joseph Golec found, quote, "Whereas European Union firms introduced about twice as many new medicines as U.S. firms between 1987 and 1991, they introduced about 20 percent fewer than U.S. firms between 2000 and 2004."

So here we sit, with potential price controls that will be similar to Europe. I think America ought to pause—actually, I think America ought to wake up. Because there is a wave of socialism that is truly coming to the shores of America. And we better wake up.

Now, all of us either have friends or someone or a family member that has a narrow disease. So when you think of types of narrow disease—adenoid cystic carcinoma, Alpers' disease, Bell's palsy, Dandy-Walker malformation, Hodgkin's disease, sickle-cell disease, sudden infant death syndrome—there is a very long list. And so, what is the demand when someone has a narrow spectrum of a disease? Well, they want the pharmaceutical companies to find that drug that can help.

Well, if it is very narrow and there is not any ability to have a profit, what is the incentive for industries to go? So government tries to provide the incentive. If we are going to wipe out and move to price controls and wipe out incentives in R&D, then many of

these disease groups, people are going to be left on the outside. And that is not how we define compassion for public health for America.

I yield back.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Mr. Chairman, thank you for having this hearing on prescription drug prices.

We have seen many reports on the high cost and rising prices of prescription drugs. The most recent report released by AARP Policy Institute in November found that, between October 2008 and September 2009, the brand-name drug prices increased 9.3 percent, the highest drug inflation since 2002. Prices for specialty drugs used by Medicare beneficiaries increased even more, by 10.3 percent. Over the same time, prices for generic drugs declined by 8.7 percent. The high cost of these prescription drugs has an impact on Medicare, due to the increased taxpayer expenditures and increased premiums.

I am also concerned that every member of this committee has heard from seniors in their district who are enrolled in Medicare Part D who have fallen into the donut hole, which is a result of the Medicare Modernization Act of 2003. This forced Medicare Part D enrollees to pay 100 percent of drugs between $2,700 and $6,154. Each year, 4,400 seniors in our district hit the donut hole and are forced to pay their full drug costs despite having Part D drug coverage.

Throughout the country, seniors pay thousands in out-of-pocket expenditures they are unprepared for with fixed incomes. The donut hole often causes seniors to choose between purchasing medication and food, which is not something they should ever have to do. This is not the kind of benefit seniors deserve, and it needs to be corrected by Congress.

The House passed a health reform bill, H.R. 3962, which makes several major changes in prescription drug programs to ensure seniors and low-income individuals receive the prescription drug medication they need at an affordable cost. H.R. 3962 increases current Medicaid drug rebates that manufacturers pay to the government and closes a program loophole that prevent full rebate payments.

It also ensures the drug prices for dual-eligible and other low-income enrollees are no higher for Medicare Part D than they are under Medicaid. H.R. 3962 reduces the donut hole by $500 immediately and institutes a 50 percent discount for brand-name drugs in the donut hole upon passage. It actually eliminates that donut hole over a period of years by 2019.

The legislation gives the Secretary of HHS the ability to negotiate with pharmaceutical manufacturers to get the best deal possible for Medicare Part D beneficiaries. This allows the Secretary to obtain large discounts and rebates on drugs used by seniors, passing on that savings to Part D enrollees and to the taxpayers.

The Senate is working on their health care bill right now, but their bill does not allow the Secretary to negotiate the lower Part D prices and does not create new Part D drug rebates and does not

close the Part D donut hole. If we want to make real health-care reforms, we must address the problems that exist in Medicare, particularly those that cost our seniors thousands of dollars each year.

And, again, I want to thank the witnesses and appreciate them for appearing before our committee, Mr. Chairman.

Mr. PALLONE. Thank you.

The gentleman from Georgia, Mr. Gingrey.

Dr. GINGREY. Mr. Chairman, I will waive my opening statement in the interest of having more time for questions. Thank you.

Mr. PALLONE. Thank you.

Our vice chair, the gentlewoman from California, Mrs. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Chairman Pallone, for holding this hearing on such a timely and urgent situation.

As we move forward with health-care reform efforts, we need to ensure that we aren't just providing access to health care services in theory, but we need to actually make it affordable, both for individuals and for the government. With prescription drugs accounting for 10 percent of medical expenditures, it is imperative that we assure affordability for the people who rely on them.

I am particularly concerned with the impact of rising drug costs on our seniors, who, for the most part, live on fixed incomes. I am sure all of our colleagues have heard from constituents who have literally had to decide each week between medication and groceries because the costs are so prohibitive; or other constituents who decide to take only half of their prescription, their dosage, because they can't afford to pay for the entire amount.

While there are assistance programs to help individuals pay for their medications, they aren't always reliable, and they don't always apply to the particular medication that the senior needs. And that is why it is so important that we have this hearing today to look into the possible reasons for the rapidly increasing costs of medication.

I certainly understand that drug manufacturers must recoup the expensive costs of research and development. But, at the same time, isn't it unconscionable for us to be watching as drug companies' profits rise the way they are, while more and more of their patients with chronic disease lose their ability to afford life-saving medications? I look forward to hearing our witnesses' thoughts on why these price increases are occurring and how we can address the costs as we move forward.

And I yield back. Thank you.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Dr. BURGESS. Thank you, Mr. Chairman.

I am sure if there are people watching this hearing this morning, they are wondering what in the world is the purpose of what we are doing here this morning. If it is to answer the question, "Are

prescription drug prices rising too fast?" then they probably have a couple of concerns.

And the first is, why have we not waited until the report requested by Chairman Waxman from the General Accountability Office on this very question was received? We really can't debate the proper increase in prices, what they should look like, until we know the facts—not the facts as reported by the New York Times or an advocacy group with a policy agenda, but that provided by an independent entity which has the responsibility of providing Congress with information.

And the second concern is, why in the world did we not initiate this in the Subcommittee on Oversight and Investigations where we have subpoena power if necessary and can take testimony under oath? If the concern is that prices are being manipulated and causing harm to Americans on programs under this committee's jurisdiction, then that would seem to be the natural place to hold that hearing.

Maybe this is all about that monstrosity of a bill that we passed late in the night a couple of Saturdays ago. Again, it is just hard to know. But you do have to ask the question, where is the General Accountability Office, where is the Congressional Budget Office, where are the actuaries at the Center for Medicare and Medicaid Services that could make sense of some of this for us? None of those people are testifying today. Mr. Chairman, why is that?

Now, I know some people look at drug prices and say, "All drug companies are evil, and they shouldn't make a profit, and we need to take those away from them." This government's history, in the past year, of manipulating in the market is wrong on so many principles. I don't think we should encourage that type of behavior in this committee today.

But you know what we really don't know? If this manipulation does exist, what part of it was fostered by those secret negotiations that occurred down at the White House in May and June? And why has this committee had absolutely no curiosity about what was going on in those secret negotiations in May and June? And why is it that so many of these things were stumbled upon in the workup of the legislation in this committee and on the Senate Finance Committee? Why is it that pharmacy prices can't be changed? Why is it that the American Hospital Association has some of the things that it has brought to the table that are judged to be pretax? What other deals were struck? What deals with the AMA? What about AHIP? What about the Service Employees International Union?

We know nothing about that because this committee has had no curiosity about what might have been happening down at the White House under the cloak of darkness. This was supposed to be a transparent process available to the American people on C–SPAN from start to finish. And we can't get the most basic information about what was given up and what was given away during those secret negotiations in May or June.

Now, we can also do a lot of stuff on Medicare Part D. I have to tell you that the fact that we decided in 2006 to work with the market rather than dictate to the market has been responsible for a significant amount of success in the Part D program.

But I suspect we will hear some of the same arguments that we have heard for years about why that program is not working, despite the fact that 90 percent of Americans aged 65 and over have access or have prescription drug coverage today compared to 75 percent before we started in 2004 and that the satisfaction with that program is at an all-time high. I am not going to say that the program can't be improved, but it has worked and it has exceeded expectations. And I think we need to be careful before we start tinkering around the edges with that program.

Thank you, Mr. Chairman, for holding this hearing. And I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from California, Ms. Harman.

OPENING STATEMENT OF HON. JANE HARMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. HARMAN. Thank you, Mr. Chairman, for holding this hearing.

Let me say to Dr. Burgess that I sat through the tens of hours of markups of the health care bill, and I heard people on our side complain fiercely about the so-called deal that the White House struck with PhRMA, the $80 billion deal. And I remember voting for parts of the health care bill that were reported by this committee that scuttled that deal and that required, for example, negotiations for better drug prices under Medicare Part D. So I think whatever it is that the White House did, I want to applaud this committee for looking independently at some of those deals.

And I think the reason we are here today is because we are still enormously concerned about the escalation in drug prices. According to the AARP, the wholesale prices, not the retail prices, of brand-name drugs have risen by 9.3 percent in the last year, the highest annual increase since 1992. And this comes at a time when the Consumer Price Index has dropped by 1.3 percent.

As we head into the holidays and people are strapped to buy anything for their families over the holidays, I think it is just unconscionable and immoral that a basic necessity of life, which is drugs, is having this unexplained escalation in prices.

We already spend nearly $300 billion a year on prescription drugs. It is one of the fastest growing areas of health-care spending. And, frankly, since the very beginning, I have maintained that reducing the cost of prescription medications is the one reform that will have the biggest impact on people.

So I am very glad that we are holding this hearing. And I just want to say to our witnesses and to others who are looking at this problem that consumers are watching, and right now what I think they are seeing is price gouging.

I yield back.

Mr. PALLONE. Thank you.

The gentleman from Pennsylvania, Mr. Murphy.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman.

This is a hearing that we have long awaited, as with many other hearings of this type, to find out accurate information with regard to pharmaceutical companies and what they do. I am particularly concerned here about making sure that we are not having hearings on why drug companies are not inventing drugs to cure disease. That would be a sad state of affairs, indeed.

Many of my constituents are senior citizens, and we know they struggle to pay their high medical bills. We know that we have had opportunities, sometimes squandered, with regard to how we could reduce medical bills by reducing costs of health care through preventative services, through making sure that we maintain disease management, by making sure we reduce waste in health care.

However, one thing we don't want to do is eliminate drugs that can help cure problems. After all, drugs that are not affordable offer little consolation, and a drug that is not invented offers little cure. And, as a combined thing, we have to make sure this committee does not stand in the way of coming up with those cures.

It is easy to go after companies that make money—oil companies, pharmaceutical companies, anybody else who makes a profit—as a for-profit or nonprofit company and say that they should not be making that kind of money if the cost is passed on to the consumer. I understand, and we need to be sensitive to that area and make sure that these prices of any item is not inflated to the point that people cannot afford them.

However, it is also important that this committee, nor this Congress, nor this country stands in the way of coming up with these cures to treat diseases. There was a—certainly, other things that we have done here. We have looked after the consumers. We want to make sure we continue to look after the consumers and making sure that these are things that they have.

Generic drugs also are a critical function. They have grown massively in their use. They provide some good choices for people. And we need to continue to support generic drug use. However, they are not involved in the research-and-development sector, and we have to make sure that the research and development continues on.

Congress funds much of that through NIH, through NIMH, through a lot of studies that take place, and we need to continue to do that, as well. And somehow we have to look at how combining these efforts to fund research and development, to fund all levels of research continue on so that this country leads the way in coming up with ways that we can find affordable prescription drugs.

And, to that end, I am looking forward to hearing the testimony of the panelists here and seeing if they can offer us some solutions that is based upon how we can maintain this search for cures as well as search for affordable costs.

I yield back.

Mr. PALLONE. Thank you.

The gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Chairman Pallone. I appreciate your having this hearing today to better understand why prescrip-

tion drug costs are rising exponentially at a time when millions of Americans are struggling to make ends meet.

I assure you my constituents applaud the fact that we are having this hearing today. A recent AARP survey of Illinois seniors confirmed the concerns that I hear from my constituents every single day. Sixty-three percent of AARP members in Illinois said they were concerned about affording their prescription drugs. Close to 20 percent reported having to cut back on necessities to pay for prescriptions. Twenty-one percent reported not filling or delaying a filled prescription because they simply couldn't afford it. And one in five said they took less than the prescribed amount to make their medicines last longer.

Facing a severe budget deficit, our State took the bold step of expanding its prescription drug program, called Illinois Cares Rx, designed to benefit seniors and people with disabilities. When asked about the reason for the expansion of the Illinois—when asked for a reason, we asked Barry Maram, who is head of the Illinois Health Care and Family Services Division, and he said, quote, "The cost of prescription drugs has escalated to the point of being unaffordable for many of the people who rely on them most, especially seniors and people with disabilities. No one should have to go without medication that keeps them healthy," unquote.

The cost of brand-name prescription drugs are rising at a pace that far exceeds price increases for other consumer products. My constituents, both as consumers and as taxpayers, want to know whether the pharmaceutical industry is preparing for health-care reform by trying to squeeze every bit of profit they can now.

Health consumers are desperate for health-care reform, and there are many provisions in H.R. 3962 that would lower drug prices, including the language that I had the honor of offering to this committee to eliminate the ban on Medicare negotiating for drug prices. But they can't afford to have the drug industry use the time between now and the implementation to artificially raise prices and profit at their expense.

Again, I thank you, Mr. Chairman. And I yield back.

Mr. PALLONE. I thank the gentlewoman.

Next is the gentlewoman from Ohio, Ms. Sutton.

OPENING STATEMENT OF HON. BETTY SUTTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Ms. SUTTON. Thank you, Mr. Chairman. And I appreciate you holding this hearing today.

I would like to be able to say that I am shocked that we are here talking about this, but, sadly, I am not. Americans pay the highest drug prices in the world. We pay between 35 percent and 55 percent higher than people in other developed countries. And we have been paying these exorbitant prices for a long time. Drug prices account for 10 percent of all health-care spending.

Over the past year, we have been working hard in this committee and in Congress to make health care more affordable for families, businesses, and individuals. And the "Affordable Health Care for America Act" health care bill contains a number of initiatives aimed at curbing the out-of-control drug prices for America's families and seniors.

And yet, during this period, drug companies increased prices by over 9 percent at a time when inflation was negative. Increased drug prices hurt us all. They hurt older Americans on fixed incomes, who saw their drug bills increase by $550 last year. They hurt people who have insurance and who now have higher co-pays. They hurt taxpayers and the government, who are now paying higher drug prices. And, more than anyone else, they hurt the uninsured, who do not have anyone to negotiate on their behalf.

There is something wrong when Americans are paying record-high drug prices and drug companies are reporting such high profits. The CEO salaries at some of the largest drug makers are evidence enough that something is seriously wrong. At Abbott Laboratories, the CEO made over $28 million last year. At Merck, the CEO made over $25 million. And at Pfizer, the CEO made over $15 million.

And it does not end there. Drug companies often claim that they must charge higher prices in order to fund research and development for new drugs. But the truth is, drug companies spend more on advertising than they do on R&D. It is time for some answers. It is time for the drug companies to explain why they are raising prices, especially right now.

And I yield back.

Mr. PALLONE. Thank you.

The gentleman from Pennsylvania, Mr. Pitts, waives.

The gentleman from Georgia, Mr. Barrow.

Mr. BARROW. Thank you, Mr. Chairman. I will waive.

Mr. PALLONE. Thank you.

I think that concludes our opening statements from the Members, so we will now turn to our witnesses. We have just one panel today, and I would ask the panel to come forward at this time.

Welcome. And thank you for being here today.

Let me just introduce each of you. Starting on my left is Professor Stephen Schondelmeyer, who is professor and head of the Department of Pharmaceutical Care and Health Systems and director of the PRIME Institute at the University of Minnesota. Second is Mr. Rick Smith, who is senior vice president for policy, research, and strategic planning at PhRMA, which is the Pharmaceutical Research and Manufacturing Association. And then we have Kathleen Stoll, who is deputy executive director of Families USA. And Dr. John Vernon, who is a professor, Department of Health Policy and Management, at the University of North Carolina at Chapel Hill, and he is a faculty research fellow with the National Bureau of Economic Research. And finally is Ms. Bonnie Cramer, who is Chair of the Board of Directors of AARP.

Thank you all for being here today. We have 5-minute opening statements. They become part of the record. And you may, of course, with our discretion, submit additional statements in writing. And you may get some additional questions after the hearing, too, to respond to in writing.

And I will start with Dr. Schondelmeyer.

STATEMENTS OF STEPHEN SCHONDELMEYER, PROFESSOR AND HEAD, DEPARTMENT OF PHARMACEUTICAL CARE AND HEALTH SYSTEMS, DIRECTOR, PRIME INSTITUTE, UNIVERSITY OF MINNESOTA; RICHARD I. SMITH, SENIOR VICE PRESIDENT FOR POLICY, RESEARCH, AND STRATEGIC PLANNING, PHARMACEUTICAL RESEARCH AND MANUFACTURING ASSOCIATION; KATHLEEN STOLL, DEPUTY EXECUTIVE DIRECTOR, FAMILIES USA; JOHN VERNON, PROFESSOR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL, FACULTY RESEARCH FELLOW, NATIONAL BUREAU OF ECONOMIC RESEARCH; BONNIE CRAMER, CHAIR, BOARD OF DIRECTORS, AARP

STATEMENT OF STEPHEN SCHONDELMEYER

Mr. SCHONDELMEYER. Thank you, Mr. Chairman.

And my apologies for being late with my testimony. I was rather pressed with time and short notice on this particular hearing.

I am here to speak on my own behalf as a researcher and one who has studied this marketplace for more than 30 years. I am not here representing AARP or even the University of Minnesota other than the fact that I am a professor there and that is where I do my research.

And, also, let me comment that the Medicare Part D drug program has expanded coverage for prescription drugs for people who would not otherwise have had such coverage, and it has provided many benefits, and we have made some progress in that area.

Realizing that drugs and drug prices and drug expenditures were an issue, the AARP and others, such as myself, researchers in the marketplace, determined that we need to, kind of, follow the advice, for example, of President Reagan when he said, with respect to nuclear disarmament, "Trust and verify." One, let's trust that there is a reason for the price changes, but let's track them and see what they are and report that and reflect those price changes in the marketplace. And so, individuals at the AARP Public Policy Institute had an interest in tracking drug prices, and I had been doing that for a number of years in the marketplace, and we decided to get together and collaborate.

That collaboration has led to a series of studies of drug prices over the last 5 or 6 years with AARP, one of which was the study that got reported in the New York Times back about a month ago. The details of that study and how we conduct our reports can be found in the reports that are available on AARP's Web site. And so the detailed methodology, I would refer you to those reports rather than take time today to go through them, but I would be happy to answer any questions.

Just to put it in perspective, though, we used actual Medicare Part D prescription data and identified the most frequently prescribed, the highest expenditure drugs, and the drugs that accounted for the most days of therapy. And, with 548 individual drug products in our market basket, we were able to account for over 81 percent of all prescription expenditures under Medicare Part D, over 79 percent of the prescriptions dispensed, and over 91 percent of the days of therapy. So this market basket represents

virtually all of the Medicare Part D market with the exception of a very small set.

The data that we use is a price called the wholesale acquisition price. And let me remind you that wholesale acquisition price is a price that is set by the manufacturer and reported to the price databases such as Blue Book, Red Book, or Medispan, and these prices are the manufacturers' set price. On the one hand, even the wholesale acquisition cost is, in a sense, a type of a list price, but this list price very directly affects the price that is paid for prescription drugs at the retail level for virtually all third-party programs in the U.S., including the Medicare Part D plan which is in the private market as well.

So let's get down to the meat. What has the trend been for prescription drug prices in the past year? And here we are comparing prices from October of 2008 up through September of 2009, so I am talking about annualized prices, a 12-month period. And we use a rolling average which actually levels out and actually pulls down, in some cases, the price increase that is reported.

Brand-name drug prices—that is, largely patented single-source drugs—increased on average from this Medicare market basket 9.3 percent in the 12 months ending in September 2009. That 2009 increase of 9.3 percent was the highest that we have seen in at least 7 years prior to this for that same market basket of drugs. The previous years, we saw 5.3 to 8.7 percent increases, nothing to brag about, but now we are up to 9.3 percent.

The average cost of just one brand-name medication if a patient is taking it on a chronic basis would be over $2,000. And this 9.3 percent increase then means that the individual taking just one chronic medication experienced a $200 increase in the cost of that medication last year. The average elderly person is on two to three medications, so they would have experienced a $400 to $600 increase in expense.

Ninety-six percent of the brand-name drugs that we tracked experienced a price increase. None had a price decrease.

The annual price increases of individual brand drugs that were notable—and there were many, and I will only give a few examples: Ambien CR, a heavily advertised drug, increased 20.8 percent; Aricept, an anti-dementia drug with generic competition, increased 17.2 percent; Zetia, a drug with a questionable value and efficacy, increased 14.3 percent; Nexium, a heavily advertised drug with a patent until 2020, increased 7.1 percent.

That is brand-name drugs. We also pulled out specialty drugs. These are often the drugs you are talking about in terms of biologicals or biosimilars. Not all of them are, but the vast majority of specialty drugs are biologicals. The biologicals and specialty drugs experienced a 10.3 percent average increase in 2009. And there, we can look—for example, the drug Betaseron, used for multiple sclerosis, had an increase of 28.2 percent.

There were five drugs—actually, four drugs and five different presentations of those drugs in our market basket. All five of the multiple sclerosis drugs increased more than 17 percent, ranging from 17.5 up to 28.2 percent increase in price. There were 12 cancer drugs in our specialty database. They ranged from a low of 4.9

percent up to 20.8 percent. And, again, remember, inflation overall was negative last year.

The bright spot is we also tracked generic drugs, and generic drugs actually went down 8.7 percent. This is one of the few——

Mr. PALLONE. I am going to ask you to summarize because you are, like, a minute and a half over.

Mr. SCHONDELMEYER. OK, I will.

Generic drugs are one of the few sectors that truly has a marketplace and has economic competition, and generics have continually gone down in price. The question isn't what do we use to measure price inflation, the Consumer Price Index for Rx drugs or the AARP index. Each of them provides information that is unique and different. Our index was created to show the difference between brand names and specialty and generic, not just the aggregate index. And my full report—and I would be glad to answer in questions the role that rebates and discounts—that other methodological issues have in how we viewed this.

The bottom line, though, is the average senior last year got a zero percent cost-of-living increase for Social Security income.

They experienced an 11 percent increase in the premiums they had to pay for their Part D plans. That is for the drug benefit plan. They also face a 9.3 percent for brand name and 10.3 percent increase for specialty drugs. The only bright spot there is the 8.7 decrease in generic drug prices.

These prices are real. They are felt by your constituents.

Mr. PALLONE. Thank you.

[The prepared statement of Mr. Schondelmeyer follows:]

Statement on

Prescription Drug Price Inflation: Are Prices Rising Too Fast?

Statement before

Subcommittee on Health
Congress of the United States
House of Representatives
December 8, 2009

Statement of

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09-1201A

Thank you Representative Pallone and other members of the House Subcommittee on Health for this opportunity to provide information and insights on drug price inflation and its impact on the Medicare Part D drug program. I am Stephen W. Schondelmeyer, Professor of Pharmaceutical Management & Economics at the University of Minnesota where I serve as Director of the *PRIME* Institute. The *PRIME* Institute focuses its research on policy issues related to pharmaceutical economics and the management of drug expenditures at all levels in society. These remarks are my own views based upon my research and experience in studying the pharmaceutical marketplace for over thirty years. Previously, I have had the opportunity to serve Congress on the Prescription Drug Payment Review Commission that was established under the Catastrophic Coverage Act of 1988—a law that was repealed before the program was implemented—to provide prescription drugs to Medicare beneficiaries.

This hearing on drug price inflation and its impact on the Medicare Part D drug benefit provides a timely forum for examining the effect that drug prices have had on health care expenditures of both patients and payers. Also, this hearing provides an opportunity to look ahead to what we can expect as Congress crafts health market reform provisions that will be implemented and will shape our health care outcomes and expenditures for years to come. Today, I will briefly address findings related to recent changes in drug prices and the expected impact of these changes on the Medicare Part D drug program and health market reform.

Prescription Drug Coverage Under Medicare Part D

First, let me begin by commenting that the Medicare Part D program has provided improved coverage of prescription drugs for many Medicare beneficiaries that did not have such coverage prior to 2006. The Medicare Part D program, in general, has been a major step forward for providing appropriate and accessible drug therapy to the nation's elderly and disabled. While some advocates and observers projected that the Medicare Part D program would introduce competitive forces that would restrain drug prices, others contended that the legislation did not contain adequate provisions for ensuring competition that would reduce, or even slow, the escalation of drug prices. The issue of drug prices was, and still is, both critically important and hotly debated. Drug prices continue to be a concern for government programs such as Medicare and Medicaid, for private market payers such as employers and unions, and for individuals including Medicare beneficiaries who pay for all, or part, of the cost of their drug therapy.

Realizing that drug prices were a major hot button issue for those who pay for their own prescriptions—many of whom are AARP members—the AARP determined that it should do something to keep the public informed about prescription drug prices. AARP followed the advice of former President Reagan with respect to nuclear disarmament when he declared that the U.S. should "trust and verify." AARP entered into a dialogue

with the major pharmaceutical manufacturers asking, and trusting, that they would hold their price increases near the level of general inflation. At the same time, the AARP Public Policy Institute inaugurated a process in 2004 to monitor and verify changes in manufacturer's drug prices over time. The findings—both favorable and unfavorable—are routinely reported to AARP members and to the general public. Researchers at the AARP Public Policy Institute were aware of drug price studies that had previously been conducted by the PRIME Institute at the University of Minnesota under my direction and they invited me to collaborate with them to track drug prices in the period before Medicare Part D began and after the program was implemented.

Tracking Prescription Drug Prices

The Rx Watchdog reports were designed to track changes in *manufacturer* prices for prescription drugs widely used by Medicare Part D beneficiaries over time. The market basket for the AARP price studies was designed so that manufacturer pricing patterns for specific segments of the pharmaceutical market could be examined either individually or in aggregate. For example, the market basket allows calculation of separate indices for: (1) brand name drug products; (2) specialty drug products, including both brand and generic versions of specialty drug products; (3) generic drug products; and (4) a combined market basket (i.e., brand, specialty and generic). No other measure of drug prices in the market provides this level of detail and insight into drug pricing patterns.

The Rx Watchdog reports are the only published reports that provide for analyses of price trends such as: (1) brand versus generic status of drug products; (2) traditional drug products versus specialty drug products; (3) specific therapeutic categories of drug products; (4) individual drug manufacturers; and (5) individual drug products.

The prescription drugs that are most widely used by Medicare beneficiaries served as the basis for the market basket used in the Rx Watchdog reports. The most widely dispensed drug products (including brand name, specialty and generic drugs), the drug products with the highest sales levels, and the drug products with the highest number of days of therapy were identified from among the prescriptions provided by the largest Medicare Part D plan provider. Details of the method used to identify the market basket of drugs are described in our previously published reports.[1]

The market basket used included 548 specific drug products with 219 brand name products, 144 specialty products, and 185 generic products. This combined market

[1] See detailed methodology in Appendix A of the AARP Public Policy Institute's March 2008 report, "Rx Watchdog Report: Trends in Manufacturer Prices of Brand Name Prescription Drugs Used by Medicare Beneficiaries, 2002 to 2007" for details. Previous reports from this series can be found on the AARP Web site at http://www.aarp.org/research/ppi/health-care/medicare/articles/rx_watchdog.html.

basket accounted for 81.6% of all prescription drug expenditures, 79.2% of all prescriptions dispensed, and 91.2% of all days of therapy provided by a Medicare Part D plan provider in 2006.

Although the market basket studied was identified using data from a Medicare Part D plan provider, changes in prices charged by drug manufacturers to wholesalers and other direct purchasers were measured using changes in the wholesale acquisition cost (WAC) as published by the Medi-Span Price Rx® database.[2] Wholesale acquisition cost is a price set by, and reported directly by, drug manufacturers to the drug price databases such as MediSpan, First Data Bank (Blue Book), and Thomson Reuters (Red Book®). The average annual change in prices was calculated for each individual drug product as a 12-month rolling average. The aggregate estimates of price, or change in drug prices, were calculated for this study by weighting each drug product's value by its share among the Medicare Part D annual sales.[3]

Drug Price Trends By Market Segment

What has the trend been for prescription drug prices in the past year? The trends reported here are annual price changes based on the 12-month period from October 2008 to September 2009. Recall that in the past year the general inflation rate as measured by the Consumer Price Index for All Items (CPI-U)[4] actually averaged negative 0.3% for the year and it was negative 1.3% for September 2009 versus September 2008. So let's examine price changes in each of the market segments.

Brands Name Drugs
What happened with brand name prescription drug prices in 2009?

- Brand name drug prices, on average, increased 9.3% during the 12-months ending with September 2009.

- The 2009 increase (9.3%) in brand name drug prices was higher than the rate of increase observed during any of the prior seven years (i.e., 2002 to 2008) when brand name drug price increases ranged from 5.3% to 8.7%. (See Figure 1.)

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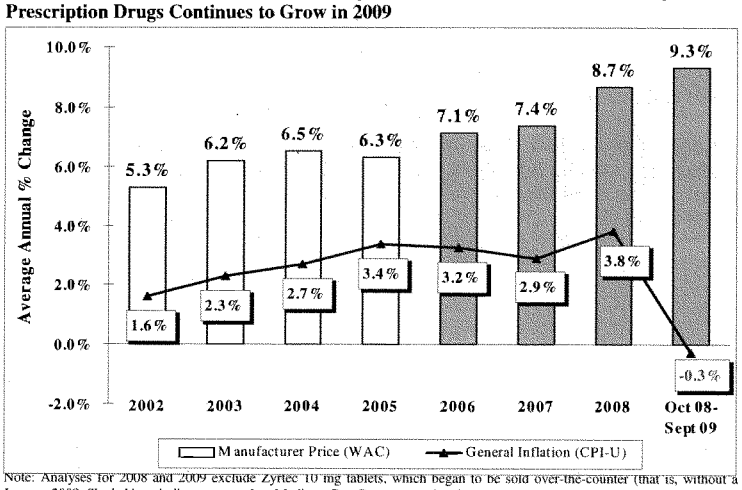
[2] Drug price data at the wholesale acquisition cost (WAC) level was obtained from the drug price database known as PriceRx© (Indianapolis, IN: Wolters Kluwer Health, Inc., Nov. 2008).

[3] The number of drugs included in the analysis for a given year varies because not all drugs in the sample were on the market in earlier years. For example, the analysis for 2004 includes 448 drug products representing 81.6% of the Medicare Part D drug expenditures.

[4] The general inflation rate, for purposes of this report, is measured by the Consumer Price Index-All Urban Consumers for All Items (seasonally adjusted) and published by Bureau of Labor Statistics series CUSR0000SA0 (CPI-U).

- The average annual cost for one brand name medication was about $2,045 in the third quarter of 2009 and this was an increase of about $202 per year for each chronic medication.
- A senior taking three chronic brand name drugs in 2009 would have total drug costs of about $6,134—more than enough to push them into the doughnut hole.
- 96% (210 of 219) of the brand name drug products experienced a price increase in the previous 12-months. All of these price increases were greater than the CPI-Rx (2.7%). None of the brand name drugs decreased its price in 2009.
- Annual prices increases of individual brand name drugs that were notable include:
  - Ambien CR, a heavily advertised drug, increased 20.8%.
  - Aricept, an anti-dementia drug with generic competition, increased 17.2%.
  - Zetia, a drug with questionable value and efficacy, increased 14.3%.
  - Nexium, a heavily advertised drug with a patent until 2020, increased 7.1%.

Figure 1: Average Annual Percent Change in Manufacturer Prices for Widely Used Brand Name Prescription Drugs Continues to Grow in 2009



Note: Analyses for 2008 and 2009 exclude Zyrtec 10 mg tablets, which began to be sold over-the-counter (that is, without a prescription) in January 2008. Shaded bars indicate years when Medicare Part D was operational.

Specialty Drugs
What happened with specialty prescription drug prices in 2009?

- Specialty drug prices, on average, increased 10.3% during the 12-months ending with September 2009. Brand name specialty drugs increased 19.2%.

- The 2009 increase (10.3%) in specialty drug prices was higher than the rate of increase observed during any of the prior five years (i.e., 2004 to 2008) when specialty drug prices increases ranged from 5.0% to 9.3%. (See Figure 2.)

- The average annual cost for one specialty medication was about $32,735 in the third quarter of 2009 and this was an increase of about $3,509 per year for each chronic specialty medication.

- 65% (94 of 144) of the specialty drug products experienced a price increase in the previous 12-months. 90% of specialty brand name drugs had a price increase in the previous year. 33% of the specialty drugs had no price increase and most of these were specialty generics. Two specialty generics had a decrease in price in 2009.

- Annual prices increases for individual specialty drugs that were notable include:

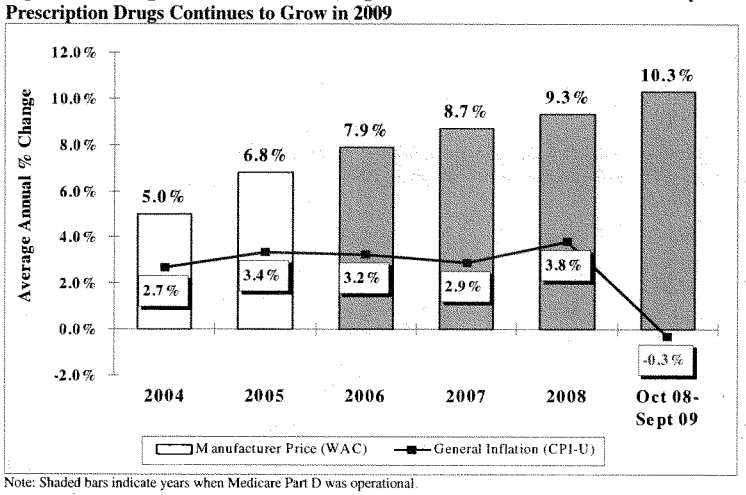
  - Infergen, an antiviral, increased 41.6%.

  - Betaseron, a multiple sclerosis drug, increased 28.2%.

  - All 5 multiple sclerosis drug products had price increases greater than 17.5%. (Range 17.5% to 28.2%)

  - All 12 cancer drugs had price increases greater than the CPI-Rx (2.7%) with price increases ranging from 4.9% to 20.8%. More than one-half (7 of 12) cancer drugs increased more than 4 times the CPI-Rx rate with increases ranging from 13.4% to 20.8%.

Figure 2: Average Annual Percent Change in Manufacturer Prices for Widely Used Specialty Prescription Drugs Continues to Grow in 2009



Note: Shaded bars indicate years when Medicare Part D was operational.

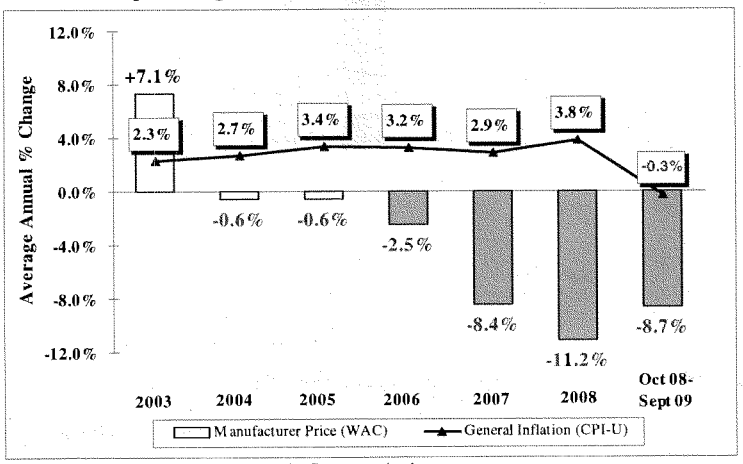
Generic Drugs

What happened with generic prescription drug prices in 2009?

- Generic drug prices, on average, decreased 8.7% during the 12-months ending with September 2009.
- Generic drugs have had an average decrease in price every year since 2004 with these decreases ranging from -0.6% to -11.2%. (See Figure 3.)
- The average annual cost for one generic medication was about $312 in the third quarter of 2009. This was a decrease of about $21 per year for a chronic generic medication.
- 84% (155 of 185) of the generic drug products had no price increase in the previous 12-months while 15% (28 of 185) of generic drugs had a price decrease. Two generics had a price increase in the previous year.
- Prices changes for individual generic drugs that were notable include:
  - Simvastatin, an cholesterol lowering agent, decreased 79.8%.

- Metformin, an oral anti-diabetic drug, decreased 86.4%.
- Gabapentin, an anti-seizure drug, decreased 35.1%.
- Klor-Con, a branded generic potassium drug, had a price increase of 37.8%.

Figure 3: The Average Annual Percent Change in Manufacturer Prices for Most Widely Used Generic Prescription Drugs Decreased More Slowly in 2009



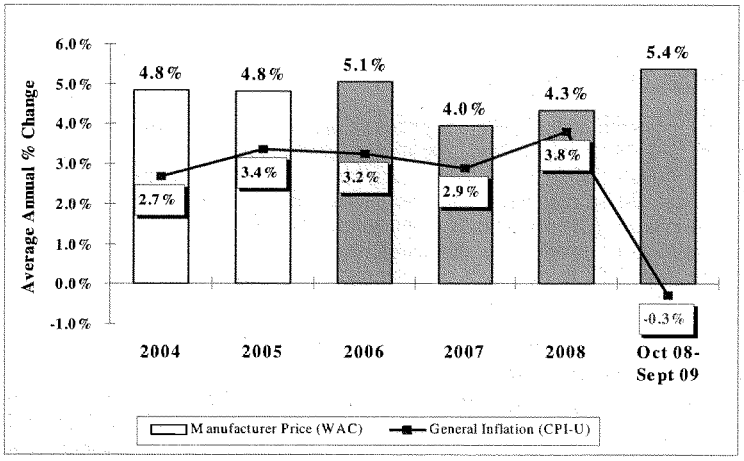
Note: Shaded bars indicate years when Medicare Part D was operational.

Combined Market Basket

What happened with the drug prices for the combined market basket in 2009?

- When combined, the average annual rate of increase for all of the drugs analyzed (brand name, specialty, and generic) was about 5.4% during the 12-months ending with September 2009.
- The combined annual rate of growth for drug prices is attributable to the unusually high levels of price growth among brand name (9.3%) and specialty drugs (10.3%) despite the fact that generic drugs experienced a substantial price decrease of -8.7%. (See Figure 4.)

Figure 4: The Average Annual Percent Change in Manufacturer Prices for Most Widely Used Prescription Drugs Continues to Increase in 2009



Note: Shaded bars indicate years when Medicare Part D was operational.

Different Measures for Different Questions

While there are several measures that track drug prices at the retail level, such as the Consumer Price Index for prescription drugs (CPI-Rx) or the National Health Expenditures (NHE) accounts, the Rx Watchdog series of studies was designed to report on trends in prices charged by drug manufacturers rather than prices at retail pharmacies. The question is not a matter of "Which is correct—The CPI-Rx or the AARP Watchdog index?" Rather, the more relevant question is "What can we learn from each of these measures of price change?" Another recent report[5] published by the AARP Public Policy Institute provides a comparison of the various measures available for tracking drug prices.

The overall price inflation rate reported by AARP Public Policy Institute is 5.4% which is a 12-month rolling average from Oct 2008 to Sept. 2009. The market basket for this price inflation measure included brands, specialty, and generic medications weighted by their relative contribution to total expenditures for those beneficiaries in Medicare Part D

[5] See Stephen W. Schondelmeyer, Leigh Purvis, and David J. Gross, *Comparative Measures of Price Change for Prescription Drugs and Other Good*, Rx Watchdog Report #2009-16, November 2009 which can be found at: http://www.aarp.org/ppi.

plans. The price changes were for manufacturer level prices and most of these medications are also widely used by persons of other age groups as well.

The CPI for prescription drugs (CPI-Rx) is not comparable to the AARP price index for several reasons: (1) different prices at different level of the market, (2) different patients and different drugs, (3) different methods.

First, these two indices measure *different prices* at *different levels of the market*. The inflation rate of CPI-Rx (2.7% in Sept. 2009) measured changes in retail prices from retail pharmacy outlets, while the inflation rate for the AARP price index (5.4% in aggregate for Sept. 2009) measured changes in manufacturer prices. A lower rate of retail-level price inflation (CPI-Rx) versus manufacturer-level price inflation (AARP price index) may result from retail price pressures that squeeze the margins of retail pharmacies but have little to no effect on manufacturer prices. In general, there has been continued downward pressure on retail prices and retail margins for the past two decades.

Second, the CPI-Rx considers *different patients* and *different drugs* than does the AARP price index. The CPI for prescription drugs is a more limited measure than the AARP combined price index for a variety of reasons as described in the AARP Rx Watchdog report[5]: "The CPI-Rx differs from the AARP price indices in several important ways. The CPI-Rx is a measure of retail price change for outpatient prescriptions used by urban consumers, while the AARP indices are measures of manufacturer price change for (outpatient) prescription drug products widely used by Medicare Part D enrollees. The CPI-Rx does not include rural U.S. residents, while the AARP indices do. The CPI-Rx also does not include specialty drugs, particularly those that are administered in physician's offices... While the AARP Rx Watchdog reports price change broken down to the level of specific manufacturers, therapeutic categories, brand versus generic drugs, traditional versus specialty drugs, or specific drug products, the CPI-Rx does not support reporting at the same level of specificity."

Third, different methodologies are used for calculating change in prices. The CPI for prescription drugs uses a methodology that incorporates factors that will typically lower the rate of inflation (e.g., substitution of generic prices for brand prices once a generic enters the market), but does not incorporate factors that would typically raise the rate of inflation (e.g., promotion and prescription of products resulting from patents on new strengths, dosage forms, or molecular manipulations for brands that go off patent). While the AARP Rx Watchdog reports price change broken down to the level of specific manufacturers, therapeutic categories, brand versus generic drugs, traditional versus specialty drugs, or specific drug products, the CPI-Rx does not support reporting at the same level of specificity.

Rebates and Discounts: Where Did They Go?

Neither the CPI-Rx nor the AARP index of prescription price change account for the effect of rebates and discounts. Rebates and discounts may potentially result in lowering the cost of prescription drugs to patients and to taxpayers, but that effect depends on where the rebates and discounts go. Rebates and discounts to the Medicaid program are collected at the program level by state Medicaid programs. In contrast, rebates and discounts, if any, under Medicare may be passed on to the consumer as a lower prescription price or as a lower Part D plan premium.

So where do the rebates go? After implementation of the Medicare Part D program, the DHHS Office of the Inspector General (OIG) conducted a study to determine whether or not the Medicare Part D prescription prices were different from the former Medicaid prescription prices for dual eligibles. The OIG found that the Medicaid reimbursement amount was actually 0.6% less than the Part D amount for a set of single source drug products.[6] This analysis was before accounting for rebates that are collected by the state Medicaid program. The Medicaid drug rebate is estimated to have provided about 33% rebate from minimum rebates, best price rebates, and inflation adjustment payments.[7] This does not even include the effect of state supplemental rebates. Pharmaceutical companies received a windfall of revenue from decreased rebate payments when dual eligibles were shifted from Medicaid to Medicar Part D.

In contrast, rebates, if any, under the Medicare Part D plans go entirely to the Part D plan rather than to CMS. Rebates to Medicare Part D plans generally do not benefit retail pharmacies and are not typically passed on to the Medicare beneficiary or to cash-paying consumers.[8] A Congressional study has found that Part D drug plans, on average, have negotiated rebates for less than 10 percent of the drug products covered by Medicare Part D. Eleven of twelve Part D drug plans surveyed by a Congressional committee indicated that they "will not pass the drug rebates they receive in 2007 through to beneficiaries in the form of lower prices at the pharmacy counter."[9]

Even though Medicare Part D plans do not generally pass rebates through to beneficiaries as a lower prescription price, they may use rebates to decrease the premiums for purchasing the Part D plan. Actual experience with Medicare Part D

[6] Office of the Inspector General, Department of Health and Human Services, *Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid*, OEI-03-07-00350, February 2009.
[7] "Dueling for Duals," *The RPM Report* (Windhover Information Inc.), Vol. 1, No.1 December 2005, pp.27-28.
[8] Rebates to Medicare Part D plans generally do not benefit retail pharmacies and are not typically passed on to the Medicare beneficiary or to cash-paying consumers (i.e., people who pay up front for their prescriptions when they are in the Medicare Part D coverage gap or who have no drug coverage or have indemnity insurance).
[9] United States House of Representatives, Committee on Oversight and Government Reform, *Medicare Part D: Drug Pricing and Manufacturer Windfalls*, July 2008. The reason such rebates have not been included in these AARP reports is not lack of interest, but rather lack of data. Absence of rebate data, however, has a limited effect on measures of change in prescription prices to Medicare Part D recipients.

premiums, however, over the past several years does not support that hypothesis. Part D premiums for 2010 have increased about 11% over 2009 Part D premiums.[10] Part D premiums also increased substantially (about 17%) in 2009 versus 2008. These increases in Medicare Part D premiums occurred at a time when drug utilization overall has leveled out or even declined slightly. Rebates, if they are having an effect on Part D premiums should lead to a reduction in premiums rather than an increase. If rebates are having an effect on Medicare beneficiaries or taxpayers, where did the rebates go? If rebates do not result in lower prescription prices or lower Part D premiums, their consideration in measuring price changes is not particularly relevant to the consumer or the taxpayer.

Forces Leading to Dramatic Drug Price Increases

There are many important prescription drugs on the market today that are relatively safe and effective and that result in improved health through prevention and management of acute and chronic conditions. In fact, when marketed, prescribed, managed, and used properly many of these medications can improve health outcomes, save lives, or even save costs in the health care market. Well-controlled and documented studies have demonstrated this positive health and economic impact from appropriate use of specific prescription drugs. However, one should not over-generalize this principle to conclude that "all increased spending on prescription drugs is always good and will always save lives and reduce expenditures." That over-generalization simply is not true.

Every drug, and its use, has an economic cost and as well it potentially has health benefits. Upon introduction the price of a new drug is established by the drug company and the drug product is monopoly protected by patents and other forms of exclusivity. In the U.S. market there is really no formal process for reviewing these prices to balance the costs and the benefits at a reasonable price. Irrespective of how the initial price is set, however, once the drug product is on the market, the beneficial effects of the drug are available to only those who have access to, and properly use, the drug product.

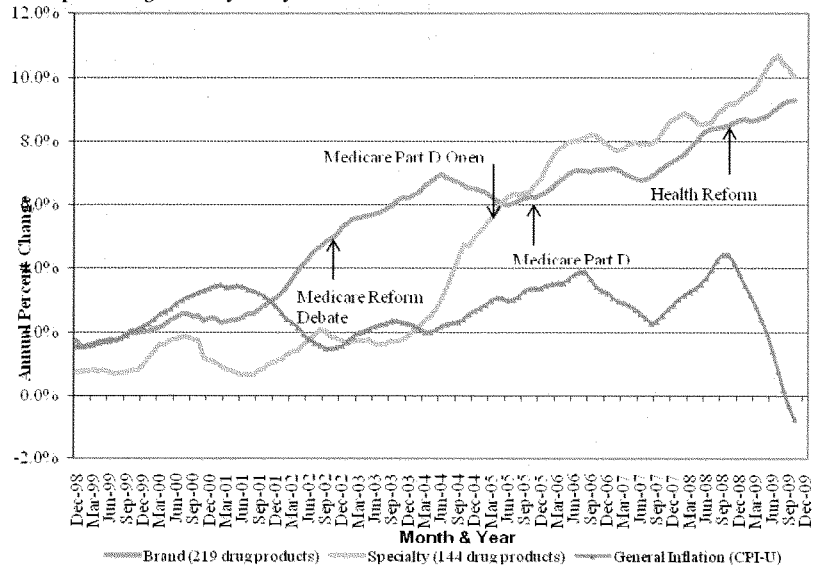
Once a drug product is on the market, any change in brand name prices (almost always an increase) at that point does not result in additional savings, but only in additional costs. For example, when the price of Zetia goes up 14.3% from Oct 2008 to Sept. 2009, the patient using this drug does not experience 14.3% in additional therapeutic benefit or 14.3% in reduced health care expenditures. The price change is entirely an added cost without added benefits from the use of that drug product. Indeed, there are serious concerns about over-promotion and over-use of prescription drugs that also raise questions about the use and value (therapeutic and economic) of many drugs

[10] Jack Hoadley, J Cubanski, E Hargrave, L Summer, and T Neuman, *Part D Plan Availability in 2010 and Key Changes Since 2006*, November 2009, Kaiser Family Foundation, www.kff.org.

currently on the market. Zetia and Vytorin, for example, most recently have come into questions about their effectiveness compared to other drugs that have been on the market for many years and that are available at substantially lower costs. Similar concerns have been raised with respect to brand name drugs used for diabetes, arthritis, hypertension, gastroesophageal reflux disease, and other conditions.

Curiously, prescription drug prices appear to rise more rapidly in periods just prior to major policy changes. Brand name and specialty drug prices accelerated before the Medicare Part D program was enacted and implemented. Now that serious legislative action related to health market reform is being discussed, again we see a dramatic acceleration in brand name and specialty prescription drug prices. (See Figure 5).

Figure 5: The Average Annual Percent Change in Manufacturer Prices for Most Widely Used Prescription Drugs and Key Policy Actions



Concluding Observations

The findings of the most recent AARP Watchdog report show that average annual increases in manufacturer prices charged to wholesalers and other direct purchasers for widely used prescription drugs have consistently and substantially exceeded the rate of general inflation. The combined set of manufacturer drug product prices grew at a faster rate in 2009 than in any of the previous 7 years. The overall drug price growth of 5.4% is attributable entirely to drug price growth among brand and specialty drugs that more than offset substantial price decreases among generic drugs.

Manufacturer drug price increases can have a direct impact on the costs borne by Medicare Part D enrollees, especially in a year when those living on Social Security income did not receive any Cost of Living Adjustment (COLA). Manufacturer price increases to the provider or pharmacy result in higher out-of-pocket costs for those beneficiaries who pay a percentage of drug costs (coinsurance) rather than a fixed dollar amount (copayment). The effect of higher drug manufacturer prices on the total price to the end payer means that Part D enrollees will get to the "donut hole"—the gap in coverage when enrollees have to pay all of their drug costs—much quicker. And, once enrollees are in the donut hole, they directly absorb the entire effect of the higher drug manufacturer prices on the prescription price to the end payer.

Mr. PALLONE. Mr. Smith.

STATEMENT OF RICK SMITH

Mr. SMITH. Thank you, Mr. Chairman, Ranking Member Deal, members of the committee; thanks for the invitation to testify today.

CBO reports that the pharmaceutical research sector is one of the most research-intensive industries in the United States. Companies' investment in discovering new medicines is yielding results. Also, according to CBO, many examples exist of major therapeutic gains achieved by the industry in recent years. The rapid increases that have been observed in R&D spending have been accompanied by major therapeutic gains. Extensive research also reports that medicines often reduce spending on other health care services.

The committee requested that I provide information on prescription drug pricing. As a trade association, PhRMA maintains a strict antitrust compliance policy. We can neither obtain nor discuss our members' proprietary information related to prices, negotiations, or discount strategies. My testimony, therefore, reflects only aggregate market data and publicly available information.

Recent government reports demonstrate that prescription drug cost growth has slowed dramatically. Findings about drug costs in the government's most recent national health expenditures data are summed up in the CMS report's title, national Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998.

According to CMS, prescription drug cost growth in 2007 was 4.9 percent, the lowest rate since 1963, and slower than health care overall. 2007 was not a 1-year blip; between 2003 and 2007, the average annual growth rate for prescription medicines dropped by half compared to the 1998 to 2002 period, and CMS's most recent 10-year projection reduced expected growth in prescription drug spending by $515 billion, or 14 percent, compared to 3 percent for the rest of health care. Likewise, CBO reports, from 2004 to 2007 drug expenditures grew by an average of just 3.2 percent per year, slightly less than the rate of growth in overall health care spending.

Since 1964, IMS Health has found that the U.S. Market grew by less than 5 percent only twice—2007 and 2008—and it now projects that growth will remain at historically low 4.5 to 5.5 percent in 2009, and will be 5 percent or less in each of the next 5 years.

At the same time the drug cost growth has slowed sharply; reports like those issued by AARP reach conclusions that conflict with government data and is skewed toward finding high price growth. These reports exaggerate drug price trends by failing to reflect the way public policy and the prescription drug market function. Our system is designed to fund the next generation of medical advances through innovator drugs that have a limited time on the market before going generic and to achieve cost savings through the high use of generics. Large, powerful payers use a variety of tools such as tiered formularies to negotiate lower brand prices while driving high use of generics, which now account for about 70 percent of all prescriptions.

We don't believe that each tool used by a purchaser always yields the best possible outcome, and we are encouraged by forward-looking purchasers who are looking at alternatives that make better use of medicines to improve care and control costs. Nonetheless, under the current system, drug costs as a whole are growing slowly, not fast, and consumers use drugs that were once innovator molecules as generics in large volume for many years with little or no return to the innovator.

The importance of understanding how the market operates when interpreting pricing data is evident in AARP's most recent report. Eight of the drugs on AARP's list of the top 25 brand drugs are sold as generics. These drugs are counted in AARP's brand price calculation as though patients continue to use them at brand prices, even though brand drugs typically lose nearly all of their sales after going generic.

In one example, for a statin, 99 percent of the utilization for that statin on AARP'S list of top-used brand drugs is now generic, and the cost per day of therapy has dropped by 58 percent over 3 years, not reflected in the AARP report.

The Federal Government CPI data on prescription medicines includes a market basket of brand and generics that reflects what consumers actually buy. In the 3 years ended October, 2009, drug prices rose by an average of 2.3 percent per year, compared to 3.8 percent for all medical care. For the most recent year, the government's measure of drug price growth was 2.7 percent.

The implicit message of reports on brand prices seems to be that the pharmaceutical research companies stand to be in a uniquely favorably position. In fact, the sector is currently characterized by slow growth, rapid substitution of generics for brand medicines, a projected $90 billion in sales facing generic entry over the next 5 years, and the exceptional challenges inherent in discovering new medicines that safely and effectively treat disease.

Through October of this year, 58,000 job cuts have been announced in the industry, on top of cuts in 2007 and 2008. Nonetheless, there is reason for optimism that new medicines will continue to improve medical care in the future. Investment in pursuing these objectives accounted for by the 10 percent of health spending going to medicines is repaid to society in longer, healthier, more productive lives.

Mr. Chairman, in conclusion, I will note that the National Economic Council recently published a document titled Strategy for American Innovation: Driving Towards Sustainable Growth and Quality Jobs, which identifies new treatments such as smart anticancer therapeutics and personalized medicine as among the 21st century's grand challenges. Achieving these challenges is viewed as important to improving the quality of life and establishing the foundation for industries and jobs of the future. The biopharmaceutical research sector looks forward to its role in bringing these goals to fruition.

Again, Mr. Chairman, Ranking Member Deal, thank you for the invitation to testify.

Mr. PALLONE. Thank you, Mr. Smith.

[The prepared statement of Mr. Smith follows:]

RICHARD I. SMITH
SENIOR VICE PRESIDENT, POLICY AND RESEARCH
PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA

BEFORE THE U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

December 8, 2009

Chairman Pallone, Ranking Member Deal, and Members of the Subcommittee, thank you for the invitation to participate in today's hearing on prescription drug prices. My name is Richard I. Smith and I am Senior Vice President for Policy and Research of the Pharmaceutical Research and Manufacturers of America (PhRMA).

PhRMA represents the pharmaceutical and biotechnology research sector, which the Congressional Budget Office (CBO) identifies as "one of the most research-intensive industries in the United States."[i] This research investment is yielding extraordinary advances for patients.

As CBO summarizes, "Many examples exist of major therapeutic gains achieved by the industry in recent years...anecdotal and statistical evidence suggests that the rapid increases that have been observed in drug-related R&D spending have been accompanied by major therapeutic gains in available drug treatments."[ii] For instance:

- The Centers for Disease Control and Prevention has identified "new drugs and expanded uses for existing drugs" as contributing to the decline in heart disease and stroke mortality.[iii] Johns Hopkins Medicine professors, writing in the journal *Health Affairs*, report that, while medicines treating cardiovascular disease are not a cure, "Protein enzymes, receptors, or channels identified by the pharmaceutical industry as 'drugable targets' have led to striking, remarkable, and repeated achievement."[iv]

- Academic researchers have associated new medicines with declines in mortality for HIV/AIDS,[v] breast cancer,[vi] and other cancers;[vii] reduced disability rates among elderly persons;[viii] and increased productivity among workers with conditions like rheumatoid arthritis[ix] and depression.[x]

- Many peer-reviewed studies report that medicines help reduce spending on other health care services, principally by helping effectively manage health conditions so that patients can avoid expensive hospitalizations or emergency care.[xi] In addition to these academic studies, a CMS evaluation of a demonstration project recently showed that improving access to medicines for 7 chronic diseases by reducing cost-sharing "reduced gross Medicare spending by 12 percent on average."[xii]

The continuing development of new medicines has a leading role in improving health and health care. For instance, the prevalence of Alzheimer's disease will

increase sharply over the next few decades, imposing large human and economic costs. A report for the Alzheimer's Association projects that new treatments that delay the onset or slow the progression of Alzheimer's by five years could save $100 billion annually in Medicare and Medicaid costs by 2020.[xiii] Likewise, researchers estimate that the number of patients with Parkinson's disease will double by 2030, resulting in an enormous public health challenge.[xiv] The authors of this projection note that the answer "will come from more research and new treatments that protect against Parkinson's, or slow its course."[xv]

Likewise, new drug development's continuing importance to our society is evident in the National Economic Council's (NEC) September 2009 report, *A Strategy for American Innovation: Driving Towards Sustainable Growth and Quality Jobs*. NEC identifies developing "smart anti-cancer therapeutics that kill cancer cells and leave their normal neighbors untouched", "personalized medicine that enables the prescription of the right doses of the right drug for the right person", "nanotechnology that delivers drugs precisely to the desired tissue" and "a universal vaccine for influenza that will protect against all future strains" as among the "Grand Challenges" of the 21st Century for which we must harness science and technology. NEC views meeting the ambitious goals embedded in these Grand Challenges as "improv[ing] our quality of life and establish[ing] the foundation for the industries and jobs of the future."[xvi]

Recent government reports show that prescription drug cost growth has slowed dramatically compared to earlier in the decade—from a high double digit annual growth rate to one in the low to mid-single digits. In fact, government data show that prescription medicine costs have grown more slowly in recent years than the costs of many other health care services. As this slowdown in cost growth has occurred, other reports have claimed that brand drug prices are rapidly increasing. These reports do not reflect the way that the prescription drug market functions and therefore exaggerate prescription drug price trends. Moreover, these reports seem to have no parallel measure of the disproportionately large benefits achieved by the small share of health spending accounted for by medicines.

As a trade association, PhRMA maintains a strict antitrust compliance policy. The antitrust laws prohibit us from obtaining or discussing our members' proprietary information about the prices or discounts each individual company negotiates independently with its customers or the ways in which each company determines the prices or discounts it will offer. Therefore, I do not have information concerning any individual company's pricing or discounting policies or practices. My testimony addresses overall trends based on aggregate, market-wide data and government reported information.

Prescription Drug Cost Trends Have Slowed Dramatically

Short term cyclical changes in prices (up or down) do not reflect underlying trends in drug spending. The most recent available National Health Expenditures (NHE) Account data, issued by CMS, covers 2007 and reports that drugs were about 10 percent of national health spending. The report's findings about drug costs are summed up in its title--"National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998." In 2007, prescription drug cost growth was 4.9 percent (the lowest rate since 1963), compared to 6.1 percent for health care overall.[xvii] This rate is far lower than growth experienced in the last decade; for example, prescription drug cost growth was 13.3 percent in 1997 and 14.0 percent in 2002. The slowdown in drug spending was not a one-year aberration. From 2003-2007, the average annual growth rate was half of the rate for 1998-2002.[xviii]

CMS's NHE data also point to prescription medicines playing a smaller role in overall health care cost growth. In 2002, prescription medicines accounted for about 18 percent of the growth in National Health Expenditures. In 2007, prescription medicines accounted for 8 percent of growth in NHE. Other services accounted for the remaining 92 percent of cost growth. In 2009, CMS's Office of the Actuary reduced its 2008-2017 cumulative projection for prescription drug spending by $515 billion, or 14 percent. This compares to a decline of 3 percent for all health care except prescription medicines.[xix]

IMS Health provides another measure of drug cost trends. Like CMS, it reports that cost trends are far lower today than a few years ago. For instance, between 1997 and 2003, IMS reports drug cost grew at a simple average rate of 14.9 percent per year.[xx] In the following five years, this dropped to 5.4 percent. For 2009 alone, IMS projects total prescription drug cost growth of 4.5 to 5.5 percent—the mid-point of this range would be the third lowest growth rate reported by IMS since 1995, and over 5 percentage points lower than the average growth rate since 1995.

IMS has reported growth rates below five percent only twice in the last forty-five years: -- 2007 (3.8 percent growth) and 2008 (1.3 percent growth).[xxi] Despite growth below 5 percent only twice since 1964, IMS now projects growth below 5 percent for each of the next five years. IMS's most up-to-date forecast states that "market growth is expected to remain at historically low levels," averaging 3.5 percent per year from 2009 through 2013.[xxii] This is about 11 percentage points lower than the growth rate reported by IMS for the 1997-2003 period.

CBO has found that Medicare Part D is costing far less than previously projected, principally because of "the competition that's occurring in the private market" among plans.[xxiii] Medicare Part D plans have achieved significant cost savings for beneficiaries and taxpayers by negotiating greater-than-expected discounts from prescription drug manufacturers. CBO's 2009 estimate for total Medicare

Part D spending over 10 years (FY 2007-2016) has dropped $520 billion, or 43 percent, compared with CBO's 2006 estimate for the same period.[xxiv] Part D plan bids for 2010 were up just 4.7 percent from the previous year, and are actually 4.3 percent lower than bids in 2006.[xxv]

CBO also confirms that the rate of growth for prescription drugs in recent years has been historically low. In an October 2009 paper, it reported that "From 2004 to 2007, drug expenditures grew by an average of just 3.2 percent per year, slightly less than the rate of growth in overall health care spending."[xxvi]

There are many reasons for this lower growth rate, including but not limited to the emergence of powerful, aggressive purchasers who bring many tools to bear in negotiating for lower drug costs. Using multi-tier formularies (which spread over the past decade from a small share of the market to nearly the entire market), prior authorization and step therapy, these purchasers have been able to drive a very high level of generic use and relatively low level of brand drug use.[xxvii] Moreover, they have driven virtually all brand use to their preferred tier where they typically receive the biggest discount from drug manufacturers.[xxviii] Many drugs have come off patent. These molecules developed by innovator companies continue to be widely used by patients and continue to achieve important health benefits at a low cost to the patient with little to no return to the innovator company.[xxix] And fewer new drugs have been approved in recent

years, notwithstanding innovator companies' intensive effort and large scale investment in drug discovery.

Reports on Prices (1) Misunderstand How Public Policy and the Market Are Structured to Promote Continued Innovation and Savings and (2) Exaggerate Price Trends

Some reports attempt to isolate price trends just for brand drugs. This approach is inconsistent with how public policy and the market operate. Our system is designed to:

(1) fund the next generation of medical advances through innovator drugs that have a limited time on the market[1] before nearly all of their use is converted to generic substitutes, while

(2) achieve cost savings through high use of generics that do not support research contributing to medical advances.

As noted above, powerful payers use numerous tools to drive generic use as high as possible, while negotiating aggressively for rebates on brand drugs. Today, nearly three out of every four prescriptions used by patients is dispensed

[1] Peer-reviewed research reports that only 3 out of 10 marketed drugs earn sufficient revenue to achieve a positive return on their research and development investment. J. DiMasi and H. Grabowski, "The Cost of Biopharmaceutical R&D: Is Biotech Different?," *Managerial and Decision Economics*, 2007. More recent analysis reports that this has dropped to 2 out of 10 marketed drugs earning sufficient revenue to achieve a positive return. J. Vernon et al., "Drug Development Costs when Financial Risk is Measured Using the Fama-French Three Factor Model," Unpublished Working Paper, 2008;

as a generic.[xxx] And CRS reports "[l]arge pharmacy benefit managers (PBMs)[2], such as Advance PCS (75 million covered individuals), Medco Health Solutions (65 million) and Express Scripts (57 million) have significant market power and an established track record in negotiating prescription drug discounts for large populations."[xxxi]

We do not believe that all of the cost containment tools used by purchasers always yield the best possible outcomes, [3] and are encouraged that some forward-looking employers and insurers are experimenting with alternative, quality-based approaches that make better use of medicines, including both brands and generics, to improve patient outcomes and control overall health costs.[xxxii] Nonetheless, this market-based system has led to drug costs that as a whole are growing more slowly than health costs overall, and it has allowed consumers to use drugs that were once innovator molecules as generics in large volume for many years.

Analyses that seek to isolate price trends for brand drugs do not recognize these features of our market system, thereby reaching conclusions that conflict with these government-reported data and appear to be skewed toward finding higher prices. For instance:

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[2] In 2009, the top five PBMs purchased 62 percent of all prescriptions sold.

[3] For example, there is extensive evidence that improved patient adherence to prescribed therapies can improve health and reduce overall costs, and that high cost sharing and barriers to access may have adverse consequences. For example, see D.T. Lau and D.P. Nau, "Oral Antihyperglycemic Medication Nonadherence and Subsequent Hospitalization Among Individuals with Type 2 Diabetes." *Diabetes Care*, September 2004; D.Goldman et al, "Pharmacy Benefits and the Use of Drugs by the Chronically Ill." *JAMA*, May 2004; D. Goldman et al, "Prescription Drug Cost-Sharing: Associations with Medication and Medical Utilization and Spending and Health." *JAMA*, July 2007.

- Analyses that track prices over time typically fail to adjust for the price drop that occurs when a brand medicine goes off patent and patients convert to using the drug's generic form. For instance, eight of the drugs included in the top 25 brands tracked by the AARP report are now sold as generics.[xxxiii] These drugs appear to be counted in that report's brand price calculation as though patients continue to use the same volume of these drugs as they did in 2006, even though brand drugs typically lose nearly all of their sales after going generic[xxxiv]—specifically because of the policy and market factors discussed above. This has the effect of overstating consumers' actual cost for these therapies.

    - For example, a statin on AARP's list has been available as a generic since 2006 and by 2009 less than 1 percent of sales were for the brand form of the medicine. Approaches that treat generic use at generic prices as if they are brand use at brand prices do not reflect consumers' experience, since they calculate price growth (1) as if the volume of the brand drug used today is the same as it was in 2006, even though 99 percent of the use is now generic and (2) as if consumers are paying brand price for this drug, even though they are paying generic price. When we use an approach based on what

consumers actually purchase to look at average price growth for this medicine, we find that between 2006 and 2009 the average price per prescription (including purchases of both brand and generic) declined by 58 percent.

- The federal government's publicly available data on medical inflation is the best, most current measure of price trends for medical costs. These government data show that prescription drug prices grew by 2.3 percent per year on average for the last three years – more slowly than prices for medical care overall and for most other medical services tracked by CPI. [xxxv]

    - Government's CPI data on prescription medicines includes a market basket of brands and generics that reflects what consumers actually buy. These same government CPI data show prescription drug prices grew 2.7 percent during the 12 months ending September 2009, which is half of the 5.4 percent reported by AARP for its own sample of drugs.[xxxvi] One analyst has written of AARP's report, "Comparing list prices for a single product category to a computed, non-list price index for a broad basket of goods (CPI-U) is mathematically illogical. After all, the CPI-U for prescription drugs increased at a rate less than half the rate of list prices."[xxxvii]

- Many reports rely on data that exclude off-invoice discounts and rebates, and so do not take into account rebates paid by brand manufacturers that lower drug costs. This is akin to analyzing sticker prices, when the actual price paid is often much lower, due to negotiations between purchasers and manufacturers.[4] Reports based on this type of data do not reflect these additional savings to purchasers. To illustrate, if Thrifty Car Rental bought a fleet of cars from Ford motor, it would negotiate a purchase price below the sticker price. An analyst wouldn't determine the cost of the deal by going to the local Ford dealer, writing down the sticker price, and multiplying it by the number of cars purchased. As discussed above and as referenced in the CRS report, the same type of negotiation that would occur between Hertz and Ford occurs when a major health plan or PBM, typically buying on behalf of millions or tens of millions of people, agrees to put a drug on their formulary.

[4] According to the Medicare Trustees, under Part D, "Many brand-name prescription drugs carry substantial rebates, often as much as 20-30 percent." In 2008, Medicare actuaries estimated savings through discounts, rebates, and utilization management techniques in Part D were 29 percent—almost double the 15 percent originally projected in the 2005 Medicare Trustees Report for the first year of the program. (2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 162; and 2005 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 144; and Testimony of Kerry Weems, CMS Acting Administrator before the House Oversight and Government Reform Committee, July 24, 2008. Medicare actuaries in OACT conduct all analyses in Medicare Trustees Reports.)

The Pharmaceutical Research Sector is Facing Significant Challenges as It Works to Develop the Next Generation of Medicines

The implicit message of reports on brand prices, such as AARP's, seems to be that the pharmaceutical research sector stands in a uniquely favorable position. In fact, the sector currently is characterized by slow growth, rapid substitution of generics for brand medicines, and the exceptional challenges inherent in discovering new medicines that safely and effectively treat disease. One source projects that 18 best selling brand medicines accounting for $90 billion of U.S. sales will go off patent over the next 4 years[xxxviii]—meaning that these drugs will become widely available and used at generic prices, as our system uses its various tools to rapidly substitute generics for virtually all use of the innovator drug. In this context, the sector has been forced to cut jobs—58,000 through October of this year as reported by *Forbes*,[xxxix] on the heels of significant cuts in 2007 and 2008.

Notwithstanding these challenges, there is much reason for optimism that valuable new medicines will continue to improve medical care into the future as they have in recent decades. This is evident in the opportunities being created by advances in scientific understanding, a pipeline of drug candidates targeting many conditions that do not currently have adequate treatments, and companies' on going efforts to reengineer the drug discovery process. The Grand Challenges identified by the National Economic Council and involving advances

in medicines can be realized. Investment in pursuing these objectives is accounted for by the share of health spending going to brand medicines is repaid to society in longer, healthier, more productive lives.[xl]

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[xvii] M. Hartman et al., "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998." *Health Affairs*, January/February 2009.
[xviii] PhRMA analysis based on Centers for Medicare & Medicaid National Health Expenditure Accounts, available at: http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage
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[xx] PhRMA calculation based on IMS Health Prescription Drug Audit, 2009.
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[xxv] CMS Office of the Actuary memo, "Release of the 2010 Part D National Average Monthly Bid Amount," August 13, 2009, found at www.cms.hhs.gov.
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Mr. PALLONE. Ms. Stoll.

STATEMENT OF KATHLEEN STOLL

Ms. STOLL. Thank you, Chairman, and thank you, Ranking Member Deal, members of the subcommittee. My voice isn't quite as loud as the previous gentleman.

I think we have heard a lot of numbers. I am going to actually give us a little pause from the numbers. I have got a few stats, but I also want to paint a picture of what it means to have rising prescription drug spending and prices for consumers. Let me just give you a few numbers, but let me mix in some stories.

Increasing access to affordable prescription drug coverage is a top issue for Families USA. We have seen prescription drug spending by consumers more than double in the last 10 years.

Now, it is fair to say that that spending is driven by more than just price increases. People are using more drugs, and in many cases that is a good thing. Prescription drug use has increased 72 percent while the population is only growing by 11 percent. That is a pretty good business proposition, I think.

Utilization has also changed. That means the kinds of drugs people take has changed. And some of the drugs, the new drugs on the market, the biologics, are more expensive. That is not necessarily a bad thing because many of them are real breakthrough drugs. But we do see statistics that show that spending on biologic drugs is growing nearly twice as quickly as other traditional chemical drugs.

And the third element of why consumers are spending more on drugs—or are trying to spend more on drugs—is the cost of prescription drugs, and that is what this hearing is about; and drugs are becoming more expensive.

We can go back and forth with stats. I think we should be careful that we understand that reduction in the rate of growth still means you have a rate of growth. What we have seen is that between 1997 and 2007, retail drug prices, which is what counts for consumers, have increased an average of about 6.9 percent a year. That is about 2½ times faster than general consumer inflation. It seems like that trend might be accelerating; it is really hard to say, and I leave that to Steve.

So what does this mean for consumers? If you look at uninsured consumers, uninsured adults, half report that they don't get their prescription drugs filled. They don't get their prescriptions filled and don't seek needed refills. And I pause here now to tell you a story, and I'm not going to tell you a story of a dramatic disease—perhaps a rare disease with a dramatic cure.

Let me just tell you about a single mom that came to our attention. She has a severe problem with migraines. They are debilitating. Her vision is impaired by them. And she is really left unable to function. And because of her migraines, she misses many days of work and many days with her son.

She doesn't have insurance. She does work full time. And she finally went to a headache specialist and they went through a couple of different drugs. He had some samples. After three or four, they found one that works. It is actually like a miracle drug for her. So we do thank the pharmaceutical industry for this breakthrough

drug. I am not going to name it. The problem is that this brand name drug that provides her tremendous relief for debilitation migraines is very, very expensive. So you know where the story is going.

She can get the prescription filled. She gets six at a time. And it really takes hundreds of dollars to fill this prescription for six pills. So what she has told us is that she saves her pills and if she gets a real severe migraine, her doctor said, Take it right away, don't wait; but she holds on to those pills because they are so expensive. And she will go ahead and have a migraine because she doesn't take it early when she should.

The end of the story is what she shared with me, which is she had one pill left 1 month, and she knew it was very expensive, she wouldn't be able to replace it, and her son pays the trumpet and he had a recital coming. So she held on to that pill, went through three severe migraines, missed time at work, missed paychecks, in order to be able to take that pill on the day of the son's recital. She ended up not having a headache that day, but she wanted the insurance.

So that is what we are dealing with at the consumer level. If we could bring down the name of that brand drug, it would mean a tremendous difference for this woman who is uninsured.

She's uninsured. Many Americans who have health insurance are still unable to afford prescription drugs. You all know that as premiums go up, people are buying plans with higher deductibles, higher copays. They may have special deductibles and copays just for prescription drugs. So they end up underinsured when it comes to prescription drug coverage. They, too, make difficult decisions. They paid for coverage; because they are underinsured or may not have prescription drug coverage at all, two out of five of these folks underinsured actually go without filling their prescriptions as well. So, a problem of the uninsured and the underinsured.

Of course, some folks don't have coverage through their employer. They are in the individual market. I would just point out that in the unregulated individual insurance market consumers are four times less likely to have prescription drug coverage at all. Certainly, for people with chronic conditions, that is where we see the most impact in terms of high prescription drug spending. A person with a single chronic condition can spend—about 36 percent of their out-of-pocket costs will be for prescription drugs. If it is a person with two or more chronic conditions, their out-of-pocket spending for drugs can be six times higher than their hospital costs.

Now that is not necessarily a bad thing. I am just giving you a sense of the impact on consumers. It may be those prescription drugs are keeping them out of the hospital. Certainly, we know that there is a toll in terms of reduced quality of life, reduced productivity; and sometimes it means death not to have access to prescription drugs. It also means that our health care system has higher costs long term.

I will tell you one more story. It is a story of a child with asthma. Both of this child's parents work full time. They have pretty good insurance coverage for themselves. They have no dependent insurance coverage. So their kid is not covered. Their son has asthma. He needs a maintenance drug that costs a couple hundred dollars

a month. Because they don't have dependent coverage for their son—and they don't qualify for CHIP, by the way—their son doesn't get the asthma medication on a regular basis. They can't afford it. It is hundreds of bucks a month. These are low-wage working parents.

They have tried things like making their fifth-grade son wear a mask when he goes to school to help with the maintenance and the management of the asthma. If you have ever tried to send a fifth-grade boy off to school with a mask, you know that is probably not going to work too well.

So the end of the story is, obviously, the child without regular asthma medication to maintain and monitor his asthma to keep it under control, he ended up in the emergency room and he had a very high-cost hospitalization, and it had a very hard financial impact on the family.

Mr. PALLONE. I appreciate it. I am going to ask you to stop now because you are almost 3 minutes, but thank you.

[The prepared statement of Ms. Stoll follows:]

Written Statement for the Record by
Kathleen Stoll, Deputy Executive Director, Director of Health Policy
Families USA

For the U.S. House of Representatives
Committee on Energy and Commerce, Subcommittee on Health

"Prescription Drug Price Inflation: Are Prices Rising Too Fast?"
Tuesday, December 8, 2009
2123 Rayburn House Office Building

Mr. Chairman, Members of the Committee:

Thank you for inviting Families USA to participate in today's hearing on the effect of rising prescription drug costs on consumers. Families USA is the national organization for health care consumers. For nearly 30 years, our organization has worked to ensure that affordable, quality health coverage becomes a reality for all Americans. Unfortunately, over the last decade, rising health care costs have priced millions of Americans out of quality coverage. As a result, millions more have joined the ranks of the uninsured and underinsured, and fewer Americans have quality prescription drug coverage. Health reform legislation passed in the House of Representatives and currently being debated in the Senate will ameliorate this problem by increasing access to quality, affordable coverage – including prescription drug coverage – for millions of families.

Increasing access to affordable prescription drug coverage is more urgent than ever. In recent years, Americans have spent a significantly larger amount on prescription drugs. In fact, total spending on prescription drugs in the United States nearly doubled between 2000 and 2007, rising from $120.6 billion to $227.5 billion.[1]

Three primary factors are driving the increase in prescription drug spending. First, people are using more prescription drugs than they previously did. Between 1997 and 2007, the number of

[1] National Health Expenditure Accounts, available online at http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf.

prescriptions filled in the United States rose by 72 percent, while the United States population grew by only 11 percent.[2] Secondly, the cost of prescription drugs has become more expensive. During the same period between 1997 and 2007, retail drug prices increased an average of 6.9 percent per year, more than 2.5 times the rate of the annual rate of inflation (which was 2.6 percent per year over the same period).[3] Finally, over the past few decades, prescription drugs have changed the face of medical treatment. Today, prescription drugs can help prevent, treat or cure many health conditions, and the potential quality of life and health improvements of these treatments are substantial. As new drugs become available, prescribing patterns change, and this drives a shift in health care spending. In recent years, the advent of biologic drugs – drugs that are created from living cells, tissues or organisms through a biologic process rather than those that are chemical in nature – have had a marked effect on both the practice of medicine and prescription drug spending. Biologic drugs have offered new treatment options for conditions such as cancer and rheumatoid arthritis, but they are extremely expensive. For example, Avastin, a biologic drug that is used to treat advanced cases of colon, lung, or breast cancer can cost up to $100,000 per year.[4] Estimates indicate that spending on biologic drugs is now growing nearly twice as quickly as spending on traditional chemical drugs.[5]

The combination of these three factors – the rise in utilization, an increase in prescription drug prices, and a shift in the type of drugs prescribed – have had a profound effect on Americans' ability to access affordable prescription drugs.

Uninsured Americans face a disproportionate barrier in accessing affordable prescription drugs.

According to the most recent Census Bureau numbers, 46.3 million Americans were uninsured for the entirety of 2008. The recent economic downturn has had a profound adverse impact on American families. Since 2008, millions of Americans have likely joined the ranks of the

[2] *Prescription Drug Trends.* (Washington: Kaiser Family Foundation: September 2008).
[3] Ibid.
[4] Gina Kolata and Andrew Pollack, "Costly Cancer Drug Offers Hope, but Also a Dilemma," *New York Times,* July 6, 2008.
[5] *Biologics in Perspective: The Case for Generic Biologic Drugs,* (Washington: AARP).

uninsured due to rising unemployment through 2009. A recent Families USA analysis found that four million more working-age adults are uninsured in 2009 than in 2008.[6]

Going without coverage – including prescription drug coverage – puts families at risk both physically and financially. The uninsured are more likely to delay or forgo care, and are more likely to be diagnosed with conditions in later stages. The uninsured are also more likely to face trouble obtaining prescription drugs when necessary and are more likely than those with insurance to report having skipped filling a prescription due to cost. In fact, in 2007, nearly 12.5 million working-age Americans without health insurance reported having unmet prescription drug needs.[7] In addition, nearly half of adults who reported having been uninsured in the past year said that they did not fill a prescription because it was too expensive.[8] With no prescription drug coverage, uninsured individuals must pay the full price out-of-pocket or rely on prescription assistance programs, which offer limited discounts.

The Affordable Health Care for America Act would extend coverage – including prescription drug coverage – to an estimated 36 million Americans by 2019, reducing barriers to access for the uninsured.

Many Americans with health insurance are still unable to afford prescription drugs. As the cost of health coverage continues to rise, many Americans are choosing to purchase coverage that is less expensive – but it comes with higher costs when they actually need the care. These health plans often have high deductibles and larger copayments, and cover fewer services. Americans who spend more than 10 percent of income on out-of-pocket costs beyond premiums (five percent of income for families with income below 200 percent of poverty) or individuals who are in a plan with a deductible that exceeds five percent of income are considered

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[6] *One-Two Punch: Unemployed and Uninsured* (Washington: Families USA, October 2009), available online at http://www.familiesusa.org/assets/pdfs/one-two-punch.pdf.

[7] Laurie E. Felland, James D. Reschovsky, Center for Studying Health System Change, "More Nonelderly Americans Face Problems Affording Prescription Drugs," (January 2009), available online at http://www.hschange.com/CONTENT/1039/.

[8] *Losing Ground: How the Loss of Adequate Health Insurance is Burdening Working Families* (Washington: The Commonwealth Fund, August 2008).

underinsured. In 2007, an estimated 25 million adults (ages 19-64) were underinsured, a 60 percent increase since 2003.[9]

When Americans are underinsured, they often have to make decisions that compromise their health. More than two in five underinsured adults reported that they did not fill a prescription because of costs in the past year.[10]

The Affordable Health Care for America Act will improve the quality of coverage for millions of Americans by eliminating annual and lifetime caps, putting caps on out-of-pocket costs in place and requiring that all plans meet minimum benefit standards. By ensuring that all Americans have access to quality coverage that provides adequate financial protection, consumers will both have the prescription drug coverage that they need and will be less likely to skip filling necessary prescriptions due to cost.

Americans who have health insurance plans in the individual market are less likely to have prescription drug coverage.

Those who do not have an offer of coverage through their place of work or through a public program often must seek coverage on their own through the individual health insurance market. Coverage in the individual market is often more costly and less comprehensive than group coverage provided through the workplace. In order to obtain affordable coverage, many consumers purchase a plan that limits the benefits covered or includes a high deductible. For example, many plans in the individual market do not include prescription drug coverage. In fact, people with individual coverage are four times more likely to have a plan that does not include prescription drug coverage compared to those with employer-based coverage (20 percent versus 5 percent).[11]

The Affordable Health Care for America Act, H.R. 3962, would require that all health plans, including those sold in the individual market, cover prescription drugs.

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[9] Cathy Schoen, Sara R. Collins, et al, "How Many Are Underinsured? Trends Among U.S. Adults, 2003 And 2007," *Health Affairs* 27, no. 4 (2008): w298-w309).

[10] Ibid.

[11] *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families* (Washington: The Commonwealth Fund: July 2009).

Americans with chronic conditions have the greatest need for affordable prescription drug coverage.

People with chronic conditions are particularly at risk when it comes to the high cost of prescription drugs. For example, 98 percent of people with diabetes use prescription drugs. In fact, adults with diabetes fill about four times as many prescriptions and spend about four times as much on prescription drugs as the general population.[12] As a result, out-of-pocket spending on prescription drugs is the single largest contributor to health-related financial burdens for those with chronic conditions. Among adults who spent more than 10 percent of their income on out-of-pocket costs (beyond premiums) in two consecutive years, spending on prescription drugs accounted for 55 percent of total out-of-pocket costs. For those with a single chronic condition, prescription drug costs accounted for 36 percent of out-of-pocket spending. Spending on prescription drugs, particularly among those with two or more chronic conditions, dwarfs spending on all other medical services. Out-of-pocket spending on prescription drugs among those with two or more chronic conditions was more than six times higher than out-of-pocket spending for hospital-based services (55 percent versus 9 percent).[13]

The Affordable Health Care for America Act, H.R. 3962, will assist those with chronic conditions by ensuring that everyone has access to quality, affordable coverage that limits out-of-pocket spending on services, including prescription drugs.

Access to affordable, quality health coverage – including prescription drug coverage – will help to improve health outcomes and decrease overall health costs.

Unaffordable prescription drug prices affect Americans across the spectrum. Each day, Americans choose not to fill their prescriptions so they can put food on the table for their families. At the same time, many other Americans cut their pills in half because they cannot afford filling an entire prescription. And every night, a parent goes to bed worrying about how to afford the medicine that someone in their family, even their child, desperately needs.

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[12] Center on Aging Society, Georgetown University. Data Profile Number 5, (September 2002), available online at http://ihcrp.georgetown.edu/agingsociety/pubhtml/rxdrugs/rxdrugs.html.

[13] *Chronic Burdens: The Persistently High Out-of-Pocket Health Care Expenses Faced by Many Americans with Chronic Conditions* (Washington: The Commonwealth Fund: July 2009).

We regularly hear stories of people who cannot afford prescription drugs, even from people who have insurance. Consider children with asthma. Parents who cannot afford their employer's coverage may turn to purchase insurance in the individual market. The only policy they can afford has a high deductible and does not include prescription drug coverage. Their child's maintenance medication for asthma costs hundreds of dollars a month that the family simply does not have. As a result, the child skips doses, and ultimately ends up being hospitalized for an asthma attack that could easily have been prevented.

When Americans cut back on the prescriptions they need, they often end up in the hospital. More emergency room visits, hospital admissions or doctor visits may increase overall health care costs. In addition, this simply makes no sense for the health and well-being of people who have chronic diseases that can be managed with prescription drugs.

The Affordable Health Care for America Act will help to ensure that American families have access to affordable, quality health care – including affordable prescription drugs – that they can count on no matter their life circumstances.

Mr. PALLONE. Professor Vernon.

STATEMENT OF JOHN A. VERNON, Ph.D.

Mr. VERNON. Mr. Chairman and members of the committee, thank you for the invitation to testify today. My name is John Vernon and I am a professor in the Department of Health Policy and Management at the University of North Carolina at Chapel Hill and a Faculty Research Fellow with the National Bureau of Economic Research.

In addition to discussing the issue of rising drug prices, I will also discuss the role drug prices pay in firm- and industry-level R&D investment. The latter is of critical importance because considering drug prices in isolation is not useful. The tradeoff between drug prices, industry profits, and innovation is what is relevant. My research on this point is based on unfunded research published in the peer-reviewed economics literature.

Regarding the issue of rising drug prices in the U.S., the conclusions drawn by the AARP report are based on flawed methods and, thus, are misleading. Some of the more serious flaws with the analysis are:

The AARP report is based on wholesale prices, not retail prices or transaction prices, which are often substantially lower than wholesale prices. This is because PBMs and insurers negotiate discounts, often steep discounts, and rebates with manufacturers.

Second, the AARP report is an analysis of branded products only. The burden to U.S. consumers of prescription medications associated with access to prescription drugs should also consider generic drugs, which in the U.S. have among the lowest prices in the world and the highest utilization rate.

For example, approximately 70 percent of all prescription drugs dispensed are generic drugs. So we have both the highest utilization rate and the lowest prices. Much of this credit goes, of course, to the 1984 Waxman-Hatch Act, which did a nice job of balancing innovation with generic competition.

Three, in the AARP report, 10 of the top 25 branded pharmaceuticals in their study actually have generic versions currently on the market. Mandatory generic substitution laws in most States implies that the lower-cost generic versions of these 10 brands drugs are dispensed to consumers, not the branded versions.

In my opinion and based on my experience as both an academic journal editor and peer-reviewer for academic journals, this study, as it stands, does not meet the peer-review standard for economic publication—and that is the hallmark of academic research. A better measure, in my opinion, of drug price trends in the U.S., one that is based on retail prices, not wholesale prices, and which also captures the cost savings from generic competition and substitution, is the prescription drug Consumer Price Index reported by the U.S. Bureau of Labor Statistics. The BLS prescription drug inflation rate for 2009 is approximately 3 percent, or roughly one-third of the 9 percent inflation rate reported by the AARP.

Moreover, the change in drug price inflation was approximately half that in the most recent year of the change in the inflation rate for nonprescription drugs and medical supplies. This suggests a small increase in prescription drug prices may reflect broader

health sector market dynamics and not an isolated increase in prescription drug prices.

As previously mentioned, the consideration of prescription drug prices in isolation is an incomplete and misleading exercise. What must be considered are the costs and the benefits of higher or lower prescription drug prices and, specifically, the economic tradeoff between access to existing medicines and access to future, yet-to-be-discovered medicines.

The expected returns on individual R&D projects are directly related to expected pharmaceutical prices and profitability; price controls or indirect price controls via such mechanisms as reimportation or technology assessment rationing lower expected net returns for firm shareholders. The result will be a decline in the rate of pharmaceutical innovation, fewer drugs developed, and it will take a longer time to find cures for many diseases.

Unlike the benefits of the price control policy, which clearly would be to improve access for today's consumers and seniors—implicit price controls, which will produce immediate and observable cost savings through lower drug prices—the costs of a price control policy in terms of forgone innovation is much more difficult to appreciate and quantify.

What might we have discovered? How much more quickly would we have found a cure for Alzheimer's disease? These are very nebulous and difficult to appreciate and certainly to quantify, but that does not justify not considering these very important costs. A full economic analysis considers both the costs and benefits of any policy or health care reform.

The sensitivity of R&D spending to pharmaceutical prices and profits has been studied with a variety of different research methods, including standard retrospective statistical analyses of industry- and firm-level data, protective simulation analyses, and financial event studies. The research findings have been strikingly consistent and robust. I will summarize the results from two recent studies published in the economics literature that I authored by myself and with coauthors.

The first study utilized publicly available firm-level financial data and exploited observable differences in the U.S. and non-U.S. pharmaceutical profit margins. Outside the U.S., most countries have some form of price regulation, explicit or implicit. Using established economic models and statistical techniques, we estimated that a new policy that reduces pharmaceutical profit margins in the U.S. to non-U.S. levels will cause firm R&D spending to decline by between 25 and 35 percent, all things considered.

A policy that regulates prices in the U.S.—for example, reimportation from foreign markets with forced sale clauses, those foreign markets, of course, having price regulation—will theoretically have this effect on U.S. profit margins.

The second study adopted a slightly different approach and utilized publicly available industry-level data to study the direct link between U.S. drug prices and industry-level R&D spending. In this study, we estimated that for every 10 percent reduction in U.S. prices, industry R&D spending will decline by approximately 6 percent. We call that an elasticity estimate of R&D with respect to

real drug prices in the U.S. This finding is also consistent with an earlier study by Harvard economist, F.M. Scherer.

In sum, the empirical evidence suggests that firm R&D spending is very sensitive to pharmaceutical prices and profits and to prices, as the economic theory would predict and the empirical literature supports. The key point is that the benefits associated with lower drug prices—and it cannot be argued that there would be benefits and improved access to medicines that are currently on the market and available—would unequivocally come at a cost: lower levels of R&D investment and a reduced rate of pharmaceutical innovation. It is critical that these costs be balanced carefully against the benefits of associated regulation, explicitly or implicitly, that regulates drug prices. This is particularly true in light of the recent evidence on the significant contributions of pharmaceutical and medical R&D to human health and life expectancies in the U.S., research that suggests the U.S. is currently underinvesting in medical and pharmaceutical research based upon the benefits that we enjoy in America as a result of improved quality of life and extended life expectancies. Thank you very much.

Mr. PALLONE. Thank you, Professor.

[The prepared statement of Mr. Vernon follows:]

Testimony of Dr. John A. Vernon

Department of Health Policy and Management, The University of North Carolina at Chapel Hill and the National Bureau of Economic Research

Before the

Committee on Energy and Commerce
Hearing on "Prescription Drug Price Inflation: Are Prices Rising Too Fast?"

December 8, 2009

Mr. Chairman and members of the Committee, thank you for the invitation to testify today on Prescription Drug Price Inflation: Are Prices Rising Too Fast?" My name is John Vernon and I am a professor in the Department of Health Policy and Management at the University of North Carolina at Chapel Hill and a Faculty Research Fellow with the National Bureau of Economic Research (NBER). I previously was a professor in the Department of Finance at the University of Connecticut and a Visiting Professor at the Wharton School of Business at the University of Pennsylvania, where, among other subjects, I taught MBA-level courses in pharmaceutical finance, economics, and policy. Also, I formerly served as Senior Economic Policy Adviser to the Office of the Commissioner at the U.S. Food and Drug Administration. My testimony today will be based on academic research, published in the peer-reviewed economics literature, that I have undertaken jointly with Joe Golec and other colleagues. The vast majority of these publications were unfunded research projects.

The opinions I am about to express are entirely my own; they do not necessarily reflect those of the institutions and organizations with which I am, or have been, affiliated.

In addition to discussing the evidence, or, more specifically, the lack thereof, of rising U.S. drug prices, I will also discuss the role drug prices play in firm- and industry-level R&D investment, and the subsequent rate of pharmaceutical innovation. The latter is of critical importance because considering drug prices in isolation is not useful: the tradeoff between drug prices and innovation is what is relevant—that is, what are the benefits and costs of higher (or lower) U.S. drug prices? As I will describe, there is strong empirical evidence that 1) Suggests that the marginal benefits of R&D spending far exceed their costs—making a compelling economic case for higher levels of R&D spending by firms; and 2) There is an unequivocal theoretical relationship between U.S. drug prices and profits and R&D investment, one that has consistently been supported by peer-

reviewed publications in leading economics journals (Vernon, 2004; Vernon, 2005; Giaccotto, Santerre, and Vernon, 2005; Golec, Hegde, and Vernon, 2009; Grabowski and Vernon, 2000).

Are U.S. Drug Prices Actually Rising? Flaws with the AARP Report

The conclusions drawn in the AARP report, which has not been evaluated and vetted through peer-reviewed evaluation—the hallmark of academic/economics journal publications—are based on flawed methods, and thus are misleading and biased. The AARP report, as it stands, does not meet peer-review standards for academic publication in reputable journals—especially recognized, quality economics journals. Some of the major flaws with the analysis are:

1) The AARP report is based on wholesale price data, not retail or transaction prices, which are often substantially lower than wholesale prices, because Pharmacy Benefit Managers (PBMs) and insurers negotiate discounts and rebates with manufacturers.

2) The AARP report is an analysis of branded products only. The burden to U.S. consumers associated with access to prescription drugs should also consider generic drugs, which in the U.S., are among the lowest prices in the world; and, according to a December 2008 AARP report, the utilization percentage for generic drugs in the U.S. has risen from 19% in 1984 (the year the Waxman-Hatch Act was passed) to 67% in 2007. The impact of this significant shift towards greater generic competition and utilization is to reduce the overall burden of access to pharmaceuticals.

3) Another flaw with the recent AARP report on rising drug prices, and related to the previous point, is that it ignores the fact that 10 of the top 25 branded pharmaceuticals in their study have generic versions currently on the market. Mandatory generic substitution laws in most states implies that the low-cost generic versions of these 10 branded drugs are dispensed to consumers—not the branded versions.

4) Lower prescription drug prices are also often available to U.S. consumers through mail order pharmacies and discount retail pharmacies—a viable cost savings option for consumers that is not reflected in the AARP estimates.

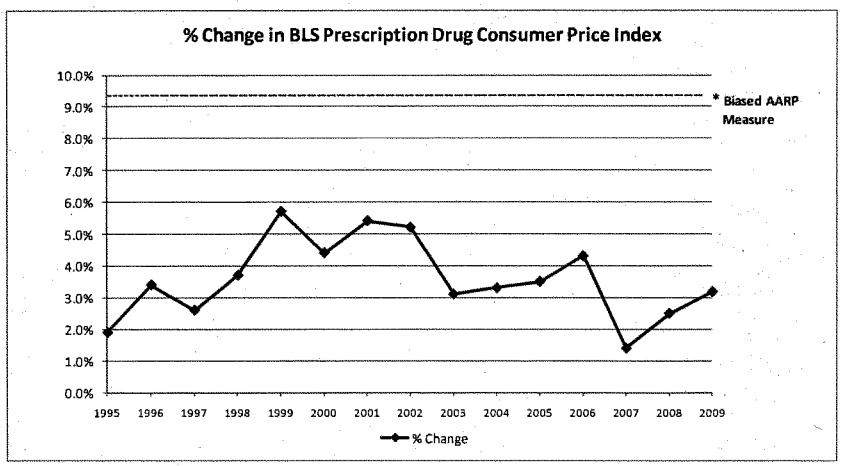
5) Insurance, particularly insurance proposed within the current healthcare reform legislation, results in consumers paying prices well below retail prices.

A much better measure of drug price trends in the U.S., one that is based on retail prices not wholesale prices, and which also captures the cost savings from generic competition and substitution (since 1995), is the prescription drug consumer price index (CPI) reported by the U.S. Bureau of Labor Statistics (BLS). As the BLS reports on their website, their index includes:

"*All drugs dispensed by prescription. Mail order outlets are included, [and] prices reported represent* ***transaction prices*** *between the pharmacy, patient, and third party payer...*"

Figure 1 is a time series of growth rates of U.S. prescription drug prices.

Figure 1: Percentage Changes in Prescription Drug CPI from BLS Data:1995 to 2009



As figure 1 illustrates, the percentage change in the BLS prescription drug CPI is substantially lower than the upwardly biased figure reported by the AARP. Moreover, the 2008 to 2009 (through October) change in prescription drug price inflation rate was approximately half that of the 2008 to 2009 inflation rate for non-prescription drugs and medical supplies (2.5% to 3.18% versus 0.9% to 2.25%). This suggests the small increase in prescription drug prices may reflect broader healthcare-sector market dynamics, and not an isolated increase in prescription drug prices.

Finally, in regard to the reasonableness of the claim that manufacturers have raised drugs prices in anticipation of forthcoming healthcare reform legislation, the most directly comparable, and recent, legislative event points to the exact opposite firm reaction (Golec, Hegde, and Vernon, 2009). At the time of the 1992-1993 Clinton administration's proposed Health Security Act, many large drug manufacturers publicly committed to keeping drug price increases at or below the overall inflation rate. This makes sense, theoretically, because firms would want to avoid political controversy regarding drug prices precisely at a time when drug prices are under great scrutiny. The publicly announced commitments by many firms to constrain drug prices at this time attracted the attention of the Federal Trade Commission (FTC), and consequently lead to FTC challenging whether such actions were a violation of anti-trust law (Ellison and Wolfram, 2002). There are numerous similarities between the current healthcare reform legislation being considered and that of the Clinton administration's HSA. This begs the question, "why would the

currently proposed healthcare reform legislation result in a different behavior by firms?" The relatively low rate of drug price increases in recent years suggests they are not acting very differently. Indeed, prescription drug prices in recent years have grown at one of the lowest rates since the 1980s, when annual drug prices increases were near 10% on average.

Even the small price increases in recent years, when they exceed the general inflation rate, can be explained more plausibly by industry dynamics. For example, as Grabowski and Kyle (2007) have shown, increased generic competition and patent challenges have resulted in a compression of the product life cycle for many drugs; thus leading, perhaps, to higher prices. Moreover, the industry's productivity in recent years has declined for pharmaceuticals (chemical molecules), which face very intense generic competition at patent expiration, but increased for biologics (biologic molecules), which currently do not face such competition and which also are more costly to develop (for example, because of the higher cost of R&D capital faced by biotech firms). This shift in the mix of innovative products (relatively more biologics and fewer pharmaceuticals), could easily explain recent price increases greater than the overall inflation rate (however small). Thus, the assertion by the AARP that firms have raised prices in the face of proposed healthcare reform can be refuted by more plausible explanations.

Prescription Drug Prices, Profits, and R&D Spending: Factors Affecting Pharmaceutical Innovation

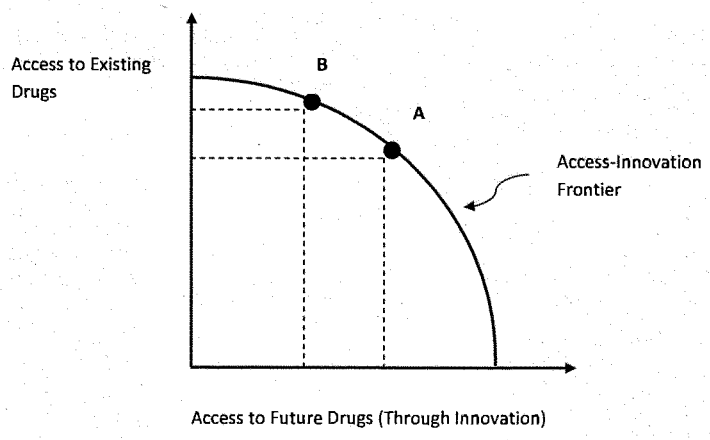
As mentioned in the preceding section of my written testimony, a consideration of prescription drug prices in isolation is an incomplete and misleading exercise. What must be considered are the costs and benefits of higher (lower) drug prices, and specifically the economic tradeoff between access to existing medicines and access to future pharmaceutical innovations (through higher levels of R&D). Prior to discussing this tradeoff, a brief overview of the pharmaceutical R&D process, the costs, risks, and returns, is warranted.

A new pharmaceutical typically takes 12-15 years to bring to market, and most investigational new drugs/molecules never make it to market. Some research suggests only about 1 in 5,000 pre-clinical molecules studied ever become FDA-approved new drugs. Moreover, of the drugs that do make it to market, only 2 out of every 10 generate returns in excess of average R&D costs (Vernon, Golec, and DiMasi, 2009).

The expected returns on individual R&D projects are directly related to expected pharmaceutical prices and profitability. Price controls, or indirect price controls via such mechanisms as re-importation or technology assessment rationing, lower expected net returns for firm shareholders[i]. The result will be a decline in the rate of pharmaceutical innovation: fewer new drugs will be developed and it will take a longer time to find cures for many diseases, all else considered[ii]. Unlike the benefits of a price control policy, explicit or implicit, which will produce immediate and observable savings through lower drug prices, the costs of such a policy are more difficult to appreciate and quantify[iii]. This is because of the considerable time lag and uncertainty associated with the R&D process, which, as already noted, is very long, costly, and risky[iv]. My academic research has focused on these costs, and specifically the economic relationships between pharmaceutical prices, profits, and R&D[v]. There is an unequivocal tradeoff between

access to existing medicines, which is improved with contemporaneous lower prescription drug prices, and access to future pharmaceutical innovations. This may be illustrated by the access-innovation frontier in Figure 2.

Figure 2: The Tradeoff Between Access to Existing Medicines and Future Medicines



The sensitivity of R&D spending to pharmaceutical prices and profits has been studied with a variety of different research methods, including standard retrospective statistical analyses of industry and firm-level data, prospective simulation analyses, and financial event studies (Vernon, 2003, 2004, 2005; Giaccotto, Santerre and Vernon, 2005; Abbott and Vernon, 2007; Santerre and Vernon, 2006; Golec, Hegde, and Vernon, 2006; Golec and Vernon, 2007). The research findings have been strikingly consistent and robust. I will summarize the results from two recent studies (Vernon, 2005; Giaccotto, Santerre, and Vernon, 2005). Both were unfunded studies that have been vetted by the academic peer-review process, and subsequently published in professional economics journals.

The first study utilized publicly available, firm-level financial data and exploited observed differences in U.S. and non-U.S. pharmaceutical profit margins (the latter were used to proxy for profit margins in the presence of price regulation). Using established economic models and statistical techniques, we estimated that a new policy that reduces pharmaceutical profit margins in the U.S. to non-U.S. levels will cause firm R&D spending to decline by between 25 and 35 percent, all things considered. A policy that regulates prices in the U.S., for example re-

importation from foreign markets with forced-sale clauses, will theoretically have this effect on U.S. profit margins.

The second study adopted a slightly different approach and used publicly available, industry-level data to study the direct link between U.S. drug prices and industry-level R&D spending (Giaccotto, Santerre, and Vernon, 2005). In this study, we estimated that for every 10% reduction in U.S. drug prices, industry R&D spending will decline by approximately 6%. This finding is consistent with an earlier study that also analyzed industry-level pharmaceutical R&D (Scherer, 1996; 2001).

In sum, the empirical evidence suggests that firm R&D spending is very sensitive to pharmaceutical prices and profits, as economic theory predicts. This is in direct contrast to the ubiquitous, non-economic notions one often hears, such as "lower prices and profits won't reduce R&D spending because firms will still have enough profit to cover their R&D" and "these firms have to invest in R&D, what else are they going to do?"

The key point is that the benefits associated with lower drug prices in the U.S. will, unequivocally, come at a cost: lower levels of R&D investment and a reduced rate of pharmaceutical innovation. It is critical that these costs be balanced carefully against the benefits of associated with regulated, explicitly or implicitly, drug prices. This is particularly true in light of the recent evidence on the significant contributions of pharmaceutical and medical R&D to human health and life expectancies in the U.S. (Murphy and Topel, 2003; Lichtenberg, 2002).

Endnotes

[i] The implicit argument being put forth is a net present value (NPV) argument. A real options framework, in the parlance of modern finance theory, will generate the same prediction (see Golec, Hegde, and Vernon, 2009).

[ii] The phrase "all else considered" is important here. The relevant comparison for assessing the impact of price regulation on R&D spending and innovation is the counterfactual event of no price regulation policy. R&D and innovation are driven by a number of factors and even if a price regulation policy is enacted real R&D spending may continue to grow over time, but it would grow at a slower rate than would have been the case if the policy were not enacted. The relevant measure of the effect of policy is one that holds all other factors constant: the comparison of the reality with the counterfactual. Some of the research I will mention in this testimony can easily be taken out of context. For example, if the statement is made that pharmaceutical price regulation will reduce R&D by x%, this is x% relative to the level of R&D spending in the absence of the policy, not R&D spending in absolute terms.

[iii] To more formally consider the balancing of the costs and benefits of a policy that constrains U.S. drug prices the following may provide some clarification. Once a pharmaceutical product has been brought to market, pricing above marginal cost results in an underutilization of the new product (from a social welfare perspective), and these costs are referred to as static inefficiency costs. Thus, a tradeoff exists between providing incentives for research and development (R&D), and thus innovation, and consumer access to today's medicines: this is the balance the U.S. patent system tries to strike. While there is nothing sacrosanct about the current structure of the U.S. patent system for pharmaceuticals, or indeed the existing rate (and stock) of R&D investment, what is immediately apparent is that regulating prescription drug prices, while it will expand access to medicines already developed (the aforementioned benefits), it diminishes the intended objective of the U.S. patent system. This, as I have mentioned, will reduce the future supply of new drugs. These costs are referred to as dynamic inefficiency costs. The optimal policy (or patent system) will minimize the sum of the static and dynamic inefficiency costs.

[iv] The term risk here refers to the technical risk of an R&D project, which is the likelihood it will make it through the various stages of drug development and become a marketed product. This is quite different from financial risk, which is the risk faced by an investor who holds the market portfolio, i.e., the relevant risk for determining the project's cost of capital (or discount rate).

[v] While understanding how R&D spending may be affected by pharmaceutical price regulation is important, what is most relevant is how this change in pharmaceutical R&D spending will influence innovation and public health. Obviously, measuring the costs associated with forgone future innovation is a near impossible task: there are many variables that can affect the outcome. However, because there is an overwhelming tendency for public policy debate to focus on the short-run benefits of lower (regulated) drug prices, it is critical that efforts be untaken to at least approximate the magnitude of what the corresponding costs would be in terms of lower levels of innovation. Only then can the benefits of lower drug prices be weighed against the costs to

determine if a price-regulation policy is a good one. A very rough first approximation of the social costs associated with various pharmaceutical price-reduction policies (measured in terms of life years and dollars) may be found in Vernon (2004).

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Mr. PALLONE. Ms. Cramer.

STATEMENT OF BONNIE CRAMER

Ms. CRAMER. Thank you, Mr. Chairman and members of the Health Subcommittee. I am Bonnie Cramer. I am chairman of AARP's all-volunteer board of directors, and on behalf of our 40 million members, thank you for including AARP in this discussion of brand-name prescription drug prices.

As you know, AARP is deeply committed to making prescription drugs affordable for our members and for all Americans; and whether we are ready to admit it or not, the United States is aging at an unprecedented rate. Starting on January 1, 2011, 10,000 people will turn age 65 every day, and this will continue for the next 20 years. When combined with the rapidly escalating brand-name prescription drug prices and the fact that older Americans use prescription drugs more than any other segment of the population, it seems evident that many Americans will soon find themselves unable to access the drugs they need at a price they can afford. And that, we believe, is not acceptable.

As part of these efforts, AARP's Public Policy Institute, working with Dr. Schondelmeyer, has been reporting on manufacturer price changes for prescription drugs. Since 2004 we have done our prescription drugwatchdog report. Our latest report found, as you have heard, that average manufacturer prices for widely used brand-name and specialty prescription drugs continued to increase substantially between October of 2008 and September of 2009, rising by 9.3 percent and 10.3 percent respectively.

Now it has been twice said that 70 percent of all prescription drugs are generic, but you need to know that 76 percent of all spending is for brand drugs.

Rising prescription drug prices are a source of concern for many of our members and it can impact their health. The inability to afford needed prescription drugs has been shown to negatively impact patient adherence to drug regimens. Many consumers report that they have not filled prescriptions, they skip doses, and they cut pills in half as a result of high prescription prices. These are stories that we hear from our members every day. This type of behavior in turn can lead to more expensive health care needs in the future.

Problems paying for prescription drugs are more common among those taking a larger number of medications, such as older adults. Approximately 20 million AARP members are over the age of 65 and eligible for Medicare. The Part D benefit, which AARP fought very hard to enact, provides much-needed prescription drug coverage for Medicare beneficiaries, but unfortunately, the Part D benefit currently contains a doughnut hole, where the beneficiary must shoulder the entire cost of the drug as well as continuing to pay their premiums. More than 3 million Americans are at risk of falling into the doughnut hole each year and feeling, firsthand, the impact of rising prescription drug prices.

Unfortunately, because the doughnut hole is indexed to prescription drug spending, the doughnut hole is growing larger each year; as a result, more people will fall into the doughnut hole in the fu-

ture. And that is why we at AARP have made closing the doughnut hole one of our top priorities as part of health care reform.

But price increases also impact Medicare Part D enrollees. It impacts their cost sharing for their brand-name prescription drugs.

A recent AARP Public Policy Institute analysis of most national Part D plans shows that in 2010, more plans will require copayments of close to $100 per drug for certain brand-name drugs. Other plans will use coinsurance or a percentage of the drug's cost for brand-name medicines as high as 65 percent of the drugs cost.

We are greatly concerned about the future of Medicare's Parts D and B, which are financed through premiums and general revenues. As prescription drug prices continue to increase, spending will grow correspondingly, which means that all Medicare beneficiaries as well as all taxpayers will be required to pay more in order to keep the program solvent.

Now, AARP was pleased to endorse the Affordable Health Care for Americans Act, H.R. 3962, that recently passed the House of Representatives. For years, AARP has been fighting to make sure that our members and all Americans have access to affordable health care coverage. Key to our endorsement was provisions that would close the doughnut hole, which the House would begin to do next year, and fully close the doughnut hole by 2019.

We also support the House health bill's provisions that would grant the Secretary of Health and Human Services the authority to negotiate on behalf of Medicare beneficiaries. We have also supported provisions that would promote medication therapy management services.

So, Mr. Chairman, thank you for your continuing efforts to improve the Nation's health care system. At AARP we look forward to continuing to work with you to ensure that prescription drugs remain affordable for our members and all health care payers.

I appreciate the opportunity to be with you today, and I look forward to your questions.

Mr. PALLONE. Thank you, Ms. Cramer.

[The prepared statement of Ms. Cramer follows:]

STATEMENT FOR THE RECORD

SUBMITTED TO THE

Energy and Commerce Health Subcommittee

on

Prescription Drug Price Inflation:

Are Prices Rising Too Fast?

December 8, 2009

AARP
601 E Street, N.W.
WASHINGTON, D. C. 20049

WITNESS: **BONNIE M. CRAMER**
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Mr. Chairman and Members of the Health Subcommittee, my name is Bonnie Cramer. I am Chair of the Board of Directors of AARP. On behalf of our nearly 40 million members, I want to thank you for holding this timely hearing and including AARP in this discussion about brand-name prescription drug prices.

AARP is committed to improving the lives of our members and all older Americans. And, whether we're ready to admit it or not, the United States is aging at an unprecedented rate. Between 2010 and 2050, the population age 65 and older is expected to more than double, rising from 40 million to 87 million, and the 85+ population is expected to more than triple, growing from 6 million to 21 million.[1] Perhaps a more understandable way of explaining this is that, starting on January 1, 2011, 10,000 people will turn 65 every day—and that this will continue for the next 20 years.[2]

When combined with rapidly escalating brand-name prescription drug prices and the fact that older Americans use prescription drugs more than any other segment of the U.S. population, it seems evident that many Americans will soon find themselves unable to access the drugs they need at a price they can afford. And that, we believe, is not acceptable.

AARP Watchdog Monitors Prescription Drug Price Increases

AARP is deeply committed to making prescription drugs affordable for our members – and all Americans. As part of these efforts, AARP's Public Policy Institute has been reporting on manufacturer price changes for prescription drug products since 2004. To help address concerns about the impact that rising drug prices have on all Americans, AARP has been monitoring prices for specific drugs at regular intervals and reporting our findings—both favorable and unfavorable—to its members and to the public.

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[1] AARP Public Policy Institute analysis of U.S. Census Bureau, Population Projections, U.S. Interim Projections by Age, Sex, Race, and Hispanic Origin: 2000-2050.
[2] Alliance for Aging Research, *The Silver Book*, 2009.

AARP has released multiple reports on a quarterly and annual basis, and has consistently found that manufacturer price increases for brand-name drug products widely used by older Americans have far outstripped the price increases for other consumer goods and services. The results of these reports have been widely reported in the press and have also been cited in numerous publications. These reports, combined with our advocacy and education efforts, reflect our deep commitment to making prescription drug prices affordable for all Americans.

Our latest report found that average manufacturer prices for widely used brand-name and specialty prescription drugs continued to increase substantially between October 2008 and September 2009, rising by 9.3 percent and 10.3 percent, respectively. In contrast, prices for common generic drugs declined by 8.7 percent over the same time period. These trends resulted in an overall average annual rate of increase of 5.4 percent, a sharp contrast to the negative rate of general inflation for all consumer goods and services.[3]

Price Increases Impact Medicare Beneficiaries

Approximately 20 million of AARP's members are over the age of 65 and enrolled in the Medicare Part D prescription drug benefit, which provides much-needed prescription drug coverage for Medicare beneficiaries. Studies continue to demonstrate that individuals who have affordable access to prescription drugs are more likely to adhere to their prescription drug treatment regimens.[4] This not only leads to better health outcomes, but also helps patients avoid unnecessary health care utilization.

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[3] S. Schondelmeyer, L. Purvis, and D. Gross, "Rx Watchdog Report: Drug Prices Continue to Climb Despite Lack of Growth in General Inflation Rate," AARP Public Policy Institute, November 2009.

[4] J. M. Madden et al., "Cost-Related Medication Nonadherence and Spending on Basic Needs Following Implementation of Medicare Part D," Journal of the American Medical Association 299, no. 26: 1922–1928; B.A. Briesacher, J.H. Gurwitz, and S.B Soumerai, "Patients At-Risk for Cost-Related Medication Nonadherence: A Review of the Literature," Journal of General Internal Medicine 22, no 6: 864-87.

We are pleased to see that the majority of Medicare beneficiaries enrolled in the Part D benefit are satisfied with the program.[5] The standard Part D benefit has an annual deductible ($295 in 2009) and initial coverage period where beneficiaries pay for 25 percent of their drug costs and their plan pays for 75 percent of the drug costs until total drug costs reach the initial coverage limit ($2,700 in 2009). After this point, beneficiaries fall into the dreaded Part D "doughnut hole", where the beneficiary must shoulder the entire cost of their drugs (as well as their premiums) until they reach catastrophic coverage ($6,154 in total drug costs). After this point, the beneficiary pays 5 percent of the cost of their drugs, their prescription drug plan pays 15 percent, and Medicare pays the remaining 80 percent.

More than 3 million Americans are at risk of falling into the Medicare Part D doughnut hole this year and feeling first hand the impact of rising prescription drug prices.[6] Countless AARP members tell us of their experiences getting caught in the doughnut hole trap. That is why we have made closing the doughnut hole one of our top priorities this year as part of the health care reform effort.

For example, we heard from Joyce in Illinois who enrolled in Medicare Part D and has fallen in the doughnut hole. She tells us that when she falls into the doughnut hole, she can no longer afford her medications (even with cutting back other basic living expenses like groceries). Instead of taking her insulin five times a day as prescribed, she takes only one or two shots every few days, even though she knows that such behavior will only worsen the complications of her diabetes. Another AARP member, Martha from Ohio, describes the doughnut hole as "a nightmare". When she enters the doughnut hole, she takes her

[5] P. Neuman and J. Cubanski, "Medicare Part D Update — Lessons Learned and Unfinished Business," New England Journal of Medicine 361, no. 4: 406-414.
[6] J. Hoadley et al., "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008.

medication every other day (rather than the daily recommended dose) or tries to cut her medications in half. She has also resorted to paying for her medications using her credit cards, but is rapidly reaching her credit limit. Finally, Shari in Virginia tells us that she and her husband have had to move in with their youngest son. She has fallen into the doughnut hole and now has to rely on her children to help pay for her prescription drug costs. Her children are raising their own children, and while they are able to provide some assistance, she recognizes that this help has its limit as their expenses are skyrocketing just like everyone else's.

These are just a few of the stories we hear from our members. Unfortunately, more and more people will be feeling the effects of the doughnut hole in the future. The structure of the Medicare Part D benefit is tied to prescription drug spending – not the Consumer Price Index (inflation) or a more realistic index as AARP has advocated – which is directly linked to prescription drug prices. As a result, the benefit's threshold amounts are growing each year. For example, under current law, the doughnut hole is projected to almost double by 2016, to more than $6,000. Thus, Part D enrollees could, upon entering the coverage gap, face the prospect of remaining in the gap while paying the full cost of their prescriptions far longer in the future. In combination with higher prescription drug prices, this will undoubtedly lead even more Medicare beneficiaries who reach the coverage gap to forgo needed brand-name medications, a phenomenon that is already being documented.[7]

Price increases also impact Medicare Part D enrollees' cost-sharing for their brand-name prescription drugs. Part D plans use tiers that group drugs by similar cost-sharing requirements. For example, Tier 1 drugs, usually generics, have the lowest copayments. Tier 2 drugs, "preferred" brands, have a higher copayment. Tier 3 drugs are "nonpreferred" brand-name drugs that are usually more expensive and/or have more safety concerns than "preferred" drugs.

[7] Id.

An AARP Public Policy Institute analysis of most national Part D plans shows that, in 2010, more plans will require copayments close to $100 for Tier 3 drugs, which are usually "nonpreferred" brand-name drugs.[8] Other plans will use coinsurance for all brand-name medicines (across tiers), which can reach as high as 65 percent. In contrast, cost-sharing for generic prescription drugs, with manufacturer prices that have actually dropped over the past few years, has remained at $7 or less.

In addition, since Part D plans began in 2006, many have incorporated a fourth tier as well, often known as a "specialty" tier. This includes many biologics and injectable drugs; coinsurance is the usual form of cost-sharing. Coinsurance represents a percentage of the drug's price, rather than a copayment that is a fixed amount regardless of the drug's price. In 2009, more than half of all Part D enrollees in plans with a specialty tier were subject to 33 percent coinsurance for specialty tier drugs. Since 2006, the number of national PDPs charging 33 percent coinsurance for specialty tier drugs has increased considerably, when only four of the 35 national or near-national PDPs charged this rate.[9] To put this in perspective, rheumatoid arthritis medicines such as Enbrel and Humira averaged $1,633 per prescription in 2008. The average cost of a multiple sclerosis drug was $2,006.[10] At 33 percent coinsurance, enrollees' cost would exceed $500 per prescription. Most patients with either of these conditions filled at least eight such prescriptions in 2008.[11]

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[8] N.L. Rucker and L. Purvis, "Medicare Beneficiary Costs Set to Rise For Part D Drug Benefit in 2010," AARP Public Policy Institute, November 2009.
[9] J. Hoadley et al., "Medicare Part D 2009 Data Spotlight: Specialty Tiers," Kaiser Family Foundation, June 2009.
[10] Express Scripts, *2008 Drug Trend Report*, April 2009, available at http://www.expressscripts.com/industryresearch/industryreports/drugtrendreport/2008/.
[11] Id.

Given that specialty drugs are currently among the most expensive on the market, with prices that can range from $5,000 to $300,000 per year,[12] it is inevitable that many individuals who use specialty drugs will fall into the doughnut hole. Further, prices for these prescription drugs – many of which are biologic drugs – continue to rise at an alarming rate. In fact, AARP has found that the manufacturer prices for specialty prescription drugs widely used by older Americans rose by 10.3 percent in the last year. This is particularly striking given that most biologic drugs studied currently do not face generic competition.

Price Increases Impact Medicare

AARP is cognizant that prescription drug price increases not only impact individual spending, but also the costs borne by the Medicare program (and, by extension, taxpayers). As previously mentioned, the Medicare program pays for 80 percent of Part D enrollees' prescription drug costs after they reach the catastrophic cap. In addition, the Medicare program offers substantial financial assistance to low-income Medicare beneficiaries who qualify for the Low-Income Subsidy (LIS). These individuals receive additional help with their Part D premiums and copayments; also, upon entering the doughnut hole, they do not experience the shock of full-cost prescriptions: their subsidized cost-sharing of only a few dollars per prescription continues unchanged. While we obviously applaud this much needed assistance to lower-income beneficiaries, the fact remains that the Medicare program is responsible for paying for the vast majority of the prescription drug costs for these individuals. Last month, the Medicare Payment Advisory Commission (MedPAC) estimated that LIS enrollees accounted for over 50 percent of all Part D spending in 2007, although these enrollees only made up 38 percent of total enrollment.[13]

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[12] B. Walsh, "The Tier 4 Phenomenon: Shifting the High Cost of Drugs to Consumers," AARP Strategic Analysis & Intelligence, March 2009.
[13] S. Suzuki and J. Sokolovsky, "Comparing LIS and Non-LIS Beneficiary Experience With Part D," MedPAC, September 17, 2009, available at http://www.medpac.gov/transcripts/LIS%20and%20non-LIS%20beneficiary%20experience%20w%20Part%20D%20public.pdf.

It should also be noted that Medicare Part D is not the only source of prescription drug coverage for Medicare beneficiaries. Medicare Part B covers prescription drugs that are administered in an outpatient setting, and beneficiaries are responsible for 20 percent of their costs. Thus, unless beneficiaries have some source of supplemental coverage, prescription drug price increases impact them directly. Further, unlike Medicare Part D, Medicare Part B does not have catastrophic coverage, so beneficiaries are responsible for their share of prescription drug costs indefinitely.

In 2007, the Medicare Part B program spent $17 billion on prescription drugs – most of which are biologic drugs.[14] The top six biologics represented $7 billion of the total, or 43 percent of all Part B drug spending.[15] To put this in context, Medicare Part B spending for one biologic drug—Epoetin alfa—in 2007 ($2.6 billion) was greater than the FDA's, with over 10,000 employees, entire FY2008 budget ($2.3 billion).[16]

Medicare Parts D and B are financed through the Supplementary Medical Insurance Trust Fund, which is financed through premiums and general revenues. Thus, as prescription drug prices continue to increase, spending will grow correspondingly, which means all Medicare beneficiaries – as well as all taxpayers – will be required to pay more in order to keep the programs solvent.

AARP is very concerned about the millions of Americans with Medicare Part D prescription drug coverage that fall into the doughnut hole each year. To help Medicare beneficiaries and their caregivers, AARP has created the Doughnut Hole Calculator – available at http://doughnuthole.aarp.org/ – an online tool that

[14] MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program, Chapter 5: Medicare Payment Systems and Follow-on Biologics*, June 2009.
[15] Id.
[16] U.S. Department of Health and Human Services, "HHS: What We Do," available at http://www.hhs.gov/about/whatwedo.html; and MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program, Chapter 5: Medicare Payment Systems and Follow-on Biologics*, June 2009.

helps individuals find lower-cost, effective drugs that might help them avoid the coverage gap. The calculator is an easy way for people to view a graph of their out-of-pocket spending by month, look up lower cost drugs for their conditions, create a Personal Medication Record and print out personalized letters to their doctors to help start a conversation about safely switching prescriptions. Since it was launched in July of 2009, over 180,000 individuals have used the calculator.

Price Increases Also Impact the Under-65 Population

Of course, AARP is fully aware that Medicare beneficiaries are not the only ones suffering the effects of rising prescription drug costs. For example, a large majority of covered workers have some sort of tiered cost-sharing formula for prescription drugs. For covered workers in plans with four cost-sharing tiers, 41 percent face a copayment for fourth-tier drugs and 29 percent face coinsurance.[17] The average copayment for drugs on this tier is $85 and the average coinsurance is 31 percent.[18]

These plans also do not have safety nets such as stop-loss or catastrophic coverage, so beneficiaries are responsible for an unlimited share of drug costs. Also, unlike Medicare, there are no special subsidies for low-income consumers in the commercial marketplace. And of course, this does not include the millions of those without health insurance, including over 7 million adults age 50 to 64 who are uninsured.[19] Non-disabled older adults generally do not have access to coverage through a public program, even if they have no access to private insurance and limited income.[20] Therefore, unless they somehow gain access to private insurance, the uninsured population age 50 to 64 faces the very real

[17] Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2009 Annual Survey*, September 2009.
[18] Id.
[19] G. Smolka, L. Purvis, and C. Figueiredo, "Health Care Reform: What's at Stake for 50- to 64-Year Olds?" AARP Public Policy Institute, March 2009.
[20] Id.

possibility of being completely exposed to prescription drug price increases until they become eligible for Medicare at age 65.

Unfortunately, the inability to afford needed prescription drugs has been shown to negatively impact patient adherence. Many consumers report that they have not filled prescriptions, skipped doses, or cut pills in half as a result of high prescription drug prices.[21] Problems paying for prescription drugs are even more common among those who take larger numbers of medications (i.e., older adults).

In fact, several large surveys have shown that older adults, who are disproportionately affected by chronic disease[22] and more likely to need a chronic medication,[23] resort to skipping doses, reducing doses, and letting prescriptions go unfilled when faced with increased medication costs.[24] Research has also found that high cost sharing delays the initiation of drug therapy for patients newly diagnosed with chronic disease.[25] These behaviors, in turn, can lead to expensive hospitalizations and adverse health outcomes[26] that must then be paid for by patients and taxpayers.

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[21] USA Today/Kaiser Family Foundation/Harvard School of Public Health, *The Public on Prescription Drugs and Pharmaceutical Companies*, March 2008.
[22] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Healthy Aging: Preserving Function and Improving Quality of Life Among Older Americans, 2008, January 2008.
[23] C. M. Roe, A. M. McNamara, and B. R. Motheral, "Use of Chronic Medications among a Large, Commercially-Insured U.S. Population," Pharmacoepidemiology and Drug Safety11, no. 4: 301–309.
[24] J. M. Madden et al., "Cost-Related Medication Nonadherence and Spending on Basic Needs Following Implementation of Medicare Part D," Journal of the American Medical Association 299, no. 26: 1922–1928.
[25] M.D. Solomon et al., "Cost Sharing and the Initiation of Drug Therapy for the Chronically Ill," Archives of Internal Medicine 169, no. 8: 740-748.
[26] H. Kohl and W. H. Shrank, "Increasing Generic Usage in Medicare Part D: The Role of Government," Journal of the American Geriatric Society 55: 1106–1109.

Health Care Reform Moving Forward

AARP was pleased to endorse the Affordable Health Care for America Act (H.R. 3962) and Medicare Physician Payment Reform Act of 2009 (H.R. 3961) that recently passed in the U.S. House of Representatives. For years AARP has been fighting to make sure that our members – and all Americans – have access to affordable health care coverage. The Affordable Health Care for America Act will protect and strengthen Medicare for current and future Medicare beneficiaries; require new, no-cost Medicare coverage of important preventive services like screenings for cancer, diabetes, and osteoporosis; and take steps to prevent waste, fraud, and abuse and inefficiency in the Medicare program. H.R. 3961 would permanently fix the flawed Medicare physician payment formula to help to ensure that physicians will continue to treat Medicare patients. For individuals who are under 65, the legislation will provide for a 2 to 1 age rating, meaning that insurance companies would be limited in how much they can charge an individual based solely on age. The legislation will also provide for affordable health insurance options for people who currently lack access to or cannot afford to purchase health insurance.

Key to our endorsement was a measure that would prevent millions of seniors from having to pay thousands of dollars in out of pocket costs for their prescriptions. Starting next year, the House health care reform bill would reduce the size of the Medicare Part D coverage gap or "doughnut hole" by $500. The bill would completely eliminate the gap in coverage in 10 years. In addition, the legislation would provide for a 50 percent discount on brand name drugs in the coverage gap. Closing the doughnut hole will help Medicare beneficiaries obtain affordable access to the prescription drugs that they need, which will not only improve their quality of life, but will help to reduce unnecessary, costlier treatments associated with medication non-compliance.

In addition, we support the House health care bill's provisions that would grant the Secretary of Health and Human Services the authority to negotiate on behalf of Medicare beneficiaries. It's a common sense approach to strengthening Medicare's ability to provide lower cost prescription drugs. The private sector already uses its bargaining clout to negotiate better prices for prescription drugs. It is time to also permit the Secretary to use the bargaining power of millions of Medicare members to get the best price possible. Medicare has an obligation to all Americans to be a prudent purchaser of health care services. The Secretary will determine how to use negotiating authority to achieve that end.

Currently, medication therapy management (MTM) services must be offered by Medicare Part D plans to enrollees (at no additional charge) who incur total Part D prescription drugs costs of at least $4,000 in 2009 (this threshold drops to $3,000 in 2010, per CMS guidance). Enrollees deemed eligible for MTM services must also meet plan-determined criteria related to the total number of different covered drugs, and the types of chronic diseases enrollees must have. Unfortunately, only a tiny proportion of MTM-eligible Part D enrollees have actually received MTM services, and even fewer have received in-person medication reviews from pharmacists or other health care professionals.[27] We were pleased to see that the House health care reform bill included provisions that would provide federal grants to promote medication therapy management (MTM) services. These grants would be given to establish community-based, multidisciplinary teams to support primary care practices that include pharmacist-delivered MTM services. Such grants would also be used to implement these services for treatment of chronic diseases. Further, performance bonuses would be provided to Part D plans that went above and beyond what is currently required under Medicare. Through these grants, pharmacists could not only review more patients' treatment regimens for lower-cost options, but more importantly could work with enrollees to ensure appropriate use of prescribed

[27] However, starting in January 2010, new CMS guidance governing MTM services will require plans to communicate with both enrollees and their prescribers, to provide an annual comprehensive medication review, and to provide quarterly targeted reviews.

medications, help manage drug-related risks, and minimize preventable drug-related medical visits and hospitalizations. Expansion of such services could promote the full value of drug therapy, while helping to keep overall program costs in check.

Finally, H.R. 3962 would provide individuals who are currently uninsured with access to health insurance coverage. Providing such coverage will help these individuals gain more affordable access to prescription drugs. Thus, they are more likely to adhere to their prescription drug treatment regimens, which will lead to better health outcomes and help to avoid unnecessary, costlier medical interventions.

As Congress continues to move forward in enacting health care reform, we appreciate provisions in the Senate health care reform proposal that would help to address rising prescription drug costs. We support provisions in the Senate bill that would reduce brand-name prescription drug costs by 50 percent for individuals while they are in the doughnut hole. However, we have strongly urged the Senate to go further and fully close the doughnut hole as President Obama has promised.

AARP supports prescription drug importation legislation and has endorsed the bi-partisan legislation sponsored by Representatives Berry and Emerson (H.R. 1298). In the quest for lower-priced prescription drugs, many Americans resort to importing prescription drugs from abroad. This legislation would create a framework for the safe, legal importation of prescription drugs that will better protect the health and pocketbooks of those desperate for lower priced prescription drugs. We are also very pleased to see that the legislation includes a number of safety requirements including inspections and measures to prevent the counterfeiting of imported drugs. AARP is supporting the bipartisan amendment sponsored by Senators Dorgan, Snowe, McCain, Grassley and Stabenow that would attach this legislation to the comprehensive health care

reform package being considered in the Senate. We urge Congress to enact this legislation this year.

AARP strongly supports the Promoting Innovation and Access to Life-Saving Medicine Act (H.R. 1472). We applaud Chairmen Waxman and Pallone and Congressman Deal and Congresswoman Emerson for putting this critical legislation forward on behalf of America's consumers. This legislation would provide a workable pathway for the FDA-approval of safe, effective, generic forms of biologic drugs and would provide for a balanced period of exclusivity. This bill is based on the successful framework of the Hatch-Waxman law passed decades ago and has proven to save consumers and the federal government billions of dollars.

Unfortunately, both the House-passed health care reform legislation and the bill currently being debated on the Senate floor include biologic provisions that would provide for an imbalanced 12 year period of exclusivity for the branded product. According to the Federal Trade Commission (FTC), brand name manufacturers do not need special incentives to support continued innovation, and the unreasonable twelve to fourteen years of market exclusivity supported by the drug industry actually negatively impacts innovation.[28] As noted by the Medicare Payment Advisory Commission (MedPAC), brand name companies have little incentive to improve their products without the threat of imminent competition.[29] We urge Congress to change this unreasonable exclusivity period and make these generic biologic drugs available as soon as possible. Many of our members have told us the costs of these are simply unaffordable. Biologic drugs cannot save anyone's lives if people cannot afford them.

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[28] Federal Trade Commission Report, *Emerging Health Care Issues: Follow-on Biologic Drug Competition*, June 2009.
[29] MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program, Chapter 5: Medicare Payment Systems and Follow-on Biologics*, June 2009.

Conclusion

Thank you again for your continuing efforts to improve our nation's health care system. We look forward to working with you to ensure that prescription drugs remain affordable for our members, all Americans, and all health care payers. I appreciate the opportunity to be with you today and I look forward to answering any questions you may have.

Mr. PALLONE. We are going to have questions now from the members, and I am going to start with myself. I am going to try to get in two topics here with you, Mr. Schondelmeyer.

When we passed or when we finalized the health care reform legislation, it will mark the second time in 6 years Congress has passed important legislation affecting the prescription drug market. In 2003, we passed the legislation creating Part D; and you have analyzed drug prices before and after Part D went into effect.

So what happened in the months before Part D went into effect, and are we seeing the same thing happening now with this health care reform legislation?

Mr. SCHONDELMEYER. Well, I would respond by providing observation and pointing you to figure 5 in the testimony that I prepared. Basically, it shows in the time period prior to Medicare Part D being first passed and then later enacted—remember, there was a delay time between when it was passed and when Part D actually got implemented, 2003 to 2006—prescription drug prices did increase during that time period substantially. They leveled out, if 6-plus percent is leveling out, in terms of price increases for a brief period, and then after last fall's elections in November when it appeared that health care reform might be a topic that comes into play again, we saw an increase.

Now, this is not a cause-and-effect relationship, but if one looks at the graphs, it is pretty apparent there is an increase.

Mr. PALLONE. So you don't think it is a coincidence, obviously.

Mr. SCHONDELMEYER. I don't think it is. There are multiple factors that affect the drug companies' choice to raise their prices, but I think this is certainly one that weighs in.

The mentality that may be going into effect is, if R&D is as important to them as they say it is—and I believe it is; and I want, we as a society want, the innovation and R&D and other factors. So if they rationalize, if they are going to start controlling or affecting my prices by having a more effective market in some way, and I have a less controlled market right now, I am going to push the price as much as I can so when they start squeezing, I am at a higher point on the mountain when they are trying to bump me down a little bit. So it makes sense to do that.

Mr. PALLONE. Mr. Smith, I will let you have an opportunity to respond, but I have to go back to him. So if you could just spend about a minute or so.

Mr. SMITH. Mr. Chairman, thank for the opportunity to respond.

Unlike Dr. Schondelmeyer, I am not going to speculate about motives. As I made clear in my statement, I can't discuss pricing decisions and so forth. But what I can say is that, number one, the Consumer Price Index, as has already been discussed, has, for the year ended with the period that AARP looked at, was up about 2.7 percent.

I can also tell you that the prices are negotiated with purchasers who are large, sophisticated and powerful and have many tools. My guess would be, and I have to underline guess, my guess would be if a company went to one of these purchasers and said, We need you to pay us more because health reform is coming, they would be laughed out of the room.

Mr. PALLONE. OK. Now I am going back to you, Dr. Schondelmeyer.

At some point—I don't know if it was in your testimony or in your written statement—you mentioned that the wholesale acquisition cost does not include discounts or rebates that are provided by the manufacturers to wholesalers. When these discounts were factored in, it has the effect of lowering the price paid.

You stated in your footnotes that there are no consistent comprehensive and publicly reported data sources for this discount and rebate information. That gets to the issue of transparency. That is my question.

How would better drug pricing transparency help patients? I mean, what would you suggest in terms of trying to create more transparency?

Mr. SCHONDELMEYER. First, if we are really talking about an economic market and making wise decisions, we need to avoid asymmetric markets, where the seller knows a whole lot more about their product than the buyer. Asymmetric markets were defined by Nobel economists who described the market for lemons, or used cars.

In a sense, drug companies, thankfully, know a lot more about our drug product than we do, but that gives them extreme economic power in the marketplace. Rebates and discounts are out there, and they may lower the actual price, but they don't lower the rate of increase unless the rebates and discounts are increasing as a proportion.

Mr. PALLONE. What do you suggest in terms of what we could do on transparency?

Mr. SCHONDELMEYER. Well, one, for example in Medicare Part D, you could require that Part D plans disclose the amount of rebates that they get. Apparently, the committee in the past couple of years has done studies of the Part D plans. The Part D plans have reported that they get rebates on about 10 to 14 percent of the drugs; and they may get some rebates, but they have admitted they don't pass them on to the consumer. And, apparently, it doesn't lower the premiums, because this last year Part D premiums went up 11 percent, and last year they went up 17 percent.

So the only two places I can see that rebates can benefit either the Medicare beneficiary or the taxpayer would be in lower premiums or lower prescription prices. And they don't appear to show up in either of those.

I don't know where they went.

Mr. PALLONE. Thank you.

Mr. Deal.

Mr. DEAL. Ms. Cramer, I am told that 52 percent of AARP's annual revenues come from royalty fees from insurance company profits, and less than 20 percent of it comes from your membership dues. In 2008, I am told that AARP generated $414 million in royalty fees from United Health Care Corporation.

Could you tell me what percentage of those revenues came from the sale of AARP Medicare supplemental insurance plans that were offered by United Health Care Corporation?

Ms. CRAMER. I don't have that figure with me. I will be glad to get it for you. Those numbers you cited are approximately correct.

But let me just say that AARP is not an insurance company; we contract with United Health Care to provide insurance to our members, and we provide market-changing policies. We make sure that our members have the best policies that we can have under State and Federal law.

Providing insurance to AARP members is the reason AARP was formed over 50 years ago, when our founder—the private market was not serving older people, and it was not serving retired teachers. Our founder was a retired teacher. It is the beginning of our organization.

But I do want to say one other thing, which I have heard said in Congress numerous times, especially over the weekend. I am the chairman of the all-volunteer board. We had over 15 to 20 meetings on health care reform—detailed meetings. Not once, not once, did the AARP board talk about the money we might make on our insurance products or the money we would lose. We would gladly forgo——

Mr. DEAL. You will get us information to the question that I have asked.

Ms. CRAMER. I will get the information on what portion is related to Medicare supplement.

Mr. DEAL. When you announced your endorsement of the immediate health care reform plan, you cited the fact that preexisting conditions would be excluded under that legislation, yet the supplemental plan that you sell has a 6-month waiting period. And the way the legislation has been crafted is that your supplemental insurance plan will still continue to have the opportunity for a 6-month waiting period as an exclusionary period.

Was that a condition that was negotiated with the White House as a condition of endorsement?

Ms. CRAMER. It was not a condition that was negotiated with the White House. And AARP has been on record for a long time of supporting guaranteed issue for Medicare beneficiaries.

Mr. DEAL. But do you think it is fair for your supplemental plan to have a preexisting condition exclusion, whereas other plans in the basic coverage would not?

Ms. CRAMER. That is something that we can look at. It was not a deal with anyone. And certainly we do support guaranteed issue.

Mr. DEAL. All right. Let me ask the panel, and this would be something that any of you could address.

We are concerned here about trying to figure out how to get consumers in the United States the best value for the dollar they are paying for prescription drugs. Do you believe that U.S. consumers are paying a disproportionate share of R&D costs compared with the rest of the consumers in the world?

Does anyone want to take a shot?

Mr. SMITH. Mr. Deal, I will note that other countries clearly underfund their R&D. They are not paying their share of R&D, particularly other developed countries, and I believe the result is, less R&D occurs and fewer new drugs are discovered, and that is a loss to Americans as well as people in their own country.

Mr. DEAL. Aren't you shifting those costs to American consumers?

Mr. SMITH. Mr. Deal, I can't speculate about how pricing might occur cross-nationally.

Mr. DEAL. Dr. Schondelmeyer, do you have an observation?

Mr. SCHONDELMEYER. Well, again, in terms of the individual decisions of companies and specific decisions, it is hard to say. But if you look at the market, and as described by Mr. Smith, if other countries are underfunding and we are paying a substantially higher price and we are getting R&D, which we value, we are overpaying; we are essentially letting other countries be free riders on the R&D that we are paying.

What we do with that is a different issue. I think we probably need to look for a new model of funding R&D. Rather than funding 10 years from now the new drugs based on the high price of drugs today to the degree that some people can't afford them, I am not sure that model is working today.

Mr. DEAL. I want to go to your analysis that brand-name drugs increased 9.3 percent in your study. Specialties, which you say were primarily biologics, increased by 10.3 percent.

Isn't it logical that in the brand names, where their patents will expire, that those prices will drop in the future; whereas if we grant, in addition to patent protection, some 12 or more years of market exclusivity on biologics, that you are going to see that increase in the biologic arena continue to be an escalation?

Mr. SCHONDELMEYER. I don't recall more than two or three brand-name drugs that I have ever seen drop their price, and those were under political pressure. It was pointed out that some of the drugs in our index have generic competitors in the market, and yet those brand-name drugs continue going up in price, sir.

Mr. DEAL. Yes. But if you build in a 12-year exclusivity period that prolongs any ability for follow-on biologic, don't we compound that problem?

Mr. SCHONDELMEYER. Not necessarily. I think one has to do an assessment of what is an appropriate time for recovering that innovation cost and R&D cost. I think if you make it too short, you can stifle innovation. I think if you make it too long, you can stifle innovation. If you make it too long, you allow companies to rely on cash cows, which is much of what we see now, products they just keep hanging on to and riding, rather than—what they find is Nexium instead of Prilosec, which isn't a new drug, it's just a right-handed version; or Ambien CR instead of Ambien, which isn't a new drug, it is just a manipulation.

So if we let the period be too long, it can be just as damaging as too short. I think the period that is currently in the bill at 12 years is on the long side.

Mr. PALLONE. Chairman Waxman.

Mr. WAXMAN. We have heard the estimate that the amount of prescription drugs over a 10-year period has increased 72 percent. That is a big increase in people using drugs, or at least a number of prescriptions. So the market for drugs has increased over the last 10 years.

Dr. Schondelmeyer, you say that the drugs in the past year have increased, on an average, 9 percent; is that a correct statement?

Mr. SCHONDELMEYER. It is, but we need to parse out increased expenditures from increased prices. Expenditures go up because of

increased utilization and increased price and increased changes in the mix.

The price index I report with AARP is a pure price index. Price only. The actual utilization of prescription drugs in the last year to 2 years has flattened out or even decreased slightly in some therapeutic markets, yet the prices keep going up. And the private payers, the large PBMs, report price increases similar to the 5.4 percent that we show for our aggregate composite index, rather than the 2.7 percent that CPI has.

Dr. Vernon commented that my study only looked at brand-name drugs. Apparently, he has only read the New York Times version of my study, because if you read the full study, you will see that we look at brand names and specialties and generics, and we calculate a composite index.

Mr. WAXMAN. So you have a composite index of all those drugs. Let's parse them out.

Are brand-name drugs where the drug manufacturer still holds a patent, which means it has a monopoly, going up faster than the increase for the prices for those drugs than generic drugs competing with a brand-name drug?

Mr. SCHONDELMEYER. In our index, brand-name drugs can be either patented, single-source products or it can be brand-name drugs. The originator, the original NDA holder, they may not have discovered the drug at all; they may have licensed it in. But the original NDA holder, even after the drug is off patent, may still be in our index, in some cases, because those products are still on the market and the prices are going up.

So we track those prices and then we track generics, and they are going in opposite directions—9.3 percent up and 8.7 down for generics.

Mr. WAXMAN. So where there is competition from generics, the generics are going down in price? And where there is no competition, the price of drugs is increasing?

Mr. SCHONDELMEYER. It is increasing. And even the brand name, when it has generic competition, doesn't enter into the economic competition by lowering its price. It may lose volume, but it doesn't lower its price.

Mr. WAXMAN. This seems to be happening whether the economy is booming or in a recession, whether the number of uninsured is going up or down; it doesn't make any difference.

Mr. SCHONDELMEYER. It doesn't appear to have done so over the last decade, and we have had both of those periods, some booms and some busts.

Mr. WAXMAN. Over the last decade, I assume that the increases are every year. Are they pretty level or is this 9 percent higher than the general increase over the last 10 years, let's say?

Mr. SCHONDELMEYER. The rate of increase is the highest, at least from the data I have done with AARP I have seen in the last 7 years. When I look at other similar data going back even 15 years or more, this is the highest level we have been at for quite some time.

Mr. WAXMAN. Now let me go back to the question Mr. Deal asked you. The specialty drugs, which really biologic, these are the new

breakthrough drugs, but they are very expensive drugs, aren't they?

Mr. SCHONDELMEYER. Yes. These, on average, cost thousands to tens of thousands of dollars, if not in some cases, hundreds of thousands of dollars per year.

Mr. WAXMAN. For the most part, these drugs have no competition?

Mr. SCHONDELMEYER. They do not have competition directly and in an economic sense.

Mr. WAXMAN. In an economic sense? What does that mean?

Mr. SCHONDELMEYER. In a sense it would lower their price. There may be two drugs for multiple sclerosis, and the drug companies may very vehemently compete through advertising and through calls on the doctors that treat those patients, but it hasn't had an effect on the price, an appreciable effect on the price.

Mr. WAXMAN. Is that because one is not substitutable for the other?

Mr. SCHONDELMEYER. Substitution has been a major mechanism to bring about economic decline of generic prices in the regular drug market, and that is not available for the biological products. There is no equivalent of an ANDA for a biological license applicant.

Mr. WAXMAN. Now there is a bill that promises the developer of a generic drug 12 years of exclusivity and then there can be competition. But that competition may not be a substitutable competitor. So we are not guaranteed a reduction in prices even after 12 years; isn't that right?

Mr. SCHONDELMEYER. That is probably correct. It depends on the terms of how that bill would bring about or allow other products in the marketplace.

What you need is an equivalent of the FDA therapeutic equivalence evaluation for normal pharmaceuticals to be developed for the biological markets.

Mr. WAXMAN. They claim they have to have a 12-year exclusivity because competition is going to drive down the price of that drug so dramatically. But, in effect, they are going to have much longer than 12 years to be recouping a huge amount for their drug.

So what we are really talking about is not just a 12-year period, but a much longer period of time in which this drug will have market dominance; isn't that correct?

Mr. SCHONDELMEYER. That is quite likely. In addition, they are likely to come out with alternate dosage forms and remarket the drug in a different dosage form that has a new patent, has a new exclusivity.

Mr. WAXMAN. We have "evergreening" in the bill that passed the House and the Senate, which means there is no end to the monopoly control they are going to have over these biologic drugs.

Monopoly control, is it fair to say, in your experience, means higher prices?

Mr. SCHONDELMEYER. Yes.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Chairman Waxman.

The gentleman from Illinois, Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman. I think we are developing more questions through this hearing, but that is a positive thing.

Ms. Stoll, I would just request that if you have these constituents' stories, one, I would ask if they have gone to their Member of Congress to ask for assistance. We deal with folks in many of these similar situations.

I would also highlight the fact that if that Member is not willing, if you provide those names to my office, we will try to intervene. Because I know the pharmaceutical companies have options in which they can provide discounted or low-cost or drugs for free; and we use those operations frequently in my congressional service.

I have limited time, but I want to throw that out as on option for these stories that you have given us today.

To Mr. Smith, we have heard a lot about the "deal" between PhRMA and the White House. Can you explain what that deal is?

Mr. SMITH. Congressman, what I can do is—I wasn't asked to come and explain the deal today. I can try to give you sort of——

Mr. SHIMKUS. I have been told it is pretty well public knowledge.

Mr. SMITH. There have been public announcements by the White House. I believe AARP attended a public announcement of the initiative at the White House. There are public announcements from the Finance Committee.

Our board concluded that in line with its longstanding support for moving forward health reform, that was mentioned by the chairman in his opening comments, that we wanted to support moving forward——

Mr. SHIMKUS. I am actually looking for more of the specifics.

Do you know if the Senate health bill reform reflects the negotiations?

Mr. SMITH. The Senate bill is so much in flux, it would be hard for me to make an assessment.

Mr. SHIMKUS. I would like for you all—these are questions that I would like to get answered. I would hope that you would. My concern is H.R. 3962, there are negotiations behind closed doors, and I want to know if those have negotiated, which then turns me to AARP.

Ms. Cramer, you said that—Mr. Chairman, I would like the consolidated financial statements from December 31, 2008, and 2007, and the IRS form 990 for 2008 submitted for the record, with your approval.

Mr. PALLONE. Can I just take a look at it, because I am not sure I know what you are talking about.

Mr. SHIMKUS. It will be followed up with these questions.

Ms. Cramer, you stated that you all don't have an insurance plan, but on the 990 you list one. On the IRS Form 990, it says "the AARP insurance plan." So my question is, do you have an insurance plan or do you not?

Ms. CRAMER. What I said is that we contract with United and other health insurers to provide insurance to our members. We also contract with Aetna for the 50- to 64-year-old product.

We contract with Genworth to provide long-term care insurance to our members. We even provide homeowners insurance and car insurance to our members.

Mr. SHIMKUS. Reclaiming my time, what it says on the IRS Form 990, At the direction of third-party insurance carriers, the plan pays AARP, Inc., a portion of the total premiums collected for the use of its intellectual property, which is reported as royalties in the consolidated statements of activities. Is that correct?

Ms. CRAMER. It is correct that we make royalties off the sale of insurance plans.

Mr. SHIMKUS. So you are acting as a grant or trust. And, in essence, when these profits are made through the selling of this insurance, the net then goes back to you all. In fact, AARP benefits from selling the most costly insurance because that portion then goes to operate AARP at a major profit; is that correct?

Ms. CRAMER. It goes back to support the advocacy and education efforts of AARP, yes.

Mr. SHIMKUS. And I would say in about current operations that is about $653 million in annual revenue, based upon this portion, which was stated by Mr. Deal as. What, three-fourths of the operating budget?

Ms. CRAMER. The budget is about $1.3 billion, but that amount is approximately correct, yes.

Mr. SHIMKUS. Fifty-two percent of your fees or annual revenues come from these insurance fees, and 20 percent of AARP's annual revenues come from membership dues, correct?

Ms. CRAMER. About 24 percent.

Mr. SHIMKUS. Could you operate without this $653 in annual revenue?

Ms. CRAMER. I have already answered that question. We were founded on providing——

Mr. SHIMKUS. Can you operate currently without this revenue that you all receive based upon selling insurance, yes or no?

Ms. CRAMER. We have never looked at that. I don't know how to answer that.

Mr. SHIMKUS. So if you are without $653 million, you don't know if your operations will change?

Ms. CRAMER. Well, obviously, it would change if it is 52 percent of the revenues.

Mr. SHIMKUS. Thank you. I yield back.

Mr. PALLONE. The gentleman from Illinois has asked for unanimous consent to enter into the record AARP's consolidated financial statements from December 31, 2008 and 2007. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Next is the gentlewoman from California, Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman. I can't help but observe the following. It is always interesting around here when advocacy organizations endorse legislation. I remember not that many years ago when my friends on the other side of the aisle had their arms wrapped around AARP, hugging them so tight, because they were supporting Medicare Part D and all that came with it.

Today, they are attacking the hell out of AARP because they have endorsed this side of the aisle's health care—universal health plan for the American people. So I guess, as Kurt Vonnegut said, "And so it goes."

But I can't help but make the observation; I guess that is the way it goes around here.

Thank you, each one of you, for coming to testify. I think if we could stay away from good guys and bad guys, we would just be much better off. What we need to do is to scratch below the surface and see what it is that is causing the prices to be what they are, which we all know is a burden to the American people and especially older citizens in our country.

I believe in research and development. I believe in science. It is at the heart of all of the work that I have done here in Congress. Some say that favors some and doesn't help others. I think that that is a source of pride to our country, and I want to keep that and innovation alive. But I also think we can do a much better job with what the costs are.

Now, the House has already passed the health care reform legislation, and hopefully the Senate is going to do the same. As we go to conference, I think it is important we get some perspective in how provisions in these bills will help to reduce drug costs. The House bill has numerous provisions to protect taxpayers and all citizens from increasing drug prices. It increases Medicaid rebates; it provides drug coverage with 36 million citizens; it requires pharmaceutical manufacturers to give a 50 percent rebate for drugs in the doughnut hole; it closes the Part D doughnut hole, which the other side all created, together with AARP, and thought it was terrific then. Now it is costly and we are being attacked for what it costs to plough back and fill this hole, but fill this hole we must do because of what it is doing to senior citizens. It allows the Secretary to negotiate for lower Part D drug costs.

Now the Senate bill contains some of these provisions, but not all. It doesn't close the Part D doughnut hole, doesn't allow the Secretary to negotiate, and it doesn't create new Part D rebates.

So, to Dr. Schondelmeyer, let me ask you generally, do you believe the provisions in the House bill or the Senate bill will do a better job of protecting seniors and taxpayers from rising drug prices? I mean, it is a softball question, but I think we need to get the answer on the record.

Mr. SCHONDELMEYER. I believe there are many useful provisions in the House bill that would assist in that goal. As with many tools that we have in society, it all depends on how they are implemented.

Ms. ESHOO. Ms. Cramer, do you agree?

Ms. CRAMER. We have strongly supported the House bill. We are working every day in the Senate to try to get the doughnut hole closed completely.

Ms. ESHOO. Let me ask about a specific provision in both bills. It is a provision that requires manufacturers to provide a 50 percent discount on brand-name drugs in the doughnut hole. My understanding is that this offer was made by the drug manufacturers as part of their negotiations with the Senate and the White House.

Now this is not a bad provision. We have it in the House bill as well. But it seems to me that it has some problems. What manufacturers give, which in this case is a 50 percent discount, manufacturers can take away by increasing the base price of their drugs.

So, to Dr. Schondelmeyer, am I understanding this correctly? As manufacturers increase prices, can they also wipe out many of the benefits of this 50 percent discount?

Mr. SCHONDELMEYER. I believe they can, and they have the market power to do so. Their current price increases for this year may have come close to wiping out the whole $80 billion over the next 10 years.

Ms. ESHOO. Let me ask the panel, whoever would like to step up and answer this, what do you think is the best way to protect us from what I just described?

Mr. SMITH. Congresswoman, thank you for the opportunity to answer.

Ms. ESHOO. Keep it short.

Mr. SMITH. I will, absolutely.

Part D, as you know, has come in at much lower cost than expected. That is because of the competition and the negotiation that goes on. Contrary to Dr. Schondelmeyer's point, of course, the 50 percent discount that will be provided in the coverage gap is a 50 percent discount off of the negotiated price. So I think that there is a real benefit to seniors there.

Ms. ESHOO. Dr. Schondelmeyer, do you want to respond?

Mr. SCHONDELMEYER. You tell me how much discount you want, and I will tell you what the price is. That is kind of the way the market works today. Yes, there is some negotiation, but it is at the margins. It is mostly about retail prices, not about meeting the retail margin and the retail dispensing fees. It is not much about brand-name, single-source drug product negotiations.

I work with major buyers in the marketplace with my own university, and we don't get discounts on those brand-name prices.

Mr. SMITH. Congresswoman, can I get 5 seconds of your time, please?

Ms. ESHOO. You have to ask the chairman, not me.

Mr. PALLONE. Yes, and then we are going to finish.

Mr. SMITH. I will simply note, contrary to Dr. Schondelmeyer's assertions, if you look in the Medicare trustees' report, they will note that while generics don't carry rebates, I believe their phrasing is many brand-name drugs carry rebates, often 20 to 30 percent.

Mr. SCHONDELMEYER. Generics are priced so low, a rebate still doesn't get the brand name close to the generic price.

Ms. ESHOO. Mr. Chairman, I think this whole issue of the increase of the prices says to us that we need to get socks on this octopus. Because if the rate continues to rise as much as it already has, and the predictions of the industry itself underscoring that, then by the time the entire national plan for universal health care takes place, then that whole new floor—a whole new floor is established.

This is about bringing prices down across the board so we have affordability for people. I think that we have got to press hard, look hard on a provision that will be placed in the bill.

You know what I would be willing to do is to say that by such and such a date this is what you have to do, and a hammer comes down by that year. If you haven't, then the prices are just going to drop.

Thank you.

Mr. PALLONE. Thank you. And I apologize for turning the clock off. I wanted to make sure Mr. Gingrey got his 8 minutes, since he didn't have an opening.

I recognize the gentleman from Georgia.

Dr. GINGREY. Mr. Chairman, thank you very much, and thank you for allowing me the extra time for questions.

I am going to direct all my questions to AARP and to Mrs. Cramer.

Ms. Cramer, my first question, to your knowledge, has AARP been contacted by the Justice Department concerning alleged large kickbacks—well, actually, you call them "royalties"—that you receive from insurance companies for your Medigap plans, a matter that, as you know, Chairman Rangel suggested he would be referring to the Justice Department during the Rules Committee hearing on H.R. 3962 last month?

Ms. CRAMER. To my knowledge, today, no.

Dr. GINGREY. Well, if you do hear of that and have that information, that the Justice Department is looking into that, would you be willing to let the committee know that you have been informed by the Justice Department?

Ms. CRAMER. Surely.

Dr. GINGREY. Good. Thank you.

The second question: Today, roughly a million customers purchase Medicare Advantage plans, roughly 8 percent of the market, and 2.8 million Medigap plans, representing roughly 30 percent of the Medigap market, bearing the AARP logo. Under the House and Senate health reform bills, Medicare Advantage plans would be cut—again, I am sure you know this—by as much as $160 billion, yet Medigap plans do not endure these same cuts. Under the House and Senate bills, Medicare Advantage plans would be forced to pay 85 percent of revenues received for medical claims, yet Medigap would only be subject to pay 65 percent of its revenues on claims.

Are you aware that Medigap plans are not held to the same 85 percent standard as all other insurance products but Medicare and non-Medicare policies under the House or the Senate health reform bills, yes or no?

Ms. CRAMER. No, I was not aware of that.

Dr. GINGREY. Would AARP be willing to forego this sweetheart exemption that clearly favors AARP and their Medigap plans in order to help reduce the cost of health care for its members who receive their insurance from the Medicare program?

Ms. CRAMER. I can't answer that on Medigap. I can say that on Medicare Advantage we have supported the reduction. We also contract for Medicare Advantage plans and——

Dr. GINGREY. Well, reclaiming my time, I don't understand how you could say that you are not sure or that you wouldn't support that.

Ms. CRAMER. I am just telling you, we have not discussed that and so I just can't answer that today. I don't have that information. We haven't even discussed that among the board.

Dr. GINGREY. Well, Ms. Cramer, in the interest of your 40 million AARP beneficiaries, including myself, don't you think it would be

your responsibility as a board, all-volunteer board, to discuss things like that?

Ms. CRAMER. As I indicated, I would be glad to get back with you on that.

Dr. GINGREY. Well, I am glad to hear that.

My third question: Representative Deal mentioned Medigap plans would not be subject to preexisting-condition coverage like every other insurance product sold in this country if H.R. 3962 were to become law.

Considering that an AARP member in New York has actually brought suit against you in January on this very issue, would you be willing to tell this committee today that AARP would like that provision changed in order to ensure that your members who currently receive their health care from the Medicare program would not be forced to purchase a Medigap plan with a preexisting condition?

Ms. CRAMER. As I indicated previously, we have for years supported guaranteed issue of Medicare policies.

Dr. GINGREY. Well, then your answer is, yes, you would be——

Ms. CRAMER. I believe I answered that we would discuss that within our board. I can't answer that today, but we do support guaranteed issue.

Dr. GINGREY. Well, I certainly would hope so, and I thank you for that response.

Next question: The House and the Senate health reform bills would cut Medicare Advantage plans by as much as $160 billion, cuts that CBO figures will force 3 million seniors to lose that coverage and then revert to the traditional Medicare, and 8 million more if insurance companies are forced to stop selling altogether by the health choices czar, if he or she chooses.

As we all know, Medicare Advantage plans offer seniors benefits that traditional Medicare doesn't, services like dental, hearing, and vision, just to name a few. Therefore, seniors will be forced to purchase a Medigap policy to make up for those lost services, policies for which AARP has a significant market share and would stand to gain substantially.

I see a significant conflict of interest in your support of legislation that would allow you, AARP, to gain customers, and therefore further royalties, from a product in which you have a significant market share, namely Medigap plans, because seniors are being forced off of Medicare Advantage plans, plans for which AARP products do not have a particular market advantage, as I think you said in your testimony.

In light of these concerns, would AARP be willing today to rescind its support of H.R. 3962, of the Pelosi health reform act, if changes to bring Medigap policies in line with all other insurance products are not made, yes or no?

Ms. CRAMER. We have supported the House bill. We have also supported the cuts to the Medicare Advantage. We also contract for Medicare Advantage. And we would willingly forego any revenue to get those changes in place to get affordable health care for our members.

Dr. GINGREY. Let me ask you one last question in my remaining time.

I have seen recent reports that AARP supports the Senate Democratic version of health-care reform. One of the ways in which a Senate health reform bill pays for the reforms it seeks is through a payroll tax on all those making $250,000 or more each year.

Unfortunately, this payroll tax is not pegged for inflation, meaning that it will negatively impact your members, including myself, aged 50 to 64 today, and over time cause those making well below $250,000 a year to pay this additional payroll tax of .5 percent, increasing the Medicare payroll tax from 2.9 to 3.4.

Does AARP support the use of a payroll tax to pay for health care reform?

Ms. CRAMER. We have not endorsed the Senate bill. We are working to get the age rating provision in the Senate bill. It does not meet what we would like to have. It is 3 to 1. We do not support that. And the Senate bill does not fully close the donut hole, which is our top priority. We have not——

Dr. GINGREY. Ms. Cramer, reclaiming my time, are you saying that you do not support the version of health-care reform in the Senate bill that raises a payroll tax a half a percent?

Ms. CRAMER. I am saying that we have not endorsed the Senate bill as of this time.

Dr. GINGREY. Again, I want to ask you specifically a yes-or-no question. As the chairman of the board of AARP, do you or do you not support increasing the payroll tax 0.5 percent to help pay for health-care reform, whether that is in the Senate version, the House version, or in a conference report that comes back to us later in the year or the 1st of the year?

Ms. CRAMER. We believe that revenues will have to be raised to provide all Americans affordable health care.

Dr. GINGREY. Last point in my remaining few seconds: Would you support a change in the final bill indexing this tax for inflation if, indeed, that increased payroll tax is in there?

Ms. CRAMER. We have not discussed that. I cannot speak to that today.

Dr. GINGREY. Well, I am disappointed that you can't speak to that as being a responsible board member, volunteer board member, advocating on behalf of 40 million seniors to try to keep costs down. Because, clearly, this is not a partisan question; this is just an issue of doing the responsible thing on behalf of your membership.

Mr. Chairman, with that, thank you for the additional time, and I will yield back.

Mr. PALLONE. Thank you, Mr. Gingrey.

Next is the gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

And, Ms. Cramer, I appreciate AARP's support for the House-passed bill that doesn't have the payroll taxes the Senate does.

But, Dr. Schondelmeyer, you conducted the study that found the brand-name drug prices increased 9 percent in the last year. We heard a lot of criticism of that study by Dr. Vernon and Mr. Smith in your testimony. How do you respond to that criticism? Does your study present a true picture of what is going on with prescription drug prices?

Mr. SCHONDELMEYER. I believe it does.

First of all, the price data we used are prices actually reported by the drug companies. And I would ask, if they are so concerned about those prices not being accurate, why are they reporting inaccurate prices in the market and to the price databases?

Second, the Consumer Price Index is a very useful measure, but it measures a market aggregate only for the retail market. The CPI doesn't even include most specialty drugs in the marketplace. And the CPI—and, by the way, I would correct another number people have thrown around, that drugs are 10 percent of our health-care expenditures. That is retail outpatient prescription drugs are 10 percent. Drugs in all settings—in hospitals, in physician's offices, and every other setting—are about 17 percent of the total national health expenditures. And yet we keep fooling ourselves saying they are only 10 percent.

So I think our market basket reflects the full spectrum of drugs in the marketplace, in the places where they are used, and it is based on prices reported by the manufacturers.

Mr. GREEN. They also say that your study does not take the discounts and rebates provided by drug manufacturers into account. Does that skew the results?

Mr. SCHONDELMEYER. I have offered opinions that I don't think it appreciably skews the results because I don't see in the marketplace where consumers get the benefit of either those rebates or discounts. I have never met a consumer nor have I, myself, directly received a rebate from a drug company, and I have never met a consumer who says they have.

Supposedly, the Medicare Part D plans do negotiate rebates, and it is supposed to either lower the premiums or the drug product price. But when the Office of the Inspector General for HHS evaluated Medicaid prices versus the Medicare prices back in 2007, he found that for brand-name drugs the Medicaid price was actually on average 0.6 percent lower than the Medicare prices before rebates were taken into account. When rebates under Medicaid were taken into account, it would have reduced the price by about 30 percent, but those rebates don't exist and aren't paid to the government on the Medicare side.

So they can have an impact, but the way they are implemented under Medicaid Part D, they don't appear to get passed to the consumer or the taxpayer.

Mr. GREEN. Well, I know we can look at the big picture, but prescription drug prices have increased at rates beyond the inflation rate in the last few years.

Mr. SCHONDELMEYER. Absolutely. I have no doubt of that.

Mr. GREEN. OK.

Mr. Smith, your testimony states that Medicare Part D costs are not as high as projected, and I tend to think just because we created the donut hole, forcing seniors to pick up that majority of the tab of their prescription drug medications. Additionally, Medicare Part D plans—the Secretary of HHS cannot negotiate drug prices with manufacturers. This forces seniors in the Part D to pay much higher drug prices. Under H.R. 3962, the health care bill, we close that donut hole by 2019.

A PhRMA statement from Senior Vice President Ken Johnson following the release of the AARP report on prescription drug

prices states, "What is more, AARP fails to mention that 50 percent discount that companies will provide to most seniors and disabled Americans who hit the so-called donut hole in Medicare Part D. That provision alone is expected to save beneficiary spending in the coverage gap as much as $1,800 in 2011."

My office has contacted many companies on behalf of our seniors who have entered into the donut hole, and these discounts are not guaranteed and should not be advocated as a benefit to seniors as a way to curb the cost of drugs. Now, we try to work with individual drug companies because we see the ads on TV just like our seniors does, but oftentimes they are not qualified for those discounts when they fall in that donut hole.

Do you have information on how many companies provide such discounts to seniors in the donut hole and the average discount they provide?

Mr. SMITH. Congressman, thank you for the question.

I do not have information about the number of companies that provide discounts in the donut hole. I can say that, under the initiative that we undertook, all companies would be providing the 50-percent discount on brand drugs in the donut hole.

Mr. GREEN. Well, I know the quote I gave you from Vice President Ken Johnson talked about $1,800. Believe me, I have seniors I talked to Friday in Houston that would love to have that because they fell in that donut hole.

If you could get us more information from PhRMA on where they came up with that $1,800, I would really appreciate it, because I think all of us would like to make sure our seniors—because we do constituent casework, and that is our next option when they hit that donut hole, outside of eliminating the donut hole, as our health care bill does.

Thank you, Mr. Chairman. I know I am out of time.

Mr. PALLONE. Thank you, Mr. Green.

The gentleman from Texas, Mr. Burgess.

Dr. BURGESS. Thank you, Mr. Chairman.

I think Mr. Shimkus's questioning just a few moments ago really showed to us why this hearing should be on the Subcommittee of Oversight and Investigations where we can, indeed, swear people in, get them under oath, so that we get answers that we can depend upon, because we have heard some conflicting information today.

I still remain troubled by the fact that we had PhRMA, AMA, AHIP, SEIU, AdvaMed down at the White House in May and June doing these deals, some of them, to be sure, part of the public record, but we don't have the phone logs, we don't have the e-mails, we don't have the minutes from those meetings, and we are in the dark as to what was struck.

So what I read in the newspaper is that PhRMA created an $80 billion deal to help the health care bill get through. OK, that sounds like a good thing, but I don't know what PhRMA gave up, I don't know what the White House gave up. It is just difficult to evaluate that.

And then, of course, you do have the Congressional Budget Office sitting back there and saying, "Wait a minute, if you are doing

something you should have been doing in the first place, we don't actually score that as a savings." So does that $80 billion decline?

I would just like to point out, since I was criticized about the aspect of negotiation from the Secretary of HHS with Part D, I mean, the Congressional Budget Office—who we should have at this hearing, by the way; they should be here—but they sat at that very table last fall in a secret meeting that we had that wasn't open to the press. The Congressional Budget Office reiterated that direct negotiation from the Secretary of Health and Human Services on Part D prescription drugs would not result in any significant savings. They have said this over and over again. I don't know what we need to do to kill that notion, but it is one that certainly deserves to die.

On the issue of the donut hole, Ms. Cramer, I will just ask you, if we did away with that, what would be the effect, the practical effect, on those very low-priced policies that are available to people? Now, in my State of Texas, I think there are some 40 policies that are available for Medicare Part D. What is the practical effect of those very low-cost policies if the donut hole goes away and essentially everything is the same?

Ms. CRAMER. If I understand your question, I believe only about 20 percent of the Part D drug plans provide coverage in the donut hole. And I believe, at that point, it is primarily for generic drugs.

Dr. BURGESS. But a person does have that option to buy coverage that would provide coverage in the gap if they so chose. Is that correct? I mean, that happens today. There is no donut hole for that individual, is that correct?

Ms. CRAMER. Well, that is correct. And, as I said, 20 percent——

Dr. BURGESS. But a person who doesn't use much in the way of medications is free to purchase one of these very low-cost policies that costs a minimal amount each month. And if something happens during the course of that year, yes, then their out-of-pocket expenditure may not be covered, but they also do have a maximum catastrophic coverage above which their drug costs are covered.

But because the way Part D is set up, next year in the open enrollment period, they may switch to one of those programs that provides coverage in the gap. Will we lose that flexibility if we go down this road of closing the donut hole, as has been outlined in the House bill?

Ms. CRAMER. Well, I don't believe so, Congressman. You know, our top priority is to completely close the donut hole because 26 percent of people enter that donut hole; only about 3 to 4 percent really exit that. And during that coverage gap, you have heard the stories about what people do with their drugs when they don't follow their drug regimen. So we think it is extremely important to——

Dr. BURGESS. Now, I need to interrupt you there for just a moment because there are other options. And my office certainly works with individuals on an individual basis, as Mr. Shimkus pointed out. There is the option, though—next year, during the open enrollment period, you don't have to stay on that particular policy under which you have been covered previously that has allowed you to end up in the donut hole. There are policies that pro-

vide coverage in the gap which would be available to that individual in the years ahead.

I am going to have to move on because there is some other things that I just need to get asked. And, first off, Ms. Stoll, I have to ask you the name of that medicine for migraines, because I am just dying of curiosity.

Ms. STOLL. Of course I won't be telling you the name of that product. Maybe we can have a private chat later.

Dr. BURGESS. See, this is why this has to be on Oversight and Investigations, because we could put Ms. Stoll under oath and she would be required to tell me the name of the medicine and I wouldn't be left in the dark here.

Ms. STOLL. I will leave my colleagues to do the paid advertising for specific drugs. But, you know, I just want to raise an issue about——

Dr. BURGESS. Well, hold that thought. We will talk about that privately, because I do have to get one last thought in to our two participants at the end.

We talk about what may be a causal relationship and what may be a casual relationship. I do think it is important, and one of the things we can't know at this hearing, because we don't have access to all the information, we can't know what is just a casual relationship between the $80 billion that PhRMA said they are going to give up and a causal relationship, "Hey, if we give up $80 billion, then we are going to be able to have price flexibility to make up some of that ground on something else." We just don't know.

So where is the line drawn between what is a casual relationship and what is causal?

Mr. SCHONDELMEYER. Well, that is more of a scientific or statistical question. But I think, just from a policy observational perspective, we have never seen drug prices go up this high in the last decade and a half. And this is a time when there is the most risk for drug companies—that is, having either price controls or a change in the market structure in a way that affects their prices. And so, it would be logical that they are looking for ways to buffer their revenue for as much as they can and as long as they can.

Dr. BURGESS. Well, again, that is speculation. It would be better if we were all on the record and under oath.

Let me just ask you one last thing. You said you have not seen a drug price go down. We did have Prevacid which went over-the-counter this past month, and the price drop has been dramatic, and it still sold under a brand name.

Mr. PALLONE. Can we ask you to respond in writing? Because we have a number of Members, and we have a vote coming up.

Dr. BURGESS. Mr. Chairman, with all due respect, I sat here while many of our panelists—and I appreciate them being here—went significantly over time. This is an important issue.

Mr. PALLONE. I understand that the panel went over time, but I am trying to keep the Members to the minute. We are going to have a vote at 12:15. We have a lot of Members, so respond to us in writing, if you will.

Next is Chairman Dingell.

Mr. DINGELL. Thank you, Mr. Chairman.

This question is to Mr. Schondelmeyer.

Mr. Schondelmeyer, I am not sure you or the panel members remember years ago but we made some changes in the food and drug law which banned the imports of pharmaceuticals which could not be certified as safe by the Secretary of HHS. Do you remember that?

Mr. SCHONDELMEYER. Yes. I think that was back in the 1980s.

Mr. DINGELL. So the law now says you cannot import pharmaceuticals unless they can be certified as being safe. Is that right?

Mr. SCHONDELMEYER. I believe the law says that. It has not been implemented.

Mr. DINGELL. That is what the law says. So pharmaceuticals can be imported, but they have to be certified as being safe. Is that right?

Mr. SCHONDELMEYER. I believe that is the case.

Mr. DINGELL. OK. Now, we have the nice problem that, if we change that, unsafe pharmaceuticals could be imported. Is that right?

Mr. SCHONDELMEYER. It depends on your certification process and how good it is.

Mr. DINGELL. Well, if the Secretary can't certify that they are safe, they can't come in. Isn't that right?

Mr. SCHONDELMEYER. Well, they may not be able to certify for political reasons or for practical reasons.

Mr. DINGELL. Dear friend, I wrote the legislation. It didn't say political reasons. It just says you can't import them unless they are certified and safe. Are you in accord with that?

Mr. SCHONDELMEYER. In what sense?

Mr. DINGELL. Do you agree that that is good public policy?

Mr. SCHONDELMEYER. I believe there are processes by which an appropriate certification process could be undertaken.

Mr. DINGELL. Well, and I have no objection. But, up until now, they have not been able to do it. And I don't want to engage in a great big toe dance here, I just want to get the record clear, because everybody is trying to reimport, and I am keep trying to tell them, "You can do so if the pharmaceuticals are safe and the Secretary can so certify." And I just want to get that into the record.

Am I correct in my appreciation on this matter or not?

Mr. SCHONDELMEYER. I believe you are, but, again, I am not a lawyer.

Mr. DINGELL. OK. Thank you very, very much.

Now, I note several things here, and very quickly I would like to get them. There is no trap here, so just please give me a yes-or-no answer.

H.R. 2962 will provide assistance for millions of other Americans to ensure that they can afford prescription drugs. This would have a substantial impact on medical adherence. Is that correct?

Mr. SCHONDELMEYER. I don't know the bills by their number, as you have quoted it, so I can't answer that, sir.

Mr. DINGELL. All right. Now, H.R. 3962 will also close the donut hole. Is that not so, yes or no?

Mr. SCHONDELMEYER. Again, I don't recall the specific provisions of the bill.

Mr. DINGELL. I am not trying to trap you, I am just asking you facts. You are my expert here, and I would like to get your help on this thing.

All right. Let's go to Mr. Smith.

With regard to H.R. 3962, it will provide financial assistance for millions of other Americans to ensure that they can afford their prescription drugs. Is this so or not?

Mr. SMITH. Congressman, it provides assistance. Respectfully, as you know, we oppose the bill.

Mr. DINGELL. Thank you.

H.R. 3962 will also close the donut hole. Is that not so?

Mr. SMITH. Same answer, Congressman.

Mr. DINGELL. OK.

Now, Ms. Stoll, if you please, we sometimes overlook the problems that confront millions of Americans with insurance that fails to cover adequate benefits and protection from financial bankruptcy. These are the underinsured.

You mention a 60 percent increase in the number of underinsured from 2003 to 2007. Could you tell us what are the major causes for this jump?

Ms. STOLL. Well, there are about 25 million underinsured. As we figure it, a major cause of that is lack of solid prescription drug coverage. A lot of plans in the individual market don't cover prescription drugs. We will fix that with H.R. 3962, so I applaud that.

Mr. DINGELL. Now, we include a number of important provisions in H.R. 3962 such as the minimum benefit package that includes prescription drug coverage, elimination of the annual and lifetime caps, assistance for premium and out-of-pocket costs. Would these provisions help address the problems of the underinsured?

Ms. STOLL. Absolutely.

Mr. DINGELL. Thank you.

Ms. Cramer, if you please, I would like to highlight your comments on Medicare Part D, the donut hole, the point at which beneficiaries are responsible for the full cost of their prescription drugs. You state, "Under current law, the donut hole is projected to almost double by 2016 to more than $6,000. This means that Part D beneficiaries can find themselves paying the full cost of their drugs far longer in the future." This is quite unsettling to me.

H.R. 3962 provides a 50-percent discount on brand-name drugs in the donut hole, reduces the donut hole by $500 in 2010, and eliminates the donut hole entirely by 2019, and authorizes the Secretary to negotiate on behalf of seniors for lower drug prices in Part D.

Give me your judgment. Are these steps sufficient to avert the substantial donut-hole growth that you have referred to by 2016 and to provide necessary and needed relief for our seniors?

Ms. CRAMER. Yes, Congressman, it completely closes the coverage gap.

Mr. DINGELL. Thank you.

Mr. Chairman, my time has expired, and I thank you for your courtesy.

Mr. PALLONE. Thank you, Chairman Dingell.

The gentleman from Pennsylvania, Mr. Murphy.

Mr. MURPHY of Pennsylvania. Thank you, Mr. Chairman.

Dr. Schondelmeyer, do you have any research that is funded by NIH? Are you involved in any of the research funded by NIH?

Mr. SCHONDELMEYER. No, I have not conducted research in the lab, which is primarily the type of research conducted by NIH.

Mr. MURPHY of Pennsylvania. NIMH, National Science Foundation, anything of that sort?

Mr. SCHONDELMEYER. I have had research funded by the Centers for Medicare and Medicaid Services.

Mr. MURPHY of Pennsylvania. OK. When that is done, what percentage of that research is there to cover overhead costs?

Mr. SCHONDELMEYER. What percentage——

Mr. MURPHY of Pennsylvania. What percentage of your research grant just funds overhead costs, do you know?

Mr. SCHONDELMEYER. The University of Minnesota has a negotiated rate with the government——

Mr. MURPHY of Pennsylvania. How much?

Mr. SCHONDELMEYER. —that is like 51 percent, I believe.

Mr. MURPHY of Pennsylvania. So 51 percent is not involved in the actual research but it goes to the overhead?

Mr. SCHONDELMEYER. That is negotiated between the government and the university.

Mr. MURPHY of Pennsylvania. That is a standard, actually, for NIH grants, too, across the country, about 51 percent. As a matter of fact, I found it interesting that some universities, such as Harvard, have a 71 percent overhead rate; MIT, 67 percent; University of Minnesota is around 50 percent. It concerns me that so much money is set out to do actual research but over 50 percent goes to things that have nothing to do with research.

Should we stop giving universities money for their overhead at these outrageous rates of nearly two-thirds or half or more that doesn't even go to taking care of the things they are supposed to do? What do you think?

Mr. SCHONDELMEYER. Well, first, as a mischaracterization, the 51 percent overhead means about a third of the money goes to overhead. It is 51 percent on the direct——

Mr. MURPHY of Pennsylvania. With facilities and administrative, yes, we are paying for buildings. But I am just asking, should we cut that so that universities should only use their research money to go directly to research and not go to pay the things to run the university? What do you think?

Mr. SCHONDELMEYER. No. Those overhead costs do pay direct costs that are—or indirect costs that are related to the cost of conducting that research. In fact, the University of Minnesota estimates——

Mr. MURPHY of Pennsylvania. A lot of the costs that the universities get in these things are not necessarily going to the research, which is helping save lives and develop new drugs, things like that, but we should keep paying that when it is not really going? I mean, some of it goes to a university president's salary. Some of them make quite a bit of money, I understand. Should we stop doing it?

Mr. SCHONDELMEYER. I am not a university president, so I don't know what——

Mr. MURPHY of Pennsylvania. OK. All right. Well, we will just keep you within your line.

Ms. Cramer, on the AARP board of directors, you have responsibility of oversight over the insurance plans that AARP contracts with, some of these companies. Does AARP have a Medicare Part D plan?

Ms. CRAMER. Yes, we do.

Mr. MURPHY of Pennsylvania. And who do you contract that with? Or do you run it yourselves?

Ms. CRAMER. With United Health Group.

Mr. MURPHY of Pennsylvania. How much do they pay AARP in royalties or whatever you would call it to offer that plan?

Ms. CRAMER. I don't have that number with me.

Mr. MURPHY of Pennsylvania. You are a member of the board. You just told me you have oversight over that. You tell me that something that is a massive amount of the income for AARP, you don't know how much it is?

Ms. CRAMER. I don't know what portion is for the Part D plan.

Mr. MURPHY of Pennsylvania. A dollar amount, you don't know.

Ms. CRAMER. Congressman, I have answered. I don't know what portion is for the Part D plan.

Mr. MURPHY of Pennsylvania. No, you haven't answered my question. You said that over half of your income comes from insurance plans but you have no idea how much it is and you are on the board? I think you are chair of the board. And you are telling me you don't know what kind of money AARP makes? I don't understand that.

Ms. CRAMER. Well, I have answered——

Mr. MURPHY of Pennsylvania. No. Well, let me ask another question because I am trying to get an answer to that. So do you have a donut hole in your plan?

Ms. CRAMER. I am sorry?

Mr. MURPHY of Pennsylvania. Do you have a donut hole in your Medicare Part D plan?

Ms. CRAMER. Yes, we do.

Mr. MURPHY of Pennsylvania. You do. And yet you make millions and millions and millions of dollars out of your Medicare Part D plan. Why don't you use that money to fill the donut hole?

Ms. CRAMER. Our plans operate under Federal and State laws just like any other plan does.

Mr. MURPHY of Pennsylvania. But I am asking you, if Federal or State law allows you to have a plan that does not have a donut hole, why don't you fill the donut hole with the profits you make? After all, you are a nonprofit organization. Why don't you use that money—I understand your executive director makes how much money for AARP?

Ms. CRAMER. I am sorry?

Mr. MURPHY of Pennsylvania. How much does your executive director get paid per year at AARP?

Ms. CRAMER. He doesn't get paid what the Senate said he got paid.

Mr. MURPHY of Pennsylvania. How much does he get paid?

Ms. CRAMER. I would be glad to answer that offline.

Mr. MURPHY of Pennsylvania. I don't understand why we can talk about everybody else's salaries but AARP's. And you are here criticizing other companies.

Ms. CRAMER. It is around $800,000.

Mr. MURPHY of Pennsylvania. It is my time. The drug companies—I am concerned about the cost of drugs, and I am concerned how much it costs people. But I want to get to the bottom of this. And so you have the cost of manufacturing the drug. You have the profits companies make. You have research and development for those drugs. You have advertising. I want to get to the bottom of that. But there is also the cost of administering plans.

And AARP is not an innocent partner in this, because you also make a lot of money from this. And when I ask you how much your director makes, suddenly that is off limits. But we can talk about——

Ms. CRAMER. It is around $800,000.

Mr. MURPHY of Pennsylvania [continuing]. How much money pharmaceutical companies make. I don't know how much money AARP is putting into your pockets and how much is going to doing such things as eliminating the donut hole or reducing prices. What this committee needs to do is look at all of these levels.

And I think it is disingenuous for AARP to come in here and say, "When it comes to AARP, we are not telling you how much money we make or what we do with it," or, for some reason, the chairman of the board doesn't understand that stuff. When it comes to talking about——

Ms. CRAMER. Congressman, I believe our——

Mr. MURPHY of Pennsylvania. No. When it comes to talking about these prices, everything should be on the table.

I am deeply concerned about senior citizens who cannot afford drugs. I am deeply concerned about members of AARP who cannot afford drugs. But you are telling me a lot of this goes into your profits, you won't tell me how much your executives make in salaries, and you won't close your own donut hole.

And I yield back the balance of my time.

Ms. CRAMER. Congressman, I believe our——

Mr. MURPHY of Pennsylvania. I yield back the balance of my time. If you are not going to answer my questions, you don't have a right to answer.

Ms. CRAMER. And the executive director's salary——

Mr. MURPHY of Pennsylvania. Mr. Chairman, she is not going to answer my questions.

Mr. PALLONE. Look, if she wants to answer the question——

Mr. MURPHY of Pennsylvania. Mr. Chairman, she has told me she doesn't have the answers to these questions that I have asked.

Mr. PALLONE. Ms. Cramer, if you would like to answer, you can.

Ms. CRAMER. Well, as I said, I believe our audited report moments ago was entered into your record, which would include the information the congressman is asking. And also the 990, which is public document, would include information on our executive director's salary. I also said that it is around $800,000 per year.

Mr. MURPHY of Pennsylvania. Why don't you use that money to close the donut hole?

Mr. PALLONE. She tried to answer your questions as best she could, and we do have the documents that were entered into the record by Mr. Shimkus.

We have about—I guess we still have another 13 minutes or so, so I would like to get a couple more people in. Mrs. Capps is next.

Mrs. CAPPS. Thank you, Mr. Chairman.

And I want to spend most of my precious 5 minutes on the topic of medications used to treat cancer. But I want to give you a chance, Ms. Cramer, to talk 1 more minute or less, hopefully less, on the donut hole. Because, in your written statement, you reference AARP's donut hole calculator. Just to get it on the record for today's discussion, would you very briefly tell us what that is?

Ms. CRAMER. It is a new online tool that became effective in July. It is found at donuthole.aarp.org. It helps individuals calculate and track their out-of-pocket expenses. It helps individuals locate cheaper alternatives for their condition. It provides a personal medication record. And it also provides personalized letters; if individuals decide they want to pursue cheaper generics, it helps them begin the conversation with their doctor.

It is extremely popular. We have served over 180,000 people since it came online in July. That is a thousand people a day.

Mrs. CAPPS. Thank you very much.

There was an article in the New York Times this weekend, a pretty disturbing one, about the high cost of drugs treating cancer. And it reported that a new medication called Folotyn is going to be sold for about $30,000 a month.

Now, for the record, drug companies should be able to make a profit. We need a profitable and successful domestic pharmaceutical industry.

But I am going to ask you, Mr. Smith, what good do breakthrough treatments do when they are unattainable for almost all the people who need them most? Is there any point at which your industry simply says, "No, we can't charge this much"?

Mr. SMITH. Congresswoman, drugs absolutely need to be accessible for them to do good. That is one of the reasons that we are trying to, you know, help support a health reform bill.

So, you know, in terms of this particular issue, I don't know anything about this drug, I don't know this company. But what I can say is that there are certainly cases where there are high-cost drugs, and these medicines—you know, patients need high-cost medicines at times, just like they need high-cost hospitalization——

Mrs. CAPPS. Let me ask you—go ahead.

Mr. SMITH. And part of what we do with insurance is spread the risk across the entire population for the few people who need high-cost services.

Mrs. CAPPS. Well, this is a pretty big risk for a few people whose lives are hanging by a thread.

Here is the shocking part of the story, as it was reported in the newspaper. The drug hasn't even been shown to increase the life expectancy of those who take it. If a manufacturer is going to charge $30,000 a month for a drug, I would think that they would want to be able to show that it at least helps patients live a little bit longer.

Now, you have answered, and I want to use whatever time, and it is only 2 minutes, to see if others on the panel would like to respond to this particular issue, either using this story or one other

one. But I am focusing particularly on life-threatening diseases that are lumped together as cancer and the way the cost of treatment has gone up.

Dr. Schondelmeyer, you might want to speak to it or maybe Ms. Stoll, too, as well.

Mr. SCHONDELMEYER. Sure, I would. First of all, I did not see that article in New York Times this weekend. I will go back and look for that.

In our own study, the 12 cancer drugs that we had in the specialty area, those 12 drugs all went up in price, and the price increase in 1 year ranged between 4.9 percent up to as much as 20.8 percent increase in price in a single year. And then that compounds over time, of course, as prices keep going up.

I think the point you raise is one of, we have to assess what is the real margin of value that a drug adds to society. And I am going to shift away from a cancer drug, but I think it is the same principle. A drug called Zetia, which is supposedly used for cholesterol, we recently found that that drug really is not as effective as we thought and not as effective as an old drug that is very inexpensive even though it has a slight, small convenience-type side effect perhaps. But Zetia, itself, was able to raise their price dramatically in the marketplace even though it is not even effective.

Mrs. CAPPS. Let me see if Ms. Stoll—what do you think we should do now? How can this legislation of health reform address this particular egregious issue?

Ms. STOLL. Well, there are a number of drugs that are expensive like this one in the New York Times article. I think part of the answer is, again, we need to get everyone into the system; we need to have a pooled program where we are sharing costs. Not everyone is going to need these expensive drugs. We need prescription drug coverage with annual and lifetime limits. And we need special and lower limits for low-income people to protect them so that their access to this drug and other drugs like it are not limited.

And I think that is where you find, in this sort of back and forth between good and bad today, some common ground among all of us in wanting to see that everyone is in the system and has out-of-pocket protections so they can have access to drugs.

Now, drugs should be evaluated to make sure they bring more value and new value to what is already on the marketplace.

Mrs. CAPPS. Thank you very much.

I yield back.

Mr. PALLONE. We have 7 minutes left. I would like to get Mr. Buyer in, if that is OK. I am assuming that the other Members will come back after the votes. We have four votes.

Mr. Buyer.

Mr. BUYER. I have two questions of two different witnesses, one of Professor Vernon. I want to you think about this. And then I have some questions of Ms. Cramer.

In my opening statement, I made some comments regarding the impact of price controls in the European Union that has been part of your studies. And now that you have had a chance to examine H.R. 3962 and some of the price controls and the comparative effectiveness that is in that bill, I want you to talk a little bit further about the potential impact of those controls upon drug pricing and

whether it has a positive or negative impact upon public health. OK?

Secondly, Ms. Cramer, I would like for you to respond—number one, I would like to know whether AARP, whether your organization has produced requests or received any estimates about how much additional revenue per annum will be created to your organization by H.R. 3962. That is number one.

Number two, I also would like to know whether your organization had any contact with this committee, any contact with this committee, or their staff relative to the sweetheart deal that you have in Section 102 of H.R. 3962. Most insurance plans are required to have a medical loss ratio of 85 percent. However, this bill that passed the House allows Medicare supplemental insurance plans, such as AARP's Medicare supplemental insurance plan, to have a medical loss ratio of 65 percent. I would like to know whether or not your organization had any contact in the advocacy of that. And I will give you a chance to respond.

Professor.

Mr. VERNON. Thank you, Congressman.

I would begin by saying, you had referenced my study with Professor Golec at the University of Connecticut regarding the exodus of R&D investment from Europe to the U.S. That is certainly true. I mean, we have seen regulations of pharmaceutical prices in the EU become more stringent, the U.S. now being largely the only price-unregulated market for pharmaceuticals in the world. And, certainly, you know, the prize in terms of both basic research, which could be done globally, but specifically later-stage research, large clinical trials, and, you know, marketing networks, as well as a familiarity with how to get through the FDA process has resulted in a lot of R&D leaving Europe and coming to the U.S. And, as a result, we have seen a dramatic change in the levels of R&D comparing the two markets.

And then, also, generally speaking, regarding the legislation, any attempt, implicit or explicit, to control drug prices—there have been bills on reimportation, technology assessment, and perhaps negotiated drug prices—does represent a very serious threat to the incentives to undertake R&D. And, to be frank, it is remarkable, research by economists at Yale and the University of Chicago have shown that the benefits of pharmaceutical innovation and medical innovation have been astounding and far exceed the levels of investment and the cost of that investment, suggesting we should be doing more medical research, more pharmaceutical research, because the benefits exceed the costs.

Now, that being said, I am not denying the fact that cost-containment measures would benefit consumers of existing medicines that are on the market. It would make them more affordable, improve access and utilization, and improve health. But I think we have to consider that cost and that benefit, and specifically that benefit of lower-cost medicines today, with what it would mean for the rate of innovation in the future. And I think the latter is an order of magnitude greater than the former, based upon the empirical research out there.

Mr. BUYER. All right. Thank you.

Ms. Cramer.

Ms. CRAMER. The answer to both of your questions is no. We have not, to my knowledge, had any estimate of revenues that AARP would lose or gain under House bill 3962. And I have checked with staff; to my knowledge, there has been no contact with the committee looking at the medical loss ratio we advocate on behalf of members.

Mr. BUYER. The Congressional Budget Office has said that H.R. 3962 will result in fewer people enrolled in Medicare Advantage—"fewer" really is 3 million—and more people enrolled in Medicare Part D.

Isn't it true that the vast majority, probably up to 80, 90 percent, of people enrolled in Medicare Part D by a supplemental insurance policy, such as the AARP Medicare supplemental insurance plan offered by United Health Care?

Ms. CRAMER. Are you asking me?

Mr. BUYER. Wow. Who else would I be asking?

Ms. CRAMER. Well, Congressman, I don't work for United Health Care, so I don't know that I can answer that question.

Mr. BUYER. Well, I find it really hard to believe—well, first of all, there is going to be a tremendous shift to supplementals which you offer. And I cannot believe that you run an organization that you have never really calculated what the potential income flow to your organization will be. That is really, really surprising to me.

I guess you are just trying to guard yourself in exchange for questions about why you endorse the overall packet, but I think it is now obvious.

I yield back.

Mr. PALLONE. Thank you.

Now, we are going to have four votes on the floor, maybe half an hour, a little more. I am assuming that some Members are going to come back. So, if you would wait, we would ask you to wait. And the subcommittee will stand in recess.

[Recess.]

Mr. PALLONE. The subcommittee will reconvene, and I will ask the witnesses to come back to the table. I don't think we will be much longer. Thank you for bearing with us.

Next is the gentlewoman from the Virgin Islands, Ms. Christensen.

Ms. CHRISTENSEN. Thank you, Mr. Chairman. I didn't have an opening statement, so let me thank you for holding this hearing.

As a physician, I am, of course, well aware of the key importance that pharmaceutical companies have made to the advances which have made and will continue to make in our health and health care. Overall, Americans, including the patients I have served over my lifetime, are living longer with better quality lives because of the products that the companies have created.

Unfortunately, that is not true for all. Although Medicare Part D has made a substantial improvement, people of color, the elderly, disabled and the poor continue to not be able to afford medications that they need to keep them healthy, despite some of the free and discount programs.

I know that medication costs are not the only cause of increasing health care spending. I am also not against profits. And most definitely I support the research and development which has resulted

in better lives for all of us. But I do not discount the AARP report either, as it tells a true story of people across this country who cannot afford to take all their medications every day as prescribed. So I don't think we should make light of that report at all.

I will start with Ms. Cramer on my first question. AARP pays a critical role in advocating for its membership for seniors and really for everyone one in health care, retirement security, and things that all of us care about. I would assume the membership dues alone don't support these activities.

Is it safe to say that the royalties we have heard so much about this morning are used to make important services available to your members and to fund advocacy efforts on issues that even some of those companies that are paying with those royalties may not agree with AARP on?

Ms. CRAMER. Yes, that is safe to say. We often have disagreements with the providers, but the royalties do support AARP—our education, our advocacy, our member engagement—not only in Washington, D.C., but as you know, with the 53 State offices in the Territories and the States.

Ms. CHRISTENSEN. And we thank you for the support that AARP has given to the Virgin Islands.

Mr. Smith and Professor Vernon, this is on pricing, so I can understand this better. At the point at which generics come on the market, has the brand-name producer generally recouped their cost to research and develop those products, and if so, why then do the costs continue to go up after that point, especially in excess of what the inflation is?

I ask that because when we see the new technologies come on the market, they are usually really expensive. And after a few years their prices go down. But it is the opposite for pharmaceuticals. Can you explain that for me?

Mr. VERNON. Madam Congresswoman, first, I would say that recent research undertaken by myself suggests that only two out of every ten pharmaceutical products that reach the market generate after-tax present value returns in excess of average R&D costs. I would also say we have very intense generic competition at patent expiration for very large, successful products.

The price of generics is driven very rapidly down to the marginal manufacturing cost of pharmaceuticals. We have the most competitive, lowest price, highest utilization rate of generics in the world, very successful as a result largely of the Waxman-Hatch Act.

I would also say that there is some uncertainty whether pharmaceutical prices have indeed been rising as fast as has been purported in this hearing.

And also I would add one more point, and that is that the suggestion that firms are raising prices in anticipation of health care reform is not at all clear. Certainly, the most comparable recent legislation to the current legislation was the Clinton Health Security Act, where we saw firms pledging publicly—that got them in trouble with the FTC—to restrain drug prices.

There are other factors like compressed product lifecycle cash flows as a result of patent challenges, intensified generic competition, that could be driving what we are observing in the pricing of pharmaceuticals, as well as the mix of biologics and pharma-

ceuticals, a shift towards more-costly-to-develop biologics, which have higher prices, versus fewer pharmaceuticals.

Ms. CHRISTENSEN. Well, it may be 12 years, we hope, but wouldn't you expect to get back what you have put into R&D and begin to make a profit in that period of time? That is what we are assuming.

I just wonder why the prices keep going up when a product has been on the market for years; technology has the same kind of competition, but their prices go down.

Mr. VERNON. Well, I think there are a lot of dynamic factors, and certainly the market is very different now. As I said, we have much more intensive generic competition; we have a higher rate of patent challenges; we have lower productivity with respect to pharmaceuticals; and we are seeing more biologics on market, which have a higher financial cost of capital and higher manufacturing costs. So we are seeing that mix shift between pharmaceuticals and biologics.

Ms. CHRISTENSEN. Let me try to get another question in to Ms. Stoll and Dr. Schondelmeyer.

I will acknowledge that our health status in this country would not be where it is were it not for the investment in research and development that the pharmaceutical countries make, although it would be a lot higher and better if all of us were able to participate in access to those drugs.

Do you believe there has to be a tradeoff between research and development and lowering the cost to consumers? Research and development always is what comes up when you talk about lower costs.

Mr. SCHONDELMEYER. I believe there is a tradeoff we are making already, but we are not doing it very consciously. We are doing it more implicitly rather than explicitly.

In America we may generate much of the R&D for the world that finds new medicines, but we probably have a higher percentage of our population as a developed country who don't have access to medications than any other developed country, and so that is why our health status overall is down around 20th instead of at the top of the list.

So we are making that tradeoff already and some people are paying the price. Others derive the benefit of the wonderful medicines that are discovered.

Mr. PALLONE. We are going to have to stop, only because I can't allow the others.

All right.

Ms. CHRISTENSEN. Thank you.

Mr. PALLONE. Thank you.

The gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you, Mr. Chairman, and I appreciate you all coming back or staying while we came back.

Dr. Schondelmeyer, is the cost of R&D something that is accounted for before the profit numbers or something that happens with the profits?

Mr. SCHONDELMEYER. As I understand the way drug companies keep their books and the profits they report to Wall Street, R&D has already been costed out at that point.

Mr. SARBANES. Right. So we are looking at profits of $51 million in 2008 and a 19 percent return on revenue, and since 2005, $180 billion in profits. This is after the R&D. So that makes this kind of R&D justification for where the pricing is less compelling to me, if I am understanding sort of how the books are kept on that.

I have to say, Mr. Smith, I know you can't comment on the motives, but I have no doubt that the pharmaceutical companies are running up the price in anticipation of health reform, based on past experience with them doing that. We see it also happening with the health insurance industry. There is evidence that the premiums for next year's renewals have been sky high with the recent notices that have gone out.

The disappointing thing with the—I guess it cuts both ways. I am disappointed maybe that the health insurance industry didn't make a deal the way PhRMA did, but I am disappointed that PhRMA, having made a deal, appears to be price gouging in anticipation of what is coming so they can establish a new baseline.

My question was, "the deal," as it is referred to, I guess, was about $80 billion. Is that represented by the 50 percent discount that is expected to be offered to people in the doughnut hole, or does that account for some other things as well?

Mr. SMITH. Congressman, as I mentioned earlier, I didn't come prepared today to testify about "the deal," but at a broad level the industry's contribution towards the cost of health reform would include the 50 percent discounts in the coverage gap.

As you know, both bills—both House and what we see in the Senate—include very substantial increases in the Medicaid rebate, very substantial extensions of the Medicaid rebate across to much broader a population than it applies to today, beyond the currently uninsured population that would become eligible for Medicaid.

As you know, the Senate bill includes some other fees, and as you know, both bills include provisions to create a pathway for follow-on biologics. It also comes with a pretty sizable government score.

Mr. SARBANES. I would hope the contribution that PhRMA is willing to make would increase in relationship with the change in the baseline on the drug pricing that is appearing to occur right now. In other words, if at the time the deal was made, the pricing was here, and that meant that a 50 percent contribution to the cost in the doughnut hole at that pricing represented this amount of money, then if the pricing is going up substantially, then the amount needed to cover a 50 percent discount would also go up; and beyond that, the amount needed to get you back to the anticipated discount for the consumer would even be more.

So I just hope that PhRMA is ready to stick with the deal it made in terms of the effect or the benefit it would have on the consumer in relationship to the increase in the baseline that seems to be occurring as a result of, again, what I view as a kind of price gouging scheme in these last few weeks and months.

With that, I will yield back.

Mr. PALLONE. Thank you.

Let me thank all of you for coming today. This is not an easy issue. The way it works is, members can still submit written ques-

tions through the clerk. I think the clerk is supposed to get back to you within 10 days or so.

So we still may get additional written questions. I know that a number of you said you were going to respond in writing to some of the questions that were asked by the members as well. But, in any event, we do appreciate you coming.

Dr. BURGESS. Mr. Chairman, can I ask unanimous consent—we are up against the clock here at the end of the year, and to the extent possible, could we have these written responses within 5 days so we would have an opportunity to evaluate those before we get into this ping-pong match with the Senate with whatever they are going to do at the end of the year?

Mr. PALLONE. The way the rules are, we usually have 10 days for Members to submit the questions and then we send them to the witnesses. I don't think 5 days is enough time.

I would ask that you get back to us fairly quickly, but I don't want to put a date on it because I think it depends on how complex they are. But please get back to us as quickly as you can, once you get the questions.

Dr. BURGESS. Mr. Chairman, further inquiry: I think you would acknowledge it is unlikely this health care bill is going to go to a conference.

Mr. PALLONE. If it is passed by the Senate by the holiday, we will probably go to conference in January. It all depends on when the Senate passes it. But the intention is to go to conference. I don't know how we could avoid that, given there are probably going to be major differences.

Dr. BURGESS. The way we would avoid it is, your Speaker would say we simply have to accept what the Senate does, and we acquiesce to the Senate bill by the end of the year.

Mr. PALLONE. You know, Dr. Burgess, I can't predict that. Everyone is saying there will be a conference. I think it is likely that there will be.

Dr. BURGESS. Well, I am depending upon you as my subcommittee chairman to advocate that there be a conference and that it be a real conference.

Mr. PALLONE. You do not have to worry about my advocating for a conference. I will advocate for a conference, I assure you.

Dr. BURGESS. The same way you advocated for a subcommittee markup.

I yield back.

Mr. PALLONE. I guess we are done. Without objection, this subcommittee is adjourned.

[Whereupon, at 1:28 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Statement of the
Honorable John D. Dingell
Subcommittee on Health
Hearing on "Prescription Drug Price Inflation: Are Prices Rising Too Fast?"

December 8, 2009

Mr. Chairman.

Thank you for convening today's hearing, which will allow us to assess the impact rising health care costs, more specifically prescription drug costs, is having on American families, business, and the federal government.

Total spending on prescription drugs in the United States nearly doubled between 2000 and 2007, rising from $120.6 billion to $227.5 billion. This increase in spending can be attributed to a number of factors—prescription drugs have become more expensive, rising 2.5 times the rate of annual inflation between 2000 and 2007; and people are using more of these drugs.

While we can debate the rate of prescription drug inflation, one thing has been made abundantly clear—more and more Americans are losing access to prescription drugs, putting their health in jeopardy and placing undue stress on the health system. In this country, where we have access to the greatest medical innovations, children are going without needed medication to address their chronic conditions. Many Americans are being forced to decide whether to fill a prescription or put food on the table. This problem of the high costs of medication is particularly difficult for our 45 million uninsured. Half of the uninsured have reported not filling needed prescriptions because they cost too much.

These situations are the unfortunate consequence of medical and prescription drug costs that far outpace inflation and wages.

I anticipate we will hear much about the need to invest in costly pharmaceutical research & development (R&D) this morning. I believe in the need for, and the benefit of, pharmaceutical R&D. The innovative pursuits of pharmaceutical companies over the past several decades have produced a wealth of valuable new drug therapies that have made it possible to treat major illnesses. However, no business should be allowed to drive up prices to the detriment of the American people. I believe innovation and access to therapies can co-exist. And for the benefit of the American people, they must exist.

I am convinced American consumers appreciate R&D, and understand the need to invest in it. The government also understands this, as we invest heavily in critical research at NIH. Industry must also share some responsibility, by ensuring Americans consumers are charged reasonably and appropriately for their medications.

I am the lead author of H.R. 3962, comprehensive health care reform legislation that passed the House last month. In drafting the legislation, we were keenly aware of the problems American face when it comes to access to prescription drugs. I am proud that this bill will prevent Americans from having to make those unconscionable decisions I mentioned earlier – the decisions to forgo needed prescriptions in order to make sure other necessities are met. Specifically, H.R. 3962 will:

- Provide quality, affordable health care coverage – including meaningful prescription drug coverage – to 36 million Americans currently without any insurance at all, and the millions of underinsured Americans.

- Immediately reduce the Medicare Part D gap in coverage—known as the "donut hole"--by $500; and eliminates the donut hole entirely by 2019. H.R. 3962 will also provide seniors with an immediate discount of 50% on brand name drugs in the donut hole.

- Authorize the HHS Secretary to negotiate on behalf of seniors for lower drug prices in the Part D program. This would allow the Secretary to obtain larger discounts and rebates on drugs used by seniors – passing on the savings to Part D enrollees and to taxpayers. We know that negotiating on prescription drug prices works to lower costs, as our government already does it through the Veterans Administration.

Today's hearing provides more evidence for the need for swift enactment of health care reform legislation. Americans should not be forced to wait any longer for the necessary relief comprehensive reform will provide.

I look forward to the testimony of our witnesses on this very timely topic.

Thank you, Mr. Chairman.

U.S. Representative Kathy Castor
Committee on Energy and Commerce – Subcommittee on Health
Hearing on Prescription Drug Price Inflation: Are Prices Rising too Fast?
December 8, 2009

- Thank you Mr. Chairman for convening today's hearing on the critical issue of rising drug costs.

- What families and seniors are telling me is that high prescription drug costs are outrageous. They are angry that the pharmaceutical industry appears to be gouging them and banking astronomical profits.

- Seniors who are on a fixed income with only a small amount of money left after paying basic living expenses often are unable to manage copays or are concerned that their Part D premiums will rise to an unaffordable amount. Fortunately, we on course to enact important reforms in health care effort that will ensure that prescription drugs are affordable for seniors.

- I am encouraged by the provisions in the House passed Affordable Health Care for America Act that will address prescription drug costs for Americans. I am especially pleased that we included an amendment that I worked on with several members of this Subcommittee to authorize the Secretary of HHS to negotiate on behalf of seniors for lower drug prices under Medicare Part D.

- This is not a problem limited to seniors on Medicare however. One constituent recently shared her story with me: She is 62 years old, and does not yet qualify for Medicare so she pays for an individual policy which has a $900 per month premium. After that, prescriptions are luxury items.

- While families have watched and struggled with the large increases in the cost of prescriptions over the past few years, the pharmaceutical industry has earned over $180 billion in profits alone.

- What's wrong with this picture? PhRMA has offered $80 billion to help to pay for our health reform package – I think they can do more.

- According to the report that we will review today, brand name drug prices have increased by 9.3% - completely counter to the indexes of the broader economy.

- I look forward to hearing the testimony of our witnesses today for an explanation of what has caused this unconscionable spike in brand name drug prices. It appears that these increases are in anticipation of the new fairer drug prices for Americans expected after the completion of health care reform.

- Mr. Chairman, I hope that today we can get to the bottom of this unconscionable spike in costs, and seek a solution so that our neighbors do not continue to suffer from astronomical prices that limit access to quality treatment.

Congress of the United States
House of Representatives
Washington, DC 20515-6549

Subcommittee on Health Hearing: Prescription Drug Price Inflation: Are Prices Rising Too Fast?

Tuesday, December 8, 2009, 9:30 a.m. - 10:30 a.m.
2123 Rayburn House Office Building

As we look at how upcoming regulatory legislation has caused credit cards, banks and others to get that extra pound of flesh from the consumer before the axe falls - thank you Chairman Pallone and Ranking Member Deal for holding this hearing.

As a physician I am well aware of the key importance of the pharmaceutical companies to the advances we have made and will continue to make in our health. Overall Americans are living longer better quality of lives because of the products these companies have created.

Unfortunately that is not true for all - not in people of color. Although Medicare Part D has made a substantial improvement- we, the elderly, disabled, and the poor continue to not be able to afford the medications we need to keep us healthy.

I know that medication costs are not the only cause of increasing healthcare spending. I am also not against profits and most definitely support the research and development which has resulted in better lives for all of us. But I do not discount the AARP report either as it tells the true story of people across this country who cannot afford to take all of their medications, every day as prescribed.

Although I am in full support of the need for research and development we are in a health care crisis and there has to be a realignment between profits and costs to consumers. Lack of access to medication denies the right to health care to too many people in this country today!

The new biologics are important developments that are saving lives and I appreciate that hundreds of millions of dollars have to be spent o develop drugs like Avastin which treats breast, lung, and colon cancer-many would not be alive without it.

But if we truly want to reduce health care spending the focus has to be on investing much, much more in prevention. The incidence of all 3 cancers can be greatly reduced and then less individuals would have to spend the $100,000 per year to treat these disease in advanced stages.

I would like to thank the witnesses and look forward to their testimonies.

STATEMENT OF THE HONORABLE JOE BARTON
RANKING MEMBER, COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON HEALTH HEARING
"Prescription Drug Price Inflation: Are Prices Rising Too Fast?"
DECEMBER 8, 2009

Thank you, Mr. Chairman.

I'm wondering if we have our priorities out of order today. From what I understand, Chairman Waxman sent a letter to the Government Accountability Office (GAO) on November 17, 2009, asking it to investigate the allegations that are the subject of this hearing. So I'd like to ask why we're having this hearing now instead of waiting for GAO to respond?

Now, as to the substance of the hearing, I want to welcome Professor Vernon from North Carolina. I look forward to hearing what he has to say about price controls and their impact on innovation and development of new therapies. I also look forward to hearing from Professor Schondelmeyer of the University of Minnesota, Bonnie Cramer from Families USA, Kathleen Stoll from Families USA and Rick Smith from PhRMA.

Drug pricing is an issue that has an impact on everyone. I think with Medicare Part D, we helped seniors get better access to prescription drugs and kept down drug costs without disrupting the flow of investment into critical research and development.

Research and development is the driving force behind innovative health-enhancing and life-saving drugs. Unfortunately, the price controls written by the Majority into H.R. 3962 will slow the pace of developing new drugs.

One only has to look at Europe to see the havoc of government price controls. Europe once led the United States in spending on R&D. Now America leads because the Europeans have tripped themselves up with the good politics and bad economics of government price controls. Because investment dried up and research jobs vanished, fewer drugs have been developed and approved in Europe. We can follow them over the

cliff if we institute the government price controls as the Majority wants us to do in H.R. 3962. I think we can do much better, however. Instead of repeating the mistakes of others, we should be asking how we can ensure other countries pay their fair share of research and development costs.

Also at stake is the question of who gets the drugs that are available. H.R. 3962 creates a new bureaucracy to conduct comparative effectiveness research. We've discussed this problem before, but nonetheless, here's another bill under which the government could use comparative effectiveness research to tell a patient that he cannot have the drug that might save his life. In the most extreme possibility, some people may be too old to warrant the expense. Please don't say that no civilized society will ever use cold-hearted accounting rooted in comparative effectiveness research to deny treatment, because it has already happened repeatedly in England.

Congressman Rogers offered an amendment during our Committee markup that would prevent the federal government from denying access to life-saving drugs, therapies, and treatments based on government comparative effectiveness research. Unfortunately, after accepting Mr. Rogers' amendment during our Committee markup, the Majority decided to gut the amendment in H.R. 3962, the health reform bill that passed the House floor. If H.R. 3962 gets enacted into law, which I hope it doesn't, Americans could be denied access to life-saving drugs because of cost. This is wrong, and I hope we can work in a bipartisan manner to prevent this happening.

Thank you Mr. Chairman. I yield back.

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Form **990**

Department of the Treasury
Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except black lung benefit trust or private foundation)

▶ The organization may have to use a copy of this return to satisfy state reporting requirements

OMB No 1545-0047

2008

Open to Public Inspection

A For the 2008 calendar year, or tax year beginning 01-01-2008 and ending 12-31-2008

B Check if applicable
- ☐ Address change
- ☐ Name change
- ☐ Initial return
- ☐ Termination
- ☐ Amended return
- ☐ Application pending

Please use IRS label or print or type. See Specific Instructions.

C Name of organization
AARP

Doing Business As

Number and street (or P O box if mail is not delivered to street address) | Room/suite
601 E Street NW c/o Tax Dept

City or town, state or country, and ZIP + 4
Washington, DC 20049

D Employer identification number
95-1985500

E Telephone number
(202) 434-3220

G Gross receipts $ 3,067,360,638

F Name and address of Principal Officer
Robert R Hagans Jr
601 E Street NW
Washington, DC 20049

H(a) Is this a group return for affiliates? ☐ Yes ☑ No

H(b) Are all affiliates included? ☐ Yes ☐ No
(If "No," attach a list See instructions)

H(c) Group Exemption Number ▶

I Tax-exempt status ☑ 501(c) (4) ◀ (insert no) ☐ 4947(a)(1) or ☐ 527

J Web site: ▶ www aarp org

K Type of organization ☑ Corporation ☐ Trust ☐ association ☐ other ▶

L Year of Formation 1958 | M State of legal domicile DC

Part I Summary

Activities & Governance

1 Briefly describe the organization's mission or most significant activities
AARP is a nonprofit, nonpartisan membership organization for people age 50 and over AARP is dedicated to enhancing the quality of life for all as we age AARP leads positive social change and delivers value to members through information, advocacy, and service

2 Check this box ☐ if the organization discontinued its operations or disposed of more than 25% of its assets

3	Number of voting members of the governing body (Part VI, line 1a)	3	23
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	23
5	Total number of employees (Part V, line 2a)	5	2,330
6	Total number of volunteers (estimate if necessary)	6	23,000
7a	Total gross unrelated business revenue from Part VIII, line 12, column (C)	7a	133,850,962
b	Net unrelated business taxable income from Form 990-T, line 34	7b	7,118,073

		Prior Year	Current Year
Revenue 8	Contributions and grants (Part VIII, line 1h)	267,238,326	260,921,827
9	Program service revenue (Part VIII, line 2g)	139,382,009	147,964,320
10	Investment income (Part VIII, column (A), lines 3, 4, and 7d)	82,876,270	60,795,124
11	Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	474,075,337	675,111,204
12	Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	963,571,942	1,144,792,475
Expenses 13	Grants and similar amounts paid (Part IX, column (A), lines 1–3)	25,238,489	28,638,353
14	Benefits paid to or for members (Part IX, column (A), line 4)		0
15	Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)	238,711,806	361,595,504
16a	Professional fundraising fees (Part IX, column (A), line 11e)	620,743	959,866
b	(Total fundraising expenses, Part IX, column (D), line 25 5,705,334)		
17	Other expenses (Part IX, column (A), lines 11a–11d, 11f–24f)	700,862,853	716,080,060
18	Total expenses—add lines 13–17 (must equal Part IX, line 25, column (A))	965,653,891	1,109,273,783
19	Revenue less expenses Subtract line 18 from line 12	-2,081,949	35,518,692

		Beginning of Year	End of Year
Net Assets or Fund Balances 20	Total assets (Part X, line 16)	1,034,135,617	994,357,004
21	Total liabilities (Part X, line 26)	796,065,819	983,628,347
22	Net assets or fund balances Subtract line 21 from line 20	238,069,798	10,728,657

Part II Signature Block

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct, and complete Declaration of preparer (other than officer) is based on all information of which preparer has any knowledge

Please Sign Here

****** | 2009-07-01
Signature of officer | Date

Robert R Hagans Jr CFO
Type or print name and title

Paid Preparer's Use Only

Preparer's signature | Date | Check if self-employed ▶ ☐ | Preparer's PTIN (See Gen Inst)

Firm's name (or yours if self-employed), address, and ZIP + 4 ▶ | EIN ▶

Phone no ▶

May the IRS discuss this return with the preparer shown above? (See instructions) ☐ Yes ☐ No

art III Statement of Program Service Accomplishments (See the instructions.)

Briefly describe the organization's mission

e Additional Data Table

Did the organization undertake any significant program services during the year which were not listed on the prior Form 990 or 990-EZ? . . . . . ☐ Yes ☑ No

If "Yes," describe these new services on Schedule O

Did the organization cease conducting or make significant changes in how it conducts any program services? . . . . . ☐ Yes ☑ No

If "Yes," describe these changes on Schedule O

Describe the exempt purpose achievements for each of the organization's three largest program services by expenses Section 501(c)(3) and (4) organizations and 4947(a)(1) trusts are required to report the amount of grants and allocations to others, the total expenses, and revenue, if any, for each program service reported

4a (Code) (Expenses $ 226,015,431 including grants of $ 105,000) (Revenue $ 127)

Membership Service helps AARP shape its relationship with members by managing the content and quality of member interactions with AARP to ensure that AARP is providing a positive experience and excellent customer service to members through events and exhibits, mail, telephone, web, and other interactive member touch points AARP provides an interactive web site and a toll-free call center number, both of which supply members with information on members benefits, services, publications, and programs Membership Service summarizes AARP's position on activities related to the organization's strategic priorities, as well as the activities that support its strategic plan In 2006, AARP created AARP Global Network LLC to cooperate with organizations representing people 50+ in other countries to promote and deliver social change through joint international commitment to assure that people 50+ are better able to live fulfilling lives with dignity and purpose

4b (Code) (Expenses $ 183,053,365 including grants of $ 45,000) (Revenue $)

AARP's 40 million members receive "AARP The Magazine," which is published every other month (bimonthly) in three versions, each of which targets a specific age group members 50-59, members 60-69, and members 70 and over "AARP The Magazine" includes the key areas of health, personal finance, work/life transitions, and personal enrichment All members also receive 10 issues of "AARP Bulletin," a monthly publication (January/February and July/August are combined) that reports on such issues as Social Security, Medicare, and those related to work, retirement, pensions, benefits, health, and quality of life "AARP Segunda Juventud" is a quarterly, bilingual publication for Hispanic members of AARP This publication includes profiles of leading Hispanic personalities, articles on new trends in the Hispanic community, and advice for protecting health, managing money, and enjoying leisure time All publications are now available electronically on AARP's website www aarp org

4c (Code) (Expenses $ 114,095,440 including grants of $ 0) (Revenue $)

The Membership Development group is dedicated to ensuring that the member experience is valuable, members are satisfied, a relevant portfolio of benefits is available, and strategies for retention and growth are developed and properly carried out Membership Development plans and executes strategies to attract, acquire, and retain members It focuses on both membership as a whole and on specific segments within the membership Key segments include multicultural segments, boomers, AARP's primary age segments (50-59, 60-69, 70 and over), new members, retired educators, and members residing outside of the United States

(Code) (Expenses $ 283,579,512 including grants of $ 28,488,353) (Revenue $ 14,224,433)

4d Other program services (Describe in Schedule O)
(Expenses $ including grants of $) (Revenue $)

4e Total program service expenses $ 806,743,748 *Must equal Part IX, Line 25, column (B).*

art IV Checklist of Required Schedules.

			Yes	No
	Is the organization described in section 501(c)(3) or 4947(a)(1) (other than a private foundation)? *If "Yes," complete Schedule A*	1		No
	Is the organization required to complete Schedule B, Schedule of Contributors?	2	Yes	
	Did the organization engage in direct or indirect political campaign activities on behalf of or in opposition to candidates for public office? *If "Yes," complete Schedule C, Part I*	3	Yes	
	Section 501(c)(3) organizations Did the organization engage in lobbying activities? *If "Yes," complete Schedule C, Part II*	4		
	Section 501(c)(4), 501(c)(5), and 501(c)(6) organizations Is the organization subject to the section 6033(e) notice and reporting requirement and proxy tax? *If "Yes," complete Schedule C, Part III*	5		No
	Did the organization maintain any donor advised funds or any accounts where donors have the right to provide advice on the distribution or investment of amounts in such funds or accounts? *If "Yes," complete Schedule D, Part I*	6		No
	Did the organization receive or hold a conservation easement, including easements to preserve open space, the environment, historic land areas or historic structures? *If "Yes," complete Schedule D, Part II*	7		No
	Did the organization maintain collections of works of art, historical treasures, or other similar assets? *If "Yes," complete Schedule D, Part III*	8		No
	Did the organization report an amount in Part X, line 21, serve as a custodian for amounts not listed in Part X, or provide credit counseling, debt management, credit repair, or debt negotiation services? *If "Yes," complete Schedule D, Part IV*	9		No
0	Did the organization hold assets in term, permanent,or quasi-endowments? *If "Yes," complete Schedule D, Part V*	10		No
1	Did the organization report an amount in Part X, lines 10, 12, 13, 15, or 25? *If "Yes," complete Schedule D, Parts VI, VII, VIII, IX, or X as applicable*	11	Yes	
2	Did the organization receive an audited financial statement for the year for which it is completing this return that was prepared in accordance with GAAP? *If "Yes," complete Schedule D, Parts XI, XII, and XIII*	12	Yes	
3	Is the organization a school as described in section 170(b)(1)(A)(ii)? *If "Yes," complete Schedule E*	13		No
4a	Did the organization maintain an office, employees, or agents outside of the U S ?	14a		No
b	Did the organization have aggregate revenues or expenses of more than $10,000 from grantmaking, fundraising, business, and program service activities outside the U S ? *If "Yes," complete Schedule F, Part I*	14b		No
5	Did the organization report on Part IX, column (A), line 3, more than $5,000 of grants or assistance to any organization or entity located outside the United States? *If "Yes," complete Schedule F, Part II*	15		No
6	Did the organization report on Part IX, column (A), line 3, more than $5,000 of aggregate grants or assistance to individuals located outside the United States? *If "Yes," complete Schedule F, Part III*	16		No
7	Did the organization report more than $15,000 on Part IX, column (A), line 1a? *If "Yes," complete Schedule G, Part I*	17	Yes	
8	Did the organization report more than $15,000 total on Part VIII, lines 1c and 8a? *If "Yes," complete Schedule G, Part II*	18		No
9	Did the organization report more than $15,000 on Part VIII, line 9a? *If "Yes," complete Schedule G, Part III*	19		No
0	Did the organization operate one or more hospitals? *If "Yes," complete Schedule H*	20		No
1	Did the organization report more than $5,000 on Part IX, column (A), line 1? *If "Yes," complete Schedule I, Parts I and II*	21	Yes	
2	Did the organization report more than $5,000 on Part IX, column (A), line 2? *If "Yes," complete Schedule I, Parts I and III*	22		No
3	Did the organization answer "Yes" to Part VII, Section A, questions 3, 4, or 5? *If "Yes," complete Schedule J*	23	Yes	
4a	Did the organization have a tax-exempt bond issue with an outstanding principal amount of more than $100,000 as of the last day of the year, that was issued after December 31, 2002? *If "Yes," answer questions 24b-24d and complete Schedule K. If "No," go to question 25*	24a		No
b	Did the organization invest any proceeds of tax-exempt bonds beyond a temporary period exception?	24b		
c	Did the organization maintain an escrow account other than a refunding escrow at any time during the year to defease any tax-exempt bonds?	24c		
d	Did the organization act as an "on behalf of" issuer for bonds outstanding at any time during the year?	24d		
5a	Section 501(c)(3) and 501(c)(4) organizations Did the organization engage in an excess benefit transaction with a disqualified person during the year? *If "Yes," complete Schedule L, Part I*	25a		No
b	Did the organization become aware that it had engaged in an excess benefit transaction with a disqualified person from a prior year? *If "Yes," complete Schedule L, Part I*	25b		No
6	Was a loan to or by a current or former officer, director, trustee, key employee, highly compensated employee, or disqualified person outstanding as of the end of the organization's tax year? *If "Yes," complete Schedule L, Part II*	26		No
7	Did the organization provide a grant or other assistance to an officer, director, trustee, key employee, or substantial contributor, or to a person related to such an individual? *If "Yes," complete Schedule L, Part III*	27		No

Part IV Checklist of Required Schedules *(Continued)*

			Yes	No
28		During the tax year, did any person who is a current or former officer, director, trustee, or key employee			
	a	Have a direct business relationship with the organization (other than as an officer, director, trustee, or employee), or an indirect business relationship through ownership of more than 35% in another entity (individually or collectively with other person(s) listed in Part VII, Section A)? *If "Yes," complete Schedule L, Part IV*	28a		No
	b	Have a family member who had a direct or indirect business relationship with the organization? *If "Yes," complete Schedule L, Part IV*	28b		No
	c	Serve as an officer, director, trustee, key employee, partner, or member of an entity (or a shareholder of a professional corporation) doing business with the organization? *If "Yes," complete Schedule L, Part IV*	28c		No
29		Did the organization receive more than $25,000 in non-cash contributions? *If "Yes," complete Schedule M*	29		No
30		Did the organization receive contributions of art, historical treasures, or other similar assets, or qualified conservation contributions? *If "Yes," complete Schedule M*	30		No
31		Did the organization liquidate, terminate, or dissolve and cease operations? *If "Yes," complete Schedule N, Part I*	31		No
32		Did the organization sell, exchange, dispose of, or transfer more than 25% of its net assets? *If "Yes," complete Schedule N, Part II*	32		No
33		Did the organization own 100% of an entity disregarded as separate from the organization under Regulations section 301 7701-2 and 301 7701-3? *If "Yes," complete Schedule R, Part I*	33	Yes	
34		Was the organization related to any tax-exempt or taxable entity? *If "Yes," complete Schedule R, Parts II, III, IV, and V, line 1*	34	Yes	
35		Is any related organization a controlled entity within the meaning of section 512(b)(13)? *If "Yes," complete Schedule R, Part V, line 2*	35	Yes	
36		501(c)(3) organizations Did the organization make any transfers to an exempt non-charitable related organization? *If "Yes," complete Schedule R, Part V, line 2*	36		
37		Did the organization conduct more than 5 percent of its activities through an entity that is not a related organization and that is treated as a partnership for federal income tax purposes? *If "Yes," complete Schedule R, Part VI*	37		No

art V Statements Regarding Other IRS Filings and Tax Compliance

				Yes	No
1	Enter the number reported in Box 3 of Form 1096, *Annual Summary and Transmittal of U.S. Information Returns. Enter -0-* if not applicable	1a	1,479		
b	Enter the number of Forms W-2G included in line 1a *Enter -0-* if not applicable	1b	0		
c	Did the organization comply with backup withholding rules for reportable payments to vendors and reportable gaming (gambling) winnings to prize winners?		1c	Yes	
2a	Enter the number of employees reported on Form W-3, *Transmittal of Wage and Tax Statements* filed for the calendar year ending with or within the year covered by this return	2a	2,330		
b	If at least one is reported in 2a, did the organization file all required federal employment tax returns? **Note:** *If the sum of lines 1a and 2a is greater than 250, you may be required to e-file this return.*		2b	Yes	
3a	Did the organization have unrelated business gross income of $1,000 or more during the year covered by this return?		3a	Yes	
b	If "Yes," has it filed a Form 990-T for this year? *If "No," provide an explanation in Schedule O*		3b	Yes	
4a	At any time during the calendar year, did the organization have an interest in, or a signature or other authority over, a financial account in a foreign country (such as a bank account, securities account, or other financial account)?		4a	Yes	
b	If "Yes," enter the name of the foreign country HK, JA, NO, SN, SW, AS, SZ See the instructions for exceptions and filing requirements for **Form TD F 90-22.1,** *Report of Foreign Bank and Financial Accounts.*				
5a	Was the organization a party to a prohibited tax shelter transaction at any time during the tax year?		5a		No
b	Did any taxable party notify the organization that it was or is a party to a prohibited tax shelter transaction?		5b		No
c	If "Yes," to 5a or 5b, did the organization file Form 8886-T, *Disclosure by Tax-Exempt Entity Regarding Prohibited Tax Shelter Transaction?*		5c		
6a	Did the organization solicit any contributions that were not tax deductible?		6a	Yes	
b	If "Yes," did the organization include with every solicitation an express statement that such contributions or gifts were not tax deductible?		6b	Yes	
	Organizations that may receive deductible contributions under section 170(c).				
7a	Did the organization provide goods or services in exchange for any quid pro quo contribution of $75 or more?		7a		No
b	If "Yes," did the organization notify the donor of the value of the goods or services provided?		7b		
c	Did the organization sell, exchange, or otherwise dispose of tangible personal property for which it was required to file Form 8282?		7c		No
d	If "Yes," indicate the number of Forms 8282 filed during the year	7d			
e	Did the organization, during the year, receive any funds, directly or indirectly, to pay premiums on a personal benefit contract?		7e		No
f	Did the organization, during the year, pay premiums, directly or indirectly, on a personal benefit contract?		7f		No
g	For all contributions of qualified intellectual property, did the organization file Form 8899 as required?		7g		No
h	For contributions of cars, boats, airplanes, and other vehicles, did the organization file a Form 1098-C as required?		7h		No
8	*Section 501(c)(3) and other sponsoring organizations maintaining donor advised funds and section 509(a)(3) supporting organizations.* Did the supporting organization, or a fund maintained by a sponsoring organization, have excess business holdings at any time during the year?		8		
9	*Section 501(c)(3) and other sponsoring organizations maintaining donor advised funds.*				
a	Did the organization make any taxable distributions under section 4966?		9a		
b	Did the organization make a distribution to a donor, donor advisor, or related person?		9b		
10	*Section 501(c)(7) organizations.* Enter				
a	Initiation fees and capital contributions included on Part VIII, line 12	10a			
b	Gross receipts, included on Form 990, Part VIII, line 12, for public use of club facilities	10b			
11	Section 501(c)(12) organizations Enter				
a	Gross income from members or shareholders	11a			
b	Gross income from other sources (Do not net amounts due or paid to other sources against amounts due or received from them)	11b			
12a	*Section 4947(a)(1) non-exempt charitable trusts.* Is the organization filing Form 990 in lieu of Form 1041?		12a		
b	If "Yes," enter the amount of tax-exempt interest received or accrued during the year	12b			

art VI Governance, Management, and Disclosure ***(Sections A, B, and C request information about policies not required by the Internal Revenue Code.)***

Section A. Governing Body and Management

			Yes	No
	For each "Yes" response to lines 2-7 below, and for a "No" response to lines 8 or 9b below, describe the circumstances, processes, or changes in Schedule O. See instructions.			
a	Enter the number of voting members of the governing body	1a 23		
b	Enter the number of voting members that are independent	1b 23		
	Did any officer, director, trustee, or key employee have a family relationship or a business relationship with any other officer, director, trustee, or key employee?	2		No
	Did the organization delegate control over management duties customarily performed by or under the direct supervision of officers, directors or trustees, or key employees to a management company or other person?	3		No
	Did the organization make any significant changes to its organizational documents since the prior Form 990 was filed?	4		No
	Did the organization become aware during the year of a material diversion of the organization's assets?	5		No
	Does the organization have members or stockholders?	6	Yes	
a	Does the organization have members, stockholders, or other persons who may elect one or more members of the governing body?	7a		No
b	Are any decisions of the governing body subject to approval by members, stockholders, or other persons?	7b		No
	Did the organization contemporaneously document the meetings held or written actions undertaken during the year by the following			
a	the governing body?	8a	Yes	
b	each committee with authority to act on behalf of the governing body?	8b	Yes	
a	Does the organization have local chapters, branches, or affiliates?	9a	Yes	
b	If "Yes," does the organization have written policies and procedures governing the activities of such chapters, affiliates, and branches to ensure their operations are consistent with those of the organization?	9b	Yes	
0	Was a copy of the Form 990 provided to the organization's governing body before it was filed? All organizations must describe in Schedule O the process, if any, the organization uses to review the Form 990	10	Yes	
1	Is there any officer, director or trustee, or key employee listed in Part VII, Section A, who cannot be reached at the organization's mailing address? If "Yes," provide the names and addresses in Schedule O	11		No

Section B. Policies

			Yes	No
2a	Does the organization have a written conflict of interest policy? *If "No", go to line 13*	12a	Yes	
b	Are officers, directors or trustees, and key employees required to disclose annually interests that could give rise to conflicts?	12b	Yes	
c	Does the organization regularly and consistently monitor and enforce compliance with the policy? If "Yes," describe in Schedule O how this is done	12c	Yes	
3	Does the organization have a written whistleblower policy?	13	Yes	
4	Does the organization have a written document retention and destruction policy?	14	Yes	
5	Did the process for determining compensation of the following persons include a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and decision			
a	The organization's CEO, Executive Director, or top management official?	15a	Yes	
b	Other officers or key employees of the organization?	15b		No
	Describe the process in Schedule O			
6a	Did the organization invest in, contribute assets to, or participate in a joint venture or similar arrangement with a taxable entity during the year?	16a		No
b	If "Yes," has the organization adopted a written policy or procedure requiring the organization to evaluate its participation in joint venture arrangements under applicable Federal tax law, and taken steps to safeguard the organization's exempt status with respect to such arrangements?	16b		

Section C. Disclosure

7 List the States with which a copy of this Form 990 is required to be filed CA

8 Section 6104 requires an organization to make its Form 1023 (or 1024 if applicable), 990, and 990-T (501(c)(3)s only) available for public inspection Indicate how you make these available Check all that apply
☐ own website ☑ another's website ☑ upon request

9 Describe in Schedule O whether (and if so, how), the organization makes its governing documents, conflict of interest policy, and financial statements available to the public See Additional Data Table

0 State the name, physical address, and telephone number of the person who possesses the books and records of the organization
AARP
601 E Street NW
Washington, DC 20049
(202) 434-3220

Part VII Compensation of Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Independent Contractors

Section A Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

1a Complete this table for all persons required to be listed Use Schedule J-2 if additional space is needed
* List all of the organization's current officers, directors, trustees (whether individuals or organizations) and key employees regardless of amount of compensation, and current key employees Enter -0- in columns (D), (E), and (F) if no compensation was paid

* List the organization's five current highest compensated employees (other than an officer, director, trustee or key employee) who received reportable compensation (Box 5 of Form W-2 and/or Box 7 of Form 1099-MISC) of more than $100,000 from the organization and any related organizations

* List all of the organization's former officers, key employees, or highest compensated employees who received more than $100,000 of reportable compensation from the organization and any related organizations

* List all of the organization's former directors or trustees that received, in the capacity as a former director or trustee of the organization, more than $10,000 of reportable compensation from the organization and any related organizations

List persons in the following order individual trustees or directors, institutional trustees, officers, key employees, highest compensated employees, and former such persons

☐ Check this box if the organization did not compensate any officer, director, trustee or key employee

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099MISC)	(E) Reportable compensation from related organizations (W- 2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual Trustee or Director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
Jennn Clen Hansen	10 00	X						20,394	0	0
W Lee Hammond	1 00	X						4,400	0	0
Robert Romasco	1 00	X						1,006	0	0
Bonnie H Cramer	1 00	X						10,947	0	0
John F Zaglengo	1 00	X						5,692	0	0
Yash Aggarwal	1 00	X						27,427	0	0
Gail E Aldrich	1 00	X						4,410	0	0
Rekia Bamett	1 00	X						5,882	0	0
Cora L Christan	1 00	X						10,804	0	0
Joanne Disch	1 00	X						7,052	0	0
Allen Douma	1 00	X						5,079	0	0
Leobardo Estrada	1 00	X						9,326	0	0
A James Forbes Jr	1 00	X						0	0	0
William J Hall	1 00	X						0	0	0
Joanne Hendy	1 00	X						5,081	0	0
Hubert H Humphrey III	1 00	X						644	0	0
Richard Johnson	1 00	X						9,054	0	0
Jacob Lozada	1 00	X						0	0	0
Mara Mayor	1 00	X						1,771	0	0
Maeona Mendelson	1 00	X						19,987	0	0
J David Nelson	1 00	X						0	0	0
Eric D Olsen	10 00	X						15,880	0	0
Joyce N Payne	1 00	X						5,109	0	0
Clarence Pearson	1 00	X						13,138	0	0
Charles E Reed	1 00	X						6,030	0	0
Georgie T Rowan	1 00	X						1,238	0	0
Mary C Scott	1 00	X						5,525	0	0
Thomas Byron Thames	1 00	X						7,299	0	0
William D Novelli	45 00			X				788,957	0	216,423
Robert R Hagans Jr	51 00			X				362,104	0	36,328
Thomas C Nelson	66 00				X			576,893	0	48,964
Lin Mac Master	52 00				X			415,098	0	37,569
Nancy A LeaMond	58 00				X			385,598	0	36,081
Emilio Pardo	50 00				X			369,291	0	47,955
Joan S Wise	40 00				X			366,532	0	43,028
Shereen G Remer	42 00				X			339,152	0	36,297
John C Rother	39 00				X			321,747	0	39,695
Kevin J Donnellan	53 00				X			315,293	0	42,929
Ellen Hollander	52 00				X			302,543	0	48,735
Harrell Backus	48 00				X			300,824	0	33,506
Matthew Mitchell	45 00				X			275,542	0	48,677
Hugh Delehanty	49 00					X		307,022	0	42,914
Nancy Smith	50 00					X		132,087	165,775	35,003
David Sloane	51 00					X		295,578	0	39,542
Susan Reinhard	52 00					X		284,746	0	43,392
Matthew Rosser	34 00					X		279,685	0	47,608

rt VII Continued

(A) Name and Title	(B) Average hours per week	(C) Position (check all that apply)						(D) Reportable compensation from the organization (W-2/1099MISC)	(E) Reportable compensation from related organizations (W-2/1099-MISC)	(F) Estimated amount of other compensation from the organization and related organizations
		Individual Trustee or Director	Institutional Trustee	Officer	Key employee	Highest compensated employee	Former			
b Total ▶								6,623,777	165,775	924,556

Total number of individuals (including those in 1a) who received more than $100,000 in reportable compensation from the organization ▶ 18

		Yes	No
Did the organization list any former officer, director or trustee, key employee, or highest compensated employee on line 1a? *If "Yes," complete Schedule J for such individual*	3		No
For any individual listed on line 1a, is the sum of reportable compensation and other compensation from the organization and related organizations greater than $150,000? *If "Yes," complete Schedule J for such individual*	4	Yes	
Did any person listed on line 1a receive or accrue compensation from any unrelated organization for services rendered to the organization? *If "Yes," complete Schedule J for such person*	5		No

Section B. Independent Contractors

Complete this table for your five highest compensated independent contractors that received more than $100,000 of compensation from the organization

(A) Name and business address	(B) Description of services	(C) Compensation
R DONNELLEY .1 SOUTH WACKER DRIVE HICAGO, IL 60606	PRINTING SERVICES FOR PUBLICATIONS	73,374,691
SDBM IDEA CITY LLC 18 WEST 6TH STREET USTIN, TX 78703	ADVERTISING AND MARKETING FIRM	43,480,775
OORE WALLACE) HAZELWOOD DRIVE STE 100 AMHERST, NY 14228	PRINTING SERVICES FOR PUBLICATIONS	19,062,863
RC LLC .51 PETERS ROAD STE 4000 ANTATION, FL 33324	CUSTOMER CONTACT MGMT - MEMBER CALL CENT	15,406,224
ND CONSTRUCTION CORPORATION)29 NORTH ROYAL STREET EXANDRIA, VA 22314	DESIGN AND CONSTRUCTION	12,596,034
Total number of independent contractors (including those in 1) who received more than $100,000 in compensation from the organization ▶		620

Part VIII Statement of Revenue

				(A) Total Revenue	(B) Related or Exempt Function Revenue	(C) Unrelated Business Revenue	(D) Revenue Excluded from Tax under IRC 512, 513, or 514
Contributions, gifts, grants and other similar amounts	1a	Federated campaigns	1a				
	b	Membership dues	1b	249,314,078			
	c	Fundraising events	1c				
	d	Related organizations	1d				
	e	Government grants (contributions)	1e	10,795			
	f	All other contributions, gifts, grants, and similar amounts not included above	1f	11,596,954			
	g	Noncash contributions included in lines 1a-1f $					
	h	**Total (Add lines 1a-1f)**		260,921,827			
Program Service Revenue			Business Code				
	2a	Publication/Web advert	541800	133,739,761		133,739,761	
	b						
	c						
	d						
	e						
	f	All other program service revenue		14,224,559	14,224,559		
	g	**Total. Add lines 2a-2f** ▶ $ 147,964,320					
Other Revenue	3	Investment income (including dividends, interest and other similar amounts)		61,007,276			61,007,276
	4	Income from investment of tax-exempt bond proceeds					
	5	Royalties		652,701,686			652,701,686
			(i) Real / (ii) Personal				
	6a	Gross Rents	3,488,621				
	b	Less rental expenses	3,286,690				
	c	Rental income or (loss)	202,131				
	d	Net rental income or (loss)		202,131		111,201	90,930
			(i) Securities / (ii) Other				
	7a	Gross amount from sales of assets other than inventory	1,919,089,321				
	b	Less cost or other basis and sales expenses	1,918,840,959	460,514			
	c	Gain or (loss)	248,362	-460,514			
	d	Net gain or (loss)		-212,152			-212,152
	8a	Gross income from fundraising events (not including $ _____ of contributions reported on line 1c) See Part IV, line 18 *Attach Schedule G if total exceeds $15,000*	a				
	b	Less direct expenses	b				
	c	Net income or (loss) from fundraising events					
	9a	Gross income from gaming activities See part IV, line 19 *Complete Schedule G if total exceeds $15,000*	a				
	b	Less direct expenses	b				
	c	Net income or (loss) from gaming activities					
	10a	Gross sales of inventory, less returns and allowances	a				
	b	Less cost of goods sold	b				
	c	Net income or (loss) from sales of inventory					
		Miscellaneous Revenue	Business Code				
	11a	MetLife Demutualizatio		16,318,222			16,318,222
	b	Miscellaneous income		3,094,290			3,094,290
	c	Captive Insurance Prem		2,793,875			2,793,875
	d	All other revenue					
	e	**Total. Add lines 11a-11d**	$ 22,207,387				
	12	**Total Revenue.** Add lines 1h, 2g, 3, 4, 5, 6d, 7d, 8c, 9c, 10c, and 11e		1,144,792,475	14,224,559	133,850,962	735,795,127

rt IX Statement of Functional Expenses

Section 501(c)(3) and 501(c)(4) organizations must complete all columns.
All other organizations must complete column (A) but are not required to complete columns (B), (C), and (D).

› not include amounts reported on lines 6b, 7b, 8b, 9b, and 10b of Part VIII.	(A) Total expenses	(B) Program service expenses	(C) Management and general expenses	(D) Fundraising expenses
Grants and other assistance to governments and organizations in the U S See Part IV, line 21	28,638,353	28,638,353		
Grants and other assistance to individuals in the U S See Part IV, line 22				
Grants and other assistance to governments, organizations and individuals outside the U S See Part IV, lines 15 and 16				
Benefits paid to or for members				
Compensation of current officers, directors, trustees, and key employees	6,039,858	1,945,477	4,094,381	
Compensation not included above, to disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B)				
Other salaries and wages	182,247,126	126,568,424		182,357
Pension plan contributions (include section 401(k) and section 403(b) employer contributions)	133,404,636	11,333,706	122,052,207	18,723
Other employee benefits	27,949,515	19,123,248	8,798,647	27,620
l Payroll taxes	11,984,369	8,187,752	3,754,982	11,635
l Fees for services (non-employees)				
a Management				
b Legal	2,550,141	41,108	2,509,033	
c Accounting	680,303	55,886	624,417	
d Lobbying				
e Professional fundraising *See Part IV, line 17*	959,866			959,866
f Investment management fees	4,569,358	21,423	4,547,935	
g Other	134,073,735	120,382,576	13,670,348	20,811
2 Advertising and promotion	122,891,388	116,506,167	6,326,453	58,768
3 Office expenses	6,778,412	3,249,378	3,528,713	321
4 Information technology	28,796,091	21,548,707	6,897,828	349,556
5 Royalties				
6 Occupancy	23,389,220	21,139,581	2,247,738	1,901
7 Travel	10,422,490	8,520,624	1,886,629	15,237
8 Payments of travel or entertainment expenses for any Federal, state or local public officials				
9 Conferences, conventions and meetings	17,432,773	15,447,840	1,984,933	
0 Interest	11,472,683		11,472,683	
1 Payments to affiliates				
2 Depreciation, depletion, and amortization	24,889,525	8,842,776	16,039,157	7,592
3 Insurance	3,545,524		3,545,524	
4 Other expenses—Itemize expenses not covered above (Expenses grouped together and labeled miscellaneous may not exceed 5% of total expenses shown on line 25 below)				
a Printing & Postage	250,826,571	242,900,110	1,308,249	6,618,212
b Research, Surveys, & Te	19,938,118	16,920,351	2,585,572	432,195
c Member Call Center	16,163,750	16,163,750		
d Taxes & Licenses	14,751,539	1,553,522	13,198,017	
e Volunteer Travel & Acti	8,108,179	6,924,277	1,183,748	154
f All other expenses	16,800,260	10,728,712	6,071,162	386
5 **Total functional expenses.** Add lines 1 through 24f	1,109,273,783	806,743,748	293,824,701	8,705,334
6 **Joint Costs.** Check ☑ if following SOP 98-2 Complete this line only if the organization reported in column (B) joint costs from a combined educational campaign and fundraising solicitation	4888053	1,162,177		3,725,876

art X Balance Sheet

				(A) Beginning of year		(B) End of year
1	Cash—non-interest-bearing			1,881,985	1	985,389
2	Savings and temporary cash investments			85,531,955	2	196,512,354
3	Pledges and grants receivable, net				3	
4	Accounts receivable, net			52,586,063	4	51,971,771
5	Receivables from current and former officers, directors, trustees, key employees or other related parties *Complete Part II of Schedule L*				5	
6	Receivables from other disqualified persons (as defined under section 4958(f)(1)) and persons described in section 4958(c)(3)(B) *Complete Part II of Schedule L*				6	
7	Notes and loans receivable, net			1,550,137	7	14,685,577
8	Inventories for sale or use				8	
9	Prepaid expenses and deferred charges			28,431,425	9	20,158,714
10a	Land, buildings, and equipment cost basis	10a	448,842,386			
b	Less accumulated depreciation *Complete Part VI of Schedule D*	10b	162,567,428	275,099,874	10c	286,274,960
11	Investments—publicly traded securities			537,786,371	11	420,788,239
12	Investments—other securities See Part IV, line 11 *Complete Part VII of Schedule D*			46,579,309	12	3,000,000
13	Investments—program-related See Part IV, line 11 *Complete Part VIII of Schedule D*				13	
14	Intangible assets				14	
15	Other assets See Part IV, line 11 *Complete Part IX of Schedule D*			4,788,698	15	0
16	**Total assets.** *Add lines 1 through 15 (must equal line 34)*			1,034,135,617	16	994,957,004
17	Accounts payable and accrued expenses			105,462,042	17	150,183,937
18	Grants payable				18	
19	Deferred revenue			215,908,911	19	210,202,253
20	Tax-exempt bond liabilities				20	
21	Escrow account liability *Complete Part IV of Schedule D*				21	
22	Payable to current and former officers, directors, trustees, key employees, highest compensated employees, and disqualified persons *Complete Part II of Schedule L*				22	
23	Secured mortgages and notes payable to unrelated third parties				23	
24	Unsecured notes and loans payable			205,052,812	24	205,068,708
25	Other liabilities *Complete Part X of Schedule D*			269,622,254	25	418,193,451
26	**Total liabilities.** *Add lines 17 through 25*			796,095,819	26	983,628,347
	Organizations that follow SFAS 117, check here ▶ ☑ and complete lines 27 through 29, and lines 33 and 34.					
27	Unrestricted net assets			238,069,798	27	10,728,657
28	Temporarily restricted net assets				28	
29	Permanently restricted net assets				29	
	Organizations that do not follow SFAS 117, check here ▶ ☐ and complete lines 30 through 34.					
30	Capital stock or trust principal, or current funds				30	
31	Paid-in or capital surplus, or land, building or equipment fund				31	
32	Retained earnings, endowment, accumulated income, or other funds				32	
33	Total net assets or fund balances			238,069,798	33	10,728,657
34	Total liabilities and net assets/fund balances			1,034,135,617	34	994,357,004

art XI Financial Statements and Reporting

			Yes	No
	Accounting method used to prepare the Form 990 ☐ cash ☑ accrual ☐ other			
a	Were the organization's financial statements compiled or reviewed by an independent accountant?	2a		No
b	Were the organization's financial statements audited by an independent accountant?	2b	Yes	
c	If "Yes" to lines 2a or 2b, does the organization have a committee that assumes responsibility for oversight of the audit, review, or compilation of its financial statements and selection of an independent accountant?	2c	Yes	
a	As a result of a federal award, was the organization required to undergo an audit or audits as set forth in the Single Audit Act and OMB Circular A-133?	3a		No
b	If "Yes," did the organization undergo the required audit or audits?	3b		

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SCHEDULE C (Form 990 or 990-EZ)

Department of the Treasury Internal Revenue Service

Political Campaign and Lobbying Activities

For Organizations Exempt From Income Tax Under section 501(c) and section 527

To be completed by organizations described below. Attach to Form 990 or Form 990-EZ

OMB No 1545-0047

2008

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If the organization answered "Yes," to Form 990, Part IV, Line 3, or Form 990-EZ, Part VI, line 46 (Political Campaign Activities)
section 501(c)(3) organizations complete Parts I-A and B Do not complete Part I-C
section 501(c) (other than section 501(c)(3)) organizations complete Parts I-A and C below Do not complete Part I-B
section 527 organizations complete Part I-A only
If the organization answered "Yes," to Form 990, Part IV, Line 4, or Form 990EZ, Part VI, line 47 (Lobbying Activities)
section 501(c)(3) organizations that have filed Form 5768 (election under section 501(h)) complete Part II-A Do not complete Part II-B
section 501(c)(3) organizations that have NOT filed Form 5768 (election under section 501(h)) Complete Part II-B Do not complete Part II-A
If the organization answered "Yes," to Form 990, Part IV, Line 5 (Proxy Tax)
section 501(c)(4), (5), or (6) organizations complete Part III

Name of the organization	Employer identification number
VRP	95-1985500

Part I-A **To be completed by all organizations exempt under section 501(c) and section 527 organizations.** (See the instructions for Schedule C for details.)

Provide a description of the organization's direct and indirect political campaign activities in Part IV

Political expenditures	$ 1,776,375
Volunteer hours	0

Part I-B **To be completed by all organizations exempt under section 501(c)(3).** (See the instructions for Schedule C for details.)

Enter the amount of any excise tax incurred by the organization under section 4955	$
Enter the amount of any excise tax incurred by organization managers under section 4955	$
If the organization incurred in a section 4955 tax, did it file Form 4720 for this year?	☐ Yes ☐ No
Was a correction made?	☐ Yes ☐ No
If "Yes," describe in Part IV	

Part I-C **To be completed by all organizations exempt under section 501(c), except section 501(c)(3).** (See the instructions for Schedule C for details.)

Enter the amount directly expended by the filing organization for section 527 exempt function activities	$
Enter the amount of the filing organization's internal funds contributed to other organizations for section 527 exempt function activities	$
Total of direct and indirect exempt function expenditures Add lines 1 and 2 and enter here and on Form 1120-POL, line 17b	$
Did the filing organization file **Form 1120-POL** for this year?	☐ Yes ☐ No

State the names, addresses and Employer Identification Number (EIN) of all section 527 political organizations to which payments were made Enter the amount paid and indicate if the amount was paid from the filing organization's own internal funds or were political contributions received and promptly and directly delivered to a separate political organization, such as a separate segregated fund or a political action committee (PAC) If additional space is needed, provide information in Part IV

(a) Name	(b) Address	(c) EIN	(d) Amount paid from filing organization's internal funds If none, enter -0-	(e) Amount of political contributions received and promptly and directly delivered to a separate political organization If none, enter -0-

Part II-A **To be completed by organizations exempt under section 501(c)(3) that filed Form 5768 (election under section 501(h)).** (See the instructions for Schedule C for details.)

A Check ☐ if the filing organization belongs to an affiliated group
B Check ☐ if the filing organization checked box A and "limited control" provisions apply

Limits on Lobbying Expenditures— (The term "expenditures" means amounts paid or incurred.)	(a) Filing Organization's Totals	(b) Affiliated Group Totals
1a Total lobbying expenditures to influence public opinion (grass roots lobbying)		
b Total lobbying expenditures to influence a legislative body (direct lobbying)		
c Total lobbying expenditures (add lines 1a and 1b)		
d Other exempt purpose expenditures		
e Total exempt purpose expenditures (add lines 1c and 1d)		
f Lobbying nontaxable amount. Enter the amount from the following table in both columns—		
If the amount on line 1e, column (a) or (b) is: / **The lobbying nontaxable amount is:**		
Not over $500,000 / 20% of the amount on line 1e		
Over $500,000 but not over $1,000,000 / $100,000 plus 15% of the excess over $500,000		
Over $1,000,000 but not over $1,500,000 / $175,000 plus 10% of the excess over $1,000,000		
Over $1,500,000 but not over $17,000,000 / $225,000 plus 5% of the excess over $1,500,000		
Over $17,000,000 / $1,000,000		
g Grassroots nontaxable amount (enter 25% of line 1f)		
h Subtract line 1g from line 1a. Enter -0- if line g is more than line a		
i Subtract line 1f from line 1c. Enter -0- if line f is more than line c		
j If there is an amount other than zero on either line 1h or line 1i, did the organization file Form 4720 reporting section 4911 tax for this year?	☐ Yes ☐ No	

4-Year Averaging Period Under Section 501(h)
(Some organizations that made a section 501(h) election do not have to complete all of the five columns below. See the instructions for lines 1a through 1f of the instructions.)

Lobbying Expenditures During 4-Year Averaging Period

Calendar year (or fiscal year beginning in)	(a) 2005	(b) 2006	(c) 2007	(d) 2008	(e) Total
2a Lobbying non-taxable amount					
b Lobbying ceiling amount (150% of line 2a, column(e))					
c Total lobbying expenditures					
d Grassroots non-taxable amount					
e Grassroots ceiling amount (150% of line d, column (e))					
f Grassroots lobbying expenditures					

rt II-B To be completed by organizations exempt under section 501(c)(3) that have NOT filed Form 5768 (election under section 501(h)). (See the instructions for Schedule C for details.)

	(a) Yes	(a) No	(b) Amount
During the year, did the filing organization attempt to influence foreign, national, state or local legislation, including any attempt to influence public opinion on a legislative matter or referendum, through the use of			
Volunteers?			
Paid staff or management (include compensation in expenses reported on lines c through i)?			
Media advertisements?			
Mailings to members, legislators, or the public?			
Publications, or published or broadcast statements?			
Grants to other organizations for lobbying purposes?			
Direct contact with legislators, their staffs, government officials, or a legislative body?			
Rallies, demonstrations, seminars, conventions, speeches, lectures, or any other means?			
Other activities If "Yes," describe in Part IV			
Total lines 1c through 1i			
Did the activities in line 1 cause the organization to be not described in section 501(c)(3)?			
If "Yes" enter the amount of any tax incurred under section 4912			
If "Yes" enter the amount of any tax incurred by organization managers under section 4912			
If the filing organization incurred a section 4912 tax, did it file Form 4720 for this year?			

rt III-A To be completed by all organizations exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6). (See the instructions for Schedule C for details.)

		Yes	No
Were substantially all (90% or more) dues received nondeductible by members?	1	Yes	
Did the organization make only in-house lobbying expenditures of $2,000 or less?	2		No
Did the organization agree to carryover lobbying and political expenditures from the prior year?	3		No

rt III-B To be completed by all organizations exempt under section 501(c)(4), section 501(c)(5), or section 501(c)(6) if BOTH Part III-A, questions 1 and 2 are answered "No" OR if Part III-A, question 3 is answered "Yes." (See the instructions for Schedule C for details.)

Dues, assessments and similar amounts from members	1 $
Section 162(e) non-deductible lobbying and political expenditures ***(do not include amounts of political expenses for which the section 527(f) tax was paid).***	
Current Year	2a $
Carryover from last year	2b $
Total	2c $
Aggregate amount reported in section 6033(e)(1)(A) notices of nondeductible section 162(e) dues	3 $
If notices were sent and the amount on line 2c exceeds the amount on line 3, what portion of the excess does the organization agree to carryover to the reasonable estimate of nondeductible lobbying and political expenditure next year?	4 $
Taxable amount of lobbying and political expenditures (line 2c total minus 3 and 4)	5 $

Part IV Supplemental Information

Complete this part to provide the descriptions required for Part I-A, line 1, Part I-B, line 4, Part I-C, line 5, and Part II-B, line 1f. Also, complete this part for any additional information.

Identifier	Return Reference	Explanation
rt I-A, Line 1	Organizations Direct and Indirect Political Campaign Activities	AARP sends out questionnaires to candidates running for political office at the federal, state, and local level to gather information on their positions related to issues that impact AARP members AARP then publishes (either in AARP The Magazine, voters guides mailed to members, or on AARP og) the responses provided by the candidate's campaign and compares these positions to AARP's position on the issues

Part IV Supplemental Information

Identifier	Return Reference	Explanation

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HEDULE D (rm 990)

OMB No 1545-0047

Supplemental Financial Statements

2008

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partment of the asury rnal Revenue vice

▶ Attach to Form 990. To be completed by organizations that answered "Yes," to Form 990, Part IV, line 6, 7, 8, 9, 10, 11, or 12.

me of the organization RP	Employer identification number
	95-1985500

art I Organizations Maintaining Donor Advised Funds or Other Similar Funds or Accounts. Complete if the organization answered "Yes" to Form 990, Part IV, line 6.

	(a) Donor advised funds	(b) Funds and other accounts
Total number at end of year		
Aggregate Contributions to (during year)		
Aggregate Grants from (during year)		
Aggregate value at end of year		

Did the organization inform all donors and donor advisors in writing that the assets held in donor advised funds are the organization's property, subject to the organization's exclusive legal control? ☐ Yes ☐ No

Did the organization inform all grantees, donors, and donor advisors in writing that grant funds may be used only for charitable purposes and not for the benefit of the donor or donor advisor or other impermissible private benefit? ☐ Yes ☐ No

art II Conservation Easements. Complete if the organization answered "Yes" to Form 990, Part IV, line 7.

Purpose(s) of conservation easements held by the organization (check all that apply)

☐ Preservation of land for public use (e g , recreation or pleasure) ☐ Preservation of an historically importantly land area

☐ Protection of natural habitat ☐ Preservation of certified historic structure

☐ Preservation of open space

Complete lines 2a–2d if the organization held a qualified conservation contribution in the form of a conservation easement on the last day of the tax year

		Held at the End of the Year
a	Total number of conservation easements	2a
b	Total acreage restricted by conservation easements	2b
c	Number of conservation easements on a certified historic structure included in (a)	2c
d	Number of conservation easements included in (c) acquired after 8/17/06	2d

Number of conservation easements modified, transferred, released, extinguished, or terminated by the organization during the taxable year ▶

Number of states where property subject to conservation easement is located ▶

Does the organization have a written policy regarding the periodic monitoring, inspection, violations, and enforcement of the conservation easements it holds? ☐ Yes ☐ No

Staff or volunteer hours devoted to monitoring, inspecting and enforcing easements during the year ▶

Amount of expenses incurred in monitoring, inspecting, and enforcing easements during the year ▶ $

Does each conservation easement reported on line 2(d) above satisfy the requirements of section 170(h)(4)(B)(i) and 170(h)(4)(B)(ii)? ☐ Yes ☐ No

In Part XIV, describe how the organization reports conservation easements in its revenue and expense statement, and balance sheet, and include, if applicable, the text of the footnote to the organization's financial statements that describes the organization's accounting for conservation easements

art III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets. Complete if the organization answered "Yes" to Form 990, Part IV, line 8.

a If the organization elected, as permitted under SFAS 116, not to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education or research in furtherance of public service, provide, in Part XIV, the text of the footnote to its financial statements that describes these items

b If the organization elected, as permitted under SFAS 116, to report in its revenue statement and balance sheet works of art, historical treasures, or other similar assets held for public exhibition, education, or research in furtherance of public service, provide the following amounts relating to these items

(i) Revenues included in Form 990, Part VIII, line 1 ▶ $

(ii) Assets included in Form 990, Part X ▶ $

If the organization received or held works of art, historical treasures, or other similar assets for financial gain, provide the following amounts required to be reported under SFAS 116 relating to these items

a Revenues included in Form 990, Part VIII, line 1 ▶ $

b Assets included in Form 990, Part X ▶ $

rt III Organizations Maintaining Collections of Art, Historical Treasures, or Other Similar Assets *(continued)*

Using the organization's accession and other records, check any of the following that are a significant use of its collection items (check all that apply)

a ☐ Public exhibition
b ☐ Scholarly research
c ☐ Preservation for future generations
d ☐ Loan or exchange programs
e ☐ Other

Provide a description of the organization's collections and explain how they further the organization's exempt purpose in Part XIV

During the year, did the organization solicit or receive donations of art, historical treasures or other similar assets to be sold to raise funds rather than to be maintained as part of the organization's collection? ☐ Yes ☐ No

art IV Trust, Escrow and Custodial Arrangements. Complete if the organization answered "Yes" to Form 990, Part IV, line 9, or reported an amount on Form 990, Part X, line 21.

a Is the organization an agent, trustee, custodian or other intermediary for contributions or other assets not included on Form 990, Part X? ☐ Yes ☐ No

b If "Yes," explain why in Part XIV and complete the following table

		Amount
c	Beginning balance	1c
d	Additions during the year	1d
e	Distributions during the year	1e
f	Ending balance	1f

a Did the organization include an amount on Form 990, Part X, line 21? ☐ Yes ☐ No

b If "Yes," explain the arrangement in Part XIV

Part V Endowment Funds. Complete if the organization answered "Yes" to Form 990, Part IV, line 10.

		(a)Current Year	(b)Prior Year	(c)Two Years Back	(d)Three Years Back	(e)Four Years Back
a	Beginning of year balance					
b	Contributions					
c	Investment earnings or losses					
d	Grants or scholarships					
e	Other expenditures for facilities and programs					
f	Administrative expenses					
g	End of year balance					

Provide the estimated percentage of the year end balance held as

a Board designated or quasi-endowment ▶
b Permanent endowment ▶
c Term endowment ▶

3a Are there endowment funds not in the possession of the organization that are held and administered for the organization by

		Yes	No
(i) unrelated organizations	3a(i)		
(ii) related organizations	3a(ii)		
b If "Yes" to 3a(ii), are the related organizations listed as required on Schedule R?	3b		

c Describe in Part XIV the intended uses of the organization's endowment funds

art VI Investments—Land, Buildings, and Equipment. See Form 990, Part X, line 10.

Description of investment	(a) Cost or other basis (investment)	(b)Cost or other basis (other)	(c) Depreciation	(d) Book value
a Land		48,572,664		48,572,664
b Buildings		195,571,865	42,942,409	152,629,456
c Leasehold improvements		30,027,684	4,970,466	25,057,218
d Equipment				
e Other		174,670,175	114,654,553	60,015,622
otal. Add lines 1a-1e *(Column (d) should equal Form 990, Part X, column (B), line 10(c).)* ▶				286,274,960

t VII Investments—Other Securities. See Form 990, Part X, line 12.

(a) Description of security or categry (including name of security)	(b)Book value	(c) Method of valuation Cost or end-of-year market value
ıncial derivatives and other financial products		
sely-held equity interests		
er		
al. *(Column (b) should equal Form 990, Part X, col (B) line 12)* ▶		

t VIII Investments—Program Related. See Form 990, Part X, line 13.

(a) Description of investment type	(b) Book value	(c) Method of valuation Cost or end-of-year market value
al. *(Column (b) should equal Form 990, Part X, col (B) line 13)* ▶		

rt IX Other Assets. See Form 990, Part X, line 15.

(a) Description	(b) Book value
al. *(Column (b) should equal Form 990, Part X, col.(B) line 15.)* ▶	

art X Other Liabilities. See Form 990, Part X, line 25.

(a) Description of Liability	(b) Amount
leral Income Taxes	
st retirement benefits	65,372,430
ferred membership dues	237,106,369
IR Reserve	1,951,000
ısion Liability	113,763,652
al. *(Column (b) should equal Form 990, Part X, col (B) line 25)* ▶	418,193,451

Part XIV, provide the text of the footnote to the organization's financial statements that reports the organization's liability for certain tax positions under FIN 48

Part XI Reconciliation of Change in Net Assets from Form 990 to Financial Statements

	Total revenue (Form 990, Part VIII, column (A), line 12)	1	1,144,792,475
	Total expenses (Form 990, Part IX, column (A), line 25)	2	1,109,273,783
	Excess or (deficit) for the year Subtract line 2 from line 1	3	35,518,692
	Net unrealized gains (losses) on investments	4	-234,910,977
	Donated services and use of facilities	5	
	Investment expenses	6	
	Prior period adjustments	7	15,018
	Other (Describe in Part XIV)	8	-27,963,869
	Total adjustments (net) Add lines 4 - 8	9	-262,859,833
	Excess or (deficit) for the year per financial statements Combine lines 3 and 9	10	-227,341,141

Part XII Reconciliation of Revenue per Audited Financial Statements With Revenue per Return

	Total revenue, gains, and other support per audited financial statements			1	1,057,573,000
	Amounts included on line 1 but not on Form 990, Part VIII, line 12				
a	Net unrealized gains on investments	2a	-234,910,977		
b	Donated services and use of facilities	2b			
c	Recoveries of prior year grants	2c			
d	Other (Describe in Part XIV)	2d	130,660,781		
e	Add lines 2a through 2d			2e	-104,250,196
	Subtract line 2e from line 1			3	1,161,823,196
	Amounts included on Form 990, Part VIII, line 12, but not on line 1				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV)	4b	-17,030,721		
c	Add lines 4a and 4b			4c	-17,030,721
	Total Revenue Add lines 3 and 4c. (This should equal Form 990, Part I, line 12)			5	1,144,792,475

Part XIII Reconciliation of Expenses per Audited Financial Statements With Expenses per Return

	Total expenses and losses per audited financial statements			1	1,267,927,000
	Amounts included on line 1 but not on Form 990, Part IX, line 25				
a	Donated services and use of facilities	2a			
b	Prior year adjustments	2b			
c	Losses reported on Form 990, Part IX, line 25	2c			
d	Other (Describe in Part XIV)	2d	141,622,496		
e	Add lines 2a through 2d			2e	141,622,496
	Subtract line 2e from line 1			3	1,126,304,504
	Amounts included on Form 990, Part IX, line 25, but not on line 1:				
a	Investment expenses not included on Form 990, Part VIII, line 7b	4a			
b	Other (Describe in Part XIV)	4b	-17,030,721		
c	Add lines 4a and 4b			4c	-17,030,721
	Total expenses Add lines 3 and 4c. (This should equal Form 990, Part I, line 18)			5	1,109,273,783

Part XIV Supplemental Information

Complete this part to provide the descriptions required for Part II, lines 3, 5, and 9, Part III, lines 1a and 4, Part XIV, lines 1b and 2b, Part V, line 4, Part X, Part XI, line 8, Part XII, lines 2d and 4b, and Part XIII, lines 2d and 4b

Identifier	Return Reference	Explanation
art XI, Line 8 - Other Adjustments		See Schedule O for explanation
art XII, Line 2d - Other djustments		AARP Financial Services Corporation (EIN 52-1367607) $1,171,749 AARP Services, Inc (consolidated) (EIN 52-2141065) $180,257,830 AARP Foundation (EIN 52-0794300) $131,570,546 AARP Institute (EIN 52-0788950) ($512,423) Legal Counsel for the Elderly (EIN 52-1194741) $3,847,692 Consolidation elimination entries ($182,674,613)
art XII, Line 4b - Other djustments		Adjusting & eliminating entries for AARP and disregarded entities ($17,030,721)
art XIII, Line 2d - Other djustments		AARP Financial Services Corporation (EIN 52-1367607) $1,602,246 AARP Services, Inc (consolidated) (EIN 52-2141065) $163,726,653 AARP Foundation (EIN 52-0794300) $152,053,655 AARP Institute (EIN 52-0788950) $15,068 Legal Counsel for the Elderly (EIN 52-1194741) $5,052,359 Consolidation elimination entries ($180,827,485)
art XIII, Line 4b - Other djustments		Adjusting & eliminating entries for AARP and disregarded entities ($17,030,721)

Part XIV Supplemental Information *(continued)*

Identifier	Return Reference	Explanation
Part XI, Line 8 - Other Adjustments		See Schedule O for explanation
Part XII, Line 2d - Other Adjustments		AARP Financial Services Corporation (EIN 52-1367607) $1,171,749 AARP Services, Inc (consolidated) (EIN 52-2141065) $180,257,830 AARP Foundation (EIN 52-0794300) $131,570,546 AARP Institute (EIN 52-0788950) ($512,423) Legal Counsel for the Elderly (EIN 52-1194741) $3,847,692 Consolidation elimination entries ($182,674,613)
Part XII, Line 4b - Other Adjustments		Adjusting & eliminating entries for AARP and disregarded entities ($17,030,721)
Part XIII, Line 2d - Other Adjustments		AARP Financial Services Corporation (EIN 52-1367607) $1,602,246 AARP Services, Inc (consolidated) (EIN 52-2141065) $163,726,653 AARP Foundation (EIN 52-0794300) $152,053,655 AARP Institute (EIN 52-0788950) $15,068 Legal Counsel for the Elderly (EIN 52-1194741) $5,052,359 Consolidation elimination entries ($180,827,485)
Part XIII, Line 4b - Other Adjustments		Adjusting & eliminating entries for AARP and disregarded entities ($17,030,721)

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SCHEDULE G
(Form 990 or 990-EZ)

Department of the Treasury
Internal Revenue Service

Supplemental Information Regarding Fundraising or Gaming Activities

▶ Attach to Form 990 or Form 990-EZ. Must be completed by organizations that answer "Yes" to Form 990, Part IV, lines 17, 18, or 19, and by organizations that enter more than $15,000 on Form 990-EZ, line 6a.

OMB No 1545-0047

2008

Open to Public Inspection

Name of the organization
AARP

Employer identification number
95-1985500

Part I Fundraising Activities. Complete if the organization answered "Yes" to Form 990, Part IV, line 17.

1 Indicate whether the organization raised funds through any of the following activities Check all that apply

a ☑ Mail solicitations
b ☑ Email solicitations
c ☑ Phone solicitations
d ☑ In-person solicitations
e ☑ Solicitation of non-government grants
f ☑ Solicitation of government grants
g ☐ Special fundraising events

2a Did the organization have a written or oral agreement with any individual (including officers, directors, trustees or key employees listed in Form 990, Part VII) or entity in connection with professional fundraising activities? ☑ Yes ☐ No

b If "Yes," list the ten highest paid individuals or entities (fundraisers) pursuant to agreements under which the fundraiser is to be compensated at least $5,000 by the organization Form 990-EZ filers are not required to complete this table

(i) Name of individual or entity (fundraiser)	(ii) Activity	(iii) Did fundraiser have custody or control of contributions? Yes	(iii) Did fundraiser have custody or control of contributions? No	(iv) Gross receipts from activity	(v) Amount paid to (or retained by) fundraiser listed in col (i)	(vi) Amount paid to (or retained by) organization
Adams Hussey	Direct Mail and Communications		No	0	938,350	-938,350
Total			▶			

3 List all states in which the organization is registered or licensed to solicit funds or has been notified it is exempt from registration or licensing

AK,AL,AR,AZ,CA,CO,CT,DC,FL,GA,IL,KS,KY,MA,MD,ME,MI,MN,MO,MS,NC,ND,NH,NJ,NM,NY,OH,OK,OR,PA,RI,SC,TN,UT,VA,WA,WI,WV

art II Fundraising Events. Complete if the organization answered "Yes" to Form 990, Part IV, line 18, or reported more than $15,000 on Form 990-EZ, line 6a. List events with gross receipts greater than $5,000.

		(a) Event #1 (event type)	(b) Event #2 (event type)	(c) Other Events (total number)	(d) Total Events (Add col (a) through col (c))
1	Gross receipts				
2	Less Charitable contributions				
3	Gross revenue (line 1 minus line 2)				
4	Cash Prizes				
5	Non-cash Prizes				
6	Rent/Facility costs				
7	Other direct expenses				
8	Direct expense summary Add lines 4 through 7 in column (d) ▶				
9	Net income summary Combine lines 3 and 8 in column (d) ▶				

art III Gaming. Complete if the organization answered "Yes" to Form 990, Part IV, line 19, or reported more than $15,000 on Form 990-EZ, line 6a.

		(a) Bingo	(b) Pull tabs/Instant bingo/progressive bingo	(c) Other gaming	(d) Total gaming (Add col (a) through col (c))
1	Gross revenue				
2	Cash prizes				
3	Non-cash prizes				
4	Rent/facility costs				
5	Other direct expenses				
6	Volunteer labor	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	☐ Yes ____ % ☐ No	
7	Direct expense summary Add lines 2 through 5 in column (d) ▶				
8	Net gaming income summary Combine lines 1 and 7 in column (d) ▶				

			Yes	No
	Enter the state(s) in which the organization operates gaming activities _____			
a	Is the organization licensed to operate gaming activities in each of those states?	9a		
b	If "No," Explain			
10a	Were any of the organization's gaming licenses revoked, suspended or terminated during the tax year?	10a		
b	If "Yes," Explain			
11	Does the organization operate gaming activities with nonmembers?	11		
12	Is the organization a grantor, beneficiary or trustee of a trust or a member of a partnership or other entity formed to administer charitable gaming?	12		

			Yes	No
13	Indicate the percentage of gaming activity operated in			
a	The organization's facility	13a		
b	An outside facility	13b		
14	Provide the name and address of the person who prepares the organization's gaming/special events books and records			
	Name ▶			
	Address ▶			
15a	Does the organization have a contract with a third party from whom the organization receives gaming revenue?	15a		
b	If "Yes," enter the amount of gaming revenue received by the organization ▶ $ _____ and the amount of gaming revenue retained by the third party ▶ $ _____			
c	If "Yes," enter name and address			
	Name ▶			
	Address ▶			
16	Gaming manager information			
	Name ▶			
	Gaming manager compensation ▶ $ _____			
	Description of services provided ▶			
	☐ Director/officer ☐ Employee ☐ Independent contractor			
17	Mandatory distributions			
a	Is the organization required under state law to make charitable distributions from the gaming proceeds to retain the state gaming license?	17a		
b	Enter the amount of distributions required under state law distributed to other exempt organizations or spent in the organization's own exempt activities during the tax year ▶ $			

Additional Data

Software ID:
Software Version:
EIN: 95-1985500
Name: AARP

Form 990 Schedule G - Licensed States

Licensed States

[EFILE GRAPHIC print - DO NOT PROCESS | As Filed Data -]

Schedule I (Form 990)

Department of the Treasury
Internal Revenue Service

Grants and Other Assistance to Organizations, Governments and Individuals in the U.S.

Complete if the organization answered "Yes," on Form 990, Part IV, lines 21 or 22. Attach to Form 990.

OMB No 1545-0047

2008

Open to Public Inspection

Name of the organization
AARP

Employer identification number
95-1985500

Part I General Information on Grants and Assistance

1 Does the organization maintain records to substantiate the amount of the grants or assistance, the grantees' eligibility for the grants or assistance, and the selection criteria used to award the grants or assistance? . . . . . ☑ Yes ☐ No

2 Describe in Part IV the organization's procedures for monitoring the use of grant funds in the United States

Part II Grants and Other Assistance to Governments and Organizations in the United States. Complete if the organization answered "Yes" on Form 990, Part IV, line 21 for any recipient that received more than $5,000. Check this box if no one recipient received more than $5,000. Use Part IV and Schedule I-1 if additional space is needed . . . . . ▶ ☐

1(a) Name and address of organization or government	(b) EIN	(c) IRC section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
See Additional Data Table							

2 Enter total number of section 501(c)(3) and government organizations . . . . . ▶ 99

3 Enter total number of other organizations . . . . . ▶ 5

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Cat No 50055P Schedule I (Form 990) 2008

Part III **Grants and Other Assistance to Individuals in the United States.** Complete if the organization answered "Yes" on Form 990, Part IV, line 22. Use Schedule I-1 (Form 990) if additional space is needed.

(a)Type of grant or assistance	(b)Number of recipients	(c)Amount of cash grant	(d)Amount of non-cash assistance	(e) Method of valuation (book, FMV, appraisal, other)	(f)Description of non-cash assistance

Part IV **Supplemental Information.** Complete this part to provide the information required in Part I, line 2, and any other additional information.

See Additional Data Table

Identifier	Return Reference	Explanation
Other Information	Part IV	AARP'S Public Outreach Office requires all departments to submit a two-page form detailing the donee organization, its mission, and how the contribution will support AARP's goals The Public Outreach Office approves and tracks the contribution requests that best leverage relationships and accomplish AARP's social impact, people strategy, and member value goals In celebration of AARP's 50th anniversary, AARP donated a $100,000 award to a public school in the seven cities in which AARP would be having an anniversary celebration Through an application process, the schools had to demonstrate that they had an innovative program in their school that offered an intergenerational or civic engagement opportunity AARP's state office in those seven states managed the review and selection process with a locally-identified judging panel to select the top three entrants After three entrants were selected from each city, AARP established a national "blue ribbon" judging panel to carefully review the top three selections to determine the seven winners of the $100,000 award AARP also donated $10,000 to one secondary public school in each state, the District of Columbia, Puerto Rico, and the U S Virgin Islands in recognition of an innovative program or practice currently operating in the school An application process was used and the state offices managed the review and selection process

Software ID:
Software Version:
EIN: 95-1985500
Name: AARP

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
ADAMS ARAPAHOE DISTRICT 28-J (RANGEVIEW HIGH SCHOOL)15701 EAST 1ST AVE STE 106 AURORA,CO 80011	84-6000870	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
AGING RESOURCES FOUNDATION5835 GRAND AVENUE STE 106 DES MOINES,IA 50312	02-6004165	501(C)(3)	20,000				DISASTER RELIEF FOR OLDER IOWANSDISASTER RELIEF FOR OLDER IOWANS
ALLIANCE FOR HEALTH REFORM1444 EYE ST NW STE 910 WASHINGTON,DC 20005	52-1746328	501(C)(3)	20,000				GENERAL SUPPORT
AMERICAN ACADEMY OF NURSING888 17TH ST NW STE 800 WASHINGTON,DC 20006	52-2213870	501(C)(3)	20,000				GENERAL SUPPORTGENERAL SUPPORT
AMERICAN SOCIETY ON AGING833 MARKET STREET STE 511 SAN FRANCISCO,CA 94103	94-2292868	501(C)(3)	25,000				GENERAL SUPPORT
AMERICA'S CHARITIES 14150 NEWBROOK DRIVE 110 CHANTILLY,VA 20151	54-1717707	501(C)(3)	442,154				PARTNER FOR CORPORATE GIFT MATCHING PROGRAM
GERONTOLOGICAL SOCIETY OF AMERICA1220 L ST NWSTE 901 WASHINGTON,DC 20005	52-1256181	501(C)(3)	15,000				GENERAL SUPPORT
ATLANTA PUBLIC SCHOOLS130 TRINITY AVENUE SW ATLANTA,GA 30303	58-6000134	501(C)(3)	100,000				ETHEL PERCY ANDRUS LEGACY AWARD
BALTIMORE COUNTY PUBLIC SCHOOLS1100 MACE AVENUE ESSEX,MD 21221	52-6000886	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
BIBB COUNTY SCHOOL DISTRICT484 MULBERRY STREET MACON,GA 31201	58-6000191	501(C)(3)	30,238				GENERAL SUPPORT

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
BOWLING GREEN HIGH SCHOOL1801 ROCKINGHAN LANE BOWLING GREEN, KY 42104	61-6001390	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
BRANDEIS UNIVERSITY 415 SOUTH STREET MAIL STOP 035 WALTHAM, MA 02454	04-2103552	501(C)(3)	50,000				GENERAL SUPPORT
C E BYRD HIGH SCHOOL 3201 LINE AVENUE SHREVEPORT, LA 71104	72-6000224	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
CALIFORNIA HEALTH CARE COALITION1300 CLAY ST STE 600 OAKLAND, CA 94612	26-2887423	501(C)(4)	75,000				GENERAL SUPPORT
CENTER FOR AMERICAN PROGRESS ACTION FUND1333 H STREET NW 10TH FL WASHINGTON, DC 20005	30-0192708	501(C)(4)	10,000				GENERAL SUPPORT FOR HALF IN TEN CAMPAIGN TO CUT POVERTY IN HALF IN TEN YEARS
CASCADE SCHOOL DISTRICT 422PO BOX 291 CASCADE, ID 83611	82-6000907	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
CENTER FOR EXCELLENCE IN ASSITED LIVING1201 L STREET NW WASHINGTON, DC 20005	43-2080306	501(C)(3)	10,000				GENERAL SUPPORT
CENTRAL HIGH SCHOOL 275 N LEXINGTON PKWY ST PAUL, MN 55104	41-0901311	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
CHESTER AREA SCHOOL DISTRICT102 2ND AVENUE CHESTER, SD 57016	46-0282624	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
CHICAGO PUBLIC SCHOOLS DISTRICT 2993436 W WILSON AVE CHICAGO, IL 60625	36-6005821	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CHILDREN FIRST FUND 125 S CLARK 9TH FLOOR CHICAGO,IL 60603	36-4094830	501(C)(3)	24,000				GENERAL SUPPORT
CHILDREN'S HOSPITAL FOUNDATION801 ROEDER RD STE 300 SILVER SPRING,MD 20910	52-1640403	501(C)(3)	10,000				GENERAL SUPPORT
CHOICE ACADEMY1800 PERRY STREET NE STE 143 WASHINGTON,DC 20018	53-6007131	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
CIVIC VENTURES114 SANSOME STREET SAN FRANCISCO,CA 94104	94-3274339	501(C)(3)	10,000				GENERAL SUPPORT
STAFFORD COUNTY PUBLIC SCHOOLS (COLONIAL FORGE HS) 550 COURTHOUSE ROAD STAFFORD,VA 22554	54-6001628	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
COLUMBIA SCHOOL DISTRICT613 BRYAN AVENUE COLUMBIA,MS 39429	64-6000272	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARDS
COMMUNITY ACADEMY 76 SHIRLEY STREET ROXBURY,MA 02119	04-6001380	501(C)(3)	10,000				GENERAL SUPPORT
CONSUMERS UNION OF UNITED STATES101 TRUMAN AVENUE YONKERS,NY 10703	13-1776434	501(C)(3)	10,000				GENERAL SUPPORT
CORSICANA INDEPENDENT SCHOOL DISTRICT601 N 13TH STREET CORSICANA,TX 75110	75-6000800	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARDS
ASSOCIATION FOR GERONTOLOGY IN HIGHER EDUCATION 1220 L ST NW STE 901 WASHINGTON,DC 20005	52-1256181	501(C)(3)	10,000				ANNUAL CONFERENCE SPONSORSHIP - COUNCIL OF FOUNDATIONS

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
DODGELAND SCHOOL DISTRICT401 S WESTERN AVENUE JUNEAU,WI 53039	39-1034256	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARDS
EL FURR HIGH SCHOOL 520 MERCURY DRIVE HOUSTON,TX 77013	74-6001255	501(C)(3)	100,000				ETHEL PERCY ANDRUS LEGACY AWARDS
EAST ANCHORAGE HIGH SCHOOL4025 E NORTHERN LIGHTS BLVD ANCHORAGE,AK 99508	92-6000078	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARDS
ED W CLARK HIGH SCHOOL2832 EAST FLAMINGO ROAD LAS VEGAS,NV 89121	88-6000030	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARDS
ERIE COMMUNITY COLLEGE4041 SOUTH WESTERN BOVD ORCHARD PARK,NY 14127	11-3682643	501(C)(3)	10,000				GENERAL SUPPORT
ESALEN INSTITUTE55 SOUTH 55000 HIGHWAY 1 BIG SUR,CA 93920	94-6114235	501(C)(3)	10,000				GENERAL SUPPORT
ESCUELA SUPERIOR JAIME A COLLAZO DEL RIO (ID 6600636095) PO BOX 370 MOROVIS,PR 00687		501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
REBUILDING TOGETHER 1536 16TH STREET NW WASHINGTON,DC 20036	52-1585880	501(C)(3)	638,791				AARP PROVIDES GRANTS AND SPONSORSHIPS TO REBUILDING TOGETHER'S SAFE AT HOME PROGRAM
FAMILY CAREGIVER ALLIANCE180 MONTGOMERY STREET STE 1100 SAN FRANCISCO,CA 94104	94-2687079	501(C)(3)	47,902				GENERAL SUPPORT
FORT SMITH PUBLIC SCHOOLSPO BOX 1948 FORT SMITH,AR 72902	71-6020978	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
FOUNTAIN HOUSE425 WEST 47TH STREET NEW YORK, NY 10036	13-1624009	501(C)(3)	25,000				GENERAL SUPPORT
FULTON COUNTY BOARD OF EDUCATION 786 CLEVELAND AVENUE SW ATLANTA, GA 30315	58-6000246	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
GARNER-HAYFIELD COMMUNITY SCHOOL OISTRICT605 LYONS STREET GARNER, IA 50438	42-0864328	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
GEORGE WASHINGTON HIGH SCHOOL1522 TENNIS CLUB ROAD CHARLESTON, WV 25314	69-6998001	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
HANNA-WESTSIDE EXTENSION CAMPUS 1225 S MCDUFFIE STREET ANDERSON, SC 29624	57-6000222	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
HEALTH CARE FOR MICHIGAN28342 DARTMOUTH MADISON HEIGHTS, MI 48071	75-3262637		20,000				SPONSORSHIP TO HELP COVER COSTS FOR THE MI HEALTH CARE SECURITY CAMPAIGN
HERMINSTON SCHOOL DISTRICT #8R341 NE 3RO STREET HERMINSTON, OR 97838	93-6002733	501(C)(3)	10,000				GENERAL SUPPORT
HERNDON ALLIANCE 3438 EAST FLORENCE COURT SEATTLE, WA 98112	20-3438789	501(C)(3)	20,000				GENERAL SUPPORT
DENVER 2008 HOST COMMITTEE1391 SPEER BLVD DENVER, CO 80204	20-4441257	501(C)(6)	100,000				GENERAL SUPPORT
INDEPENDENT SECTOR 1200 18TH STREET NW STE 200 WASHINGTON, DC 20036	52-1081024	501(C)(3)	15,000				GENERAL SUPPORT

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
INDIANOLA PUBLIC SCHOOLSPO BOX 119 INDIANOLA,OK 74442	73-1498006	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
JACKSONVILLE HIGH SCHOOL1021 HENDERSON DRIVE JACKSONVILLE,NC 28540	56-6001089	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
WAHLUKE SCHOOL DISTRICT #73PO BOX 907 MATTAWA,WA 99349	91-6018970	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
KIHEI HIGH SCHOOL 300 OHUKAI ROAD STE 209 KIHEI,HI 96753	91-2193016	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
KLAMATH FALLS CITY SCHOOLS1336 AVALON KLAMATH FALLS,OR 97603	93-6000545	501(C)(3)	27,033				GRANT FOR COMPENSATION TO SITE COORDINATOR FOR THE OREGON COLLEGE AND CAREER PROGRAM
KULM SCHOOL DISTRICTPO BOX G KULM,ND 58456	45-6000842	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
LENOIR CITY HIGH SCHOOL1485 OLD HIGHWAY 95 LENOIR CITY,TN 37771	62-6000037	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
LEWISTOWN DISTRICT #9715501 E AVE L LEWISTOWN,IL 61542	36-4415828	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
LEGAL COUNSEL FOR THE ELDERLY601 E STREET NW WASHINGTON,DC 20049	52-1194741	501(C)(3)	1,897,159				GENERAL SUPPORT
STATE OF SOUTH CAROLINA - OFFICE OF THE LIEUTENANT GOVERNOR1301 GERVAIS STREET STE 200 COLUMBIA,SC 29201	57-6000286		9,500				GENERAL SUPPORT TO ELDERCARE TRUST FUND

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MSD OF WARREN COUNTY INDIANA101 NORTH MONROE STREET WILLIAMSPORT,IN 47993	35-1097255	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
MASSACHUSETTS INSTITUTE OF TECHNOLOGY - AGELAB 77 MASSACHUSETTS AVENUE RM E40-278 CAMBRIDGE,MA 02139	04-2103594	501(C)(3)	125,000				GENERAL SUPPORT
MAINE SCHOOL ADMINISTRATIVE DISTRICTPO BOX 360 ANSON,ME 04911	01-0284659	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
MAKE IT RIGHT FOUNDATION1055 ST CHARLES AVE STE 500 NEW ORLEANS,LA 70130	26-0723027	501(C)(3)	200,000				THE MIR FOUNDATION BUILDS AFFORDABLE GREEN HOUSING TO HELP THE VICTIMS OF THE 2006 HURRICANE KATRINA DISASTER
MCKINLEY TECHNOLOGY HIGH SCHOOL1ST T ST NE WASHINGTON,DC 20002	53-6001131	501(C)(3)	100,000				ETHEL PERCY ANDRUS LEGACY AWARD
MERRIMARK VALLEY HIGH SCHOOL106 VILLAGE STREET PENACOOK,NH 03301	02-0270194	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
MIAMI DOUGLAS MACARTHUR SENIOR HIGH SCHOOL11035 SW 84 STREET MIAMI,FL 33173	59-6000572	501(C)(3)	100,000				ETHEL PERCY ANDRUS LEGACY AWARD
MIDDLETOWN BOARD OF EDUCATION311 HUNTING HILL AVENUE MIDDLETOWN,CT 06457	06-6001672	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
MILFORD HIGH SCHOOL 62 NORTH 300 WEST MILFORD,UT 84751	87-0397602	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
MINNEAPOLIS SAINT PAUL 2008 HOST COMMITTEE180 EAST 5TH STREET STE 1200 SAINT PAUL,MN 55101	20-8397116	501(C)(3)	100,000				GENERAL SUPPORT

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
MONTPELIER SCHOOL DISTRICT58 BARRE STREET MONTPELIER,VT 05602	03-6000578	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
MT HOPE HIGH SCHOOL 199 CHESTNUT STREET BRISTOL,RI 02809	05-0462803	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
NATIONAL ACAEMY OF SOLICAL INSURANCE 1776 MASSACHUSETTS AVE NW STE 615 WASHINGTON,DC 20036	52-1451753	501(C)(3)	150,000				GENERAL SUPPORT
NATIONAL COALITION ON HEALTH CARE1120 G STREET NW STE 850 WASHINGTON,DC 20005	52-1687849	501(C)(3)	50,000				GENERAL SUPPORT
NATIONAL COUNCIL OF CHURCHES475 RIVERSIDE DRIVE RM 880 NEW YORK,NY 10115	13-5562417	501(C)(3)	20,000				GENERAL SUPPORT
NORRISTOWN AREA SCHOOL DISTRICT401 N WHITEHALL ROAD NORRISTOWN,PA 19403	23-1667974	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
NORTH CALLAWAY R1 SCHOOL DISTRICT2690 US HIGHWAY 54 KINGDOM CITY,MO 65262	43-0816264	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
NORTH FARMINGTON HIGH SCHOOL32900 THIRTEEN MILE FARMINGTON HILLS,MI 48334	38-6003051	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
NORTH OLMSTED BD OF EDUCATION27425 BUTTERNUT RIDGE RD NORTH OLMSTED,OH 44070	34-6002047	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
PAOLA HIGH SCHOOL 401 N ANGELA PAOLA,KS 66071	48-0720746	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
PAPILLION LA VISTA PUBLIC SCHOOLS420 SO WASHINGTON PAPILLION,NE 68046	47-6005159	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
PARTNERSHIP FOR PREVENTION1015 18TH ST NW WASHINGTON,DC 20036	52-1735637	501(C)(3)	30,000				GENERAL SUPPORT
PENSION RIGHTS CENTER1350 CONNECTICUT AVE NW STE 206 WASHINGTON,DC 20036	52-1059121	501(C)(3)	100,000				GENERAL SUPPORT
PHENIX CITY BOARD OF EDUCATION CENTER 1212 NINTH AVENUE PHENIX CITY,AL 36868	63-6001032	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
PHOENIX UNION PARTNERSHIP OF BUSINESS AND EDUCATION4502 N CENTRAL AVENUE PHOENIX,AZ 85012	86-0523265	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
REPUBLICAN MAIN STREET PARTNERSHIP 325 7TH ST NW STE 610 WASHINGTON,DC 20004	59-1828852	501(C)(4)	25,000				GENERAL SUPPORT
RESEARCH AMERICA 1101 KING STREET STE 520 ALEXANDRIA,VA 22314	52-1609875	501(C)(3)	10,000				GENERAL SUPPORT
ROADWAY SAFETY FOUNDATION1101 14TH STREET NW STE 750 WASHINGTON,DC 20005	53-0030282	501(C)(3)	20,000				GENERAL SUPPORT
RUTGERS THE STATE UNIVERSITY OF NEW JERSEY3 RUTGERS PLAZA NEW BRUNSWICK,NJ 08901	22-6001086	501(C)(3)	72,063				GRANT TO SUPPORT PROFESSIONAL PARTNERS SUPPORTING FAMILY CAREGIVING PROGRAM
SAVE OURSELVES2795 E BIDWELL STREET FOLSOM,CA 95630	68-0257688	501(C)(3)	10,000				GENERAL SUPPORT

'm 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

ı) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
CHOOL BOARD OF OWARD COUNTY7720 EST OAKLAND PARK .VD UNRISE, FL 33351	59-6000530	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
CLERODERMA ESEARCH OUNDATION220 ONTGOMERY ST STE 411 AN FRANCISCO, CA 4104	68-0067234	501(C)(3)	10,000				GENERAL SUPPORT
O MERSET COUNTY DUCATIONAL SERVICE O BOX 68 ARITAN, NJ 08869	22-2213688	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
T CROIX DUCATIONAL OMPLEX HIGH CHOOLRR1 BOX 10360 INGSHILL, VI 00850	66-0431678	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
EAFORD SENIOR HIGH CHOOL820 SILVER AKE BLVD STE 200 OVER, DE 19904	51-6000279	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
HE GEORGE /ASHINGTON NIVERSITY2121 EYE TREET NW STE 601 /ASHINGTON, DC 0052	53-0196584	501(C)(3)	50,000				GENERAL SUPPORT FOR THE CENTER ON AGING, HEALTH AND HUMANITY
HE SCHOOL DISTRICT F PHILADELPHIA440 N ROAD STREET HILADELPHIA, PA 9130	23-6004102	501(C)(3)	100,000				ETHEL PERCY ANDRUS LEGACY AWARD
/ETA2775 S QUINCY TREET RLINGTON, VA 22206	53-0242992	501(C)(3)	2,050,000				GRANT TO SUPPORT THE PRODUCTION AND NATIONAL TELEVISION DISTRIBUTION OF WASHINGTON WEEK WITH GWEN IFILL AND NATIONAL JOURNAL AS PRODUCTION AND BROADCAST OF SEVERAL LIVE EVENTS
OWNSEND K12 CHOOL DISTRICT #1 01 N SPRUCE OWNSEND, MT 59644	81-6000057	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
NIVERSITY OF INNESOTAMAIN AMPUS INNEAPOLIS, MN 5455	41-6042488	501(C)(3)	10,000				GENERAL SUPPORT

Form 990,Schedule I, Part II, Grants and Other Assistance to Governments and Organizations in the United States

(a) Name and address of organization or government	(b) EIN	(c) IRC Code section if applicable	(d) Amount of cash grant	(e) Amount of non-cash assistance	(f) Method of valuation (book, FMV, appraisal, other)	(g) Description of non-cash assistance	(h) Purpose of grant or assistance
US GRANT HIGH SCHOOL STUDENT BODY 13000 OXNARD STREET VALLEY GLEN,CA 91401	95-2042437	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
WEST MESA HIGH SCHOOL6701 FORTUNA ROAD NW ALBUQUERQUE,NM 87121	85-6000101	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
PLATTE COUNTY SCHOOL DISTRICT #1 WHEATLAND HIGH SCHOOL1350 OAK STREET WHEATLAND,WY 82201	08-0002060	501(C)(3)	10,000				ETHEL PERCY ANDRUS LEGACY AWARD
AARP FOUNDATION601 E STREET NW WASHINGTON,DC 20049	52-0794300	501(C)(3)	21,624,619				GENERAL SUPPORT

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hedule J (rm 990)

Compensation Information

For certain Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

▶ Attach to Form 990. To be completed by organizations that answered "Yes" to Form 990, Part IV, line 23.

OMB No 1545-0047

2008

Open to Public Inspection

partment of the asury ernal Revenue vice

ame of the organization
RP

Employer identification number
95-1985500

art I Questions Regarding Compensation

		Yes	No
	Check the appropriate box(es) if the organization provided any of the following to or for a person listed in Form 990, Part VII, Section A, line 1a Complete Part III to provide any relevant information regarding these items ☑ First class or charter travel ☐ Housing allowance or residence for personal use ☑ Travel for companions ☐ Payments for business use of personal residence ☑ Tax indemnification and gross-up payments ☐ Health or social club dues or initiation fees ☑ Discretionary spending account ☐ Personal services (e g , maid, chauffeur, chef)		
	If line 1a is checked, did the organization follow a written policy regarding payment or reimbursement or provision of all the expenses described above? If "No," complete Part III to explain	1b	Yes	
	Did the organization require substantiation prior to reimbursing or allowing expenses incurred by all officers, directors, trustees, and the CEO/Executive Director, regarding the items checked in line 1a?	2	Yes	
	Indicate which, if any, of the following the organization uses to establish the compensation of the organization's CEO/Executive Director Check all that apply ☑ Compensation committee ☑ Written employment contract ☑ Independent compensation consultant ☑ Compensation survey or study ☐ Form 990 of other organizations ☑ Approval by the board or compensation committee			
	During the year, did any person listed in Form 990, Part VII, Section A, line 1a			
a	Receive a severance payment or change of control payment?	4a	Yes	
b	Participate in, or receive payment from, a supplemental nonqualified retirement plan?	4b		No
c	Participate in, or receive payment from, an equity-based compensation arrangement?	4c		No
	If "Yes" to any of lines 4a-c, list the persons and provide the applicable amounts for each item in Part III			
	501(c)(3) and 501(c)(4) organizations only must complete lines 5-8.			
	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the revenues of			
a	The organization?	5a		No
b	Any related organization?	5b		No
	If "Yes," to line 5a or 5b, describe in Part III			
	For persons listed in form 990, Part VII, Section A, line 1a, did the organization pay or accrue any compensation contingent on the net earnings of			
a	The organization?	6a		No
b	Any related organization?	6b		No
	If "Yes," to line 6a or 6b, describe in Part III			
	For persons listed in form 990, Part VII, Section A, line 1a, did the organization provide any non-fixed payments not described in lines 5 and 6? If "Yes," describe in Part III	7		No
	Were any amounts reported in Form 990, Part VII, paid or accured pursuant to a contract that was subject to the initial contract exception described in Regs section 53 4958-4(a)(3)? If "Yes," describe in Part III	8		No

Part II Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees. Use Schedule J-1 if additional space needed.

For each individual whose compensation must be reported in Schedule J, report compensation from the organization on row (i) and from related organizations described in the instructions on row (ii). Do not list any individuals that are not listed on Form 990, Part VII.

Note. The sum of columns (B)(i)-(iii) must equal the applicable column (D) or column (E) amounts on Form 990, Part VII, line 1a.

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base compensation	(ii) Bonus & incentive compensation	(iii) Other compensation				
See Additional Data Table	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
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	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							
	(i)							
	(ii)							

Part III Supplemental Information

Complete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 4c, 5a, 5b, 6a, 6b, 7, and 8 Also complete this part for any additional information

See Additional Data Table

Identifier	Return Reference	Explanation
	Part I, Line 1a	AARP board members, officers, and key employees are provided the benefit of first-class travel on flights exeeding 5 hours when business class accommodations are not available All officers and directors (other than individuals listed as both officers and key employees) for AARP serve on a volunteer basis and are not compensated for their generous commitment to AARP The officers, directors and key employees are, however, reimbursed by AARP for travel and subsistence costs incurred in carrying out their duties In addition, officers and directors are reimbursed for travel and subsistence costs,incurred for spouses/companions accompanying them to Association functions The officers and board members receive a gross-up payment to ensure there are no out-of-pocket expenses related to the income taxes for the spouse/companion travel All spouse/companion travel reimbursements and tax gross-up payments are treated as taxable income to the officers and directors The Chief Executive Officer of AARP is given an annual net payment of $5,000 to cover any incidental expenses AARP pays the applicable withholding taxes on his behalf
	Part I, Line 4a	Lin MacMaster received a severance payment of $172,088 50 for her separation on 8/4/2008

ditional Data

Return to Form

Software ID:
Software Version:
EIN: 95-1985500
Name: AARP

n 990, Schedule J, Part II - Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees

(A) Name		(B) Breakdown of W-2 and/or 1099-MISC compensation			(C) Deferred compensation	(D) Nontaxable benefits	(E) Total of columns (B)(i)-(D)	(F) Compensation reported in prior Form 990 or Form 990-EZ
		(i) Base Compensation	(ii) Bonus & incentive compensation	(iii) Other compensation				
im D Novelli	(i) (ii)	862,459	90,857	35,641	207,529	8,894	1,005,380	
rt R Hagans Jr	(i) (ii)	319,818	41,157	1,129	34,178	2,150	398,432	
nas C Nelson	(i) (ii)	474,571	100,000	2,322	34,178	14,786	625,857	
fac Master	(i) (ii)	182,956	59,435	172,707	34,178	3,391	452,667	
:y A LeMond	(i) (ii)	335,701	47,603	2,294	34,178	1,903	421,679	
io Pardo	(i) (ii)	321,621	46,893	777	34,178	13,777	417,246	
S Wise	(i) (ii)	315,147	43,912	7,473	34,178	8,850	409,560	
ren G Ramez	(i) (ii)	293,269	42,727	3,156	34,178	2,119	375,449	
C Rother	(i) (ii)	279,898	39,236	2,913	34,178	5,427	361,352	
n J Donnellan	(i) (ii)	273,779	40,222	1,292	34,178	8,751	358,222	
ı Hollander	(i) (ii)	256,657	44,681	1,205	34,178	14,557	351,278	
oll Backus	(i) (ii)	261,099	27,816	11,999	24,978	8,528	334,330	
thew Mitchell	(i) (ii)	240,866	34,183	473	34,178	14,499	324,219	
h Dalehanty	(i) (ii)	268,365	37,751	1,816	34,178	8,736	350,836	
cy Smith	(i) (ii)	131,613 123,228	42,007	474 540	9,544 24,634	825	141,631 191,234	
id Sloane	(i) (ii)	260,131	34,509	938	34,178	5,364	335,120	
an Reinhard	(i) (ii)	247,015	36,079	1,652	34,178	9,214	328,138	
thew Rosser	(i) (ii)	244,716	34,529	336	34,178	13,430	327,293	

rt III Supplemental Information

mplete this part to provide the information, explanation, or descriptions required for Part I, lines 1a, 1b, 4c, 5a, 5b, 6a, 6b, 7, and 8 Also complete this part for any additional informetion

dentifier	Return Reference	Explanation
	Part I, Line 1a	AARP board members, officers, and key employees are provided the benefit of first-class travel on flights exceeding 5 hours when business class accommodations are not available All officers and directors (other than individuals listed as both officers and key employees) for AARP serve on a volunteer basis and are not compensated for their generous commitment to AARP The officers, directors and key employees are, however, reimbursed by AARP for travel and subsistence costs incurred in carrying out their duties In addition, officers and directors are reimbursed for travel and subsistance costs incurred for spouses/companions accompanying them to Association functions The officers and board members receive a gross-up payment to ensure there are no out-of-pocket expenses related to the income taxes for the spouse/companion travel All spouse/companion travel reimbursements and tax gross-up payments are treated as taxable income to the officers and directors The Chief Executive Officer of AARP is given an annual net payment of $5,000 to cover any incidental expenses AARP pays the applicable withholding taxes on his behalf
	Part I, Line 4a	Jin MacMaster received a severance payment of $172,088 50 for her seperation on 8/4/2008

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SCHEDULE O (Form 990)

Department of the Treasury
Internal Revenue Service

OMB No 1545-0047

Supplemental Information to Form 990

▶ Attach to Form 990. To be completed by organizations to provide additional information for responses to specific questions for the Form 990 or to provide any additional information.

2008

Open to Public Inspection

Name of the organization
AARP

Employer identification number
38-1568502

Identifier	Return Reference	Explanation
Form 990, Part III, line 4d	Other Program Services	The State Operations Program has established a field office in every state, the District of Columbia, Puerto Rico, and the Virgin Islands. These offices coordinate AARP's local efforts and provide a structure that delivers person-related services and programs to members and other older Americans in their homes and communities. These offices offer needed assistance, information, and support to older Americans. They also help many of the gaps in services that families, communities, and government are unable to address, enabling older persons to maintain their independence and dignity. Expenses $ 101476783 including grants of $ 195305 Revenue $ 859269
Form 990, Part III, line 4d	Other Program Services	Legislative Activities and Public Policy - Through AARP's Government Relations & Advocacy group, State Executive Councils, and AARP advocacy volunteers, AARP works to raise awareness and advocates for the rights of its members pertaining to the following issues: affordable health care for all Americans, ensuring the solvency of Social Security for current and future retirees, ensuring the long-term solvency of Medicare, informing members and consumers about Medicare health insurance and related issues, independent living and long-term care, and protecting consumers' financial security from fraudulent telemarketers, guardianship abuse, and predatory mortgage lenders. Expenses $ 69263532 including grants of $ 474266 Revenue $ 1401991
Form 990, Part III, line 4d	Other Program Services	Outreach and Services - AARP researches and identifies certain strategic areas and focuses its activities and resources to develop programs, provide audience information, and conduct studies on four key issues affecting members: health, economic security/work, livable communities, and consumer protection. Expenses $ 16342182 including grants of $ 197000 Revenue $ 520823
Form 990, Part III, line 4d	Other Program Services	Divided We Fall is a social initiative to propel public and private sector innovation and action on health (including long-term care) and financial security (Social Security, work, private and public pensions and savings) for Americans of all ages by moving the public to demand bipartisan, responsible, and intergenerational action from policy makers. Expenses $ 8454940 including grants of $ 7000 Revenue $ 0
Form 990, Part III, line 4d	Other Program Services	The AARP Driver Safety Program helps older drivers maintain their independence by instructing them on safety in the driver's seat. The program, which is led by volunteer instructors, teaches participants about the normal changes that occur with aging and how to use this awareness to become safer drivers. Expenses $ 6562545 including grants of $ 0 Revenue $ 5739506
Form 990, Part III, line 4d	Other Program Services	AARP Foundation (cash contributions) Expenses $ 21622744 including grants of $ 21622744 Revenue $ 0
Form 990, Part III, line 4d	Other Program Services	AARP Member Events Expenses $ 21298178 including grants of $ 3223791 Revenue $ 8222245
Form 990, Part III, line 4d	Other Program Services	International Affairs Office Expenses $ 3700002 including grants of $ 0 Revenue $ 0
Form 990, Part III, line 4d	Other Program Services	National Operations and Volunteer Resources Expenses $ 2700283 including grants of $ 0 Revenue $ 0
Form 990, Part III, line 4d	Other Program Services	National Retired Teachers Association Expenses $ 2932926 including grants of $ 0 Revenue $ 0
Form 990, Part III, line 4d	Other Program Services	Legal Counsel for the Elderly (cash contributions) Expenses $ 1957166 including grants of $ 1807158 Revenue $ 0
Form 990, Part III, line 4d	Other Program Services	Various Other Programs Expenses $ 43418442 including grants of $ 179868 Revenue $ 484928
Form 990, Part VI, Section A, line 2		AARP is a 501(c)(4) membership organization for people age 50 and over
Form 990, Part VI, Section A, line 10		The Form 990 is prepared and reviewed in AARP's internal tax department. The return is then put through a secondary review which includes the AARP Controller, General Counsel, and Outside Counsel. After the thorough review process, the Form 990 is uploaded to the Board of Directors Sharepoint site and emails are sent to each member to let them know the return is ready for their review. The board then has seven days to review and provide and comments or questions. After all issues are addressed the return is reviewed by the Chief Financial Officer prior to electronically filing with the Internal Revenue Service
Form 990, Part VI, Section B, line 12c		All board members and employees are required to review the ethics policy annually, acknowledge their understanding of the policy, and disclose any real or potential conflicts of interest. Disclosures are reviewed with the employee's manager (or in the case of a board member, the Board Governance Committee), and the Chief Ethics & Compliance Officer. The appropriate mitigation plan is implemented to include recusal from participating in any deliberations and decisions relevant to the disclosure. The Chief Ethics & Compliance Officer monitors compliance with these requirements and ensures proper follow-up as needed
Form 990, Part VI, Section B, line 15		AARP has a targeted competitive position in the marketplace that considers relevant for-profit and not-for-profit data sample that is the landscape that AARP competes for talent. Establishing the appropriate compensation for positions and jobs considers external market pricing (where possible) from an independent, third party compensation consulting firm, internal criteria, and an individual's actual performance and contribution. Internal criteria is based on a standard approach that measures the internal value of positions, including complexity and scope of responsibility, skill set and competencies, education and experience, and the reporting relationship of the position. An individual's actual performance and contribution is measured through AARP's performance management approach and then rewarded through AARP's annual base pay merit and incentive pay plans. Programs. For the CEO, information from all three areas (external data, internal data, individual performance and contribution) is submitted via the Board of Directors for review and approval. In some cases, the Board may deal directly with the independent, third party compensation consulting firm on external market pricing. The individual in the position may have legal representation and may assist on an employment contract with terms that are mutually agreed upon by the individual and the Board
Form 990, Part VI, Section C, line 19		AARP makes its Form 990 available upon request to the General Counsel's Office. AARP's audited financial statements are available on their website at www.aarp.org. AARP's governing documents and conflict of interest policy will be made available to the public in the event these documents are included in a filing with the Internal Revenue Service
Schedule G, Part I, Line 2b, Column (v)	Explanation of Fundraising Payments	Adams Hussey does not raise funds directly for AARP, but provides services and support to AARP's internal development office
Form 990, Part VIII Line 7a and 7b, Column (i)	Amounts from Sale of Securities	7a Gross amount from sales of assets other than inventory $1,018,089,321 7b Less cost or other basis and sales expenses $1,016,040,858
Form 990, Part I, Revenue Prior Year	Revenue Categorization - Prior Year	Revenues for 2007 have been reclassified to conform to the current year presentation of the Form 990 Membership dues of $748,611,271 have moved to Line 1, Contributions and grants. Royalties of $472,762,641 have moved to Line 11, Other revenue. In 2007, Royalties of $467,834,726 were reported net of service providers relationship management fees paid to our taxable subsidiary, AARP Services, Inc
Schedule O, Part XI, Line 9	Other Adjustments	In prior years AARP has included the investment in its taxable subsidiaries on its balance sheet under the equity method of accounting. The equity method of accounting reports the investment in common stock and cumulative earnings of a wholly-owned subsidiary. In 2008, AARP changed the methodology since reporting under the equity method of accounting is not required under Generally Accepted Accounting Principles. AARP now only reports the value of the common stock of its subsidiaries. These subsidiaries are included in the audited consolidated financial statements, which is not applicable to the Form 990, which only reflects AARP, Inc and its wholly-owned LLCs
Schedule R, Part V, Question 2	Transactions with Related Organizations	The AARP Insurance Plan is a grantor trust established by an Agreement and Declaration of Trust for the purpose of making group health insurance and other health-related products and services available to AARP, Inc members. Agreements between AARP, Inc , AARP Services, United HealthCare Corporation, Metropolitan Life Insurance Company, Genworth Life Insurance Company, and Aetna Life Insurance Company make certain types of insurance available to AARP members. At the direction of the third party insurance carriers, the Plan pays AARP, Inc a portion of the total premiums collected for the use of its intellectual property, which is reported as royalties in the consolidated statements of activities

SCHEDULE R (Form 990)

Department of the Treasury
Internal Revenue Service

Related Organizations and Unrelated Partnerships

► Attach to Form 990. To be completed by organizations that answered "Yes" to Form 990, Part IV, lines 33, 34, 35, 36, or 37.
► See separate instructions.

OMB No 1545-0047

2008

Open to Public Inspection

Name of the organization
AARP

Employer identification number
95-1985500

Part I Identification of Disregarded Entities

(A) Name, address, and EIN of disregarded entity	(B) Primary activity	(C) Legal domicile (state or foreign country)	(D) Total income	(E) End-of-year assets	(F) Direct controlling entity
See Additional Data Table					

Part II Identification of Related Tax-Exempt Organizations

(A) Name, address, and EIN of related organization	(B) Primary activity	(C) Legal domicile (state or foreign country)	(D) Exempt Code section	(E) Public charity status (if section 501(c)(3))	(F) Direct controlling entity
AARP Foundation 601 E Street NW Washington, DC20049 52-0794300	Foundation dedicated to persons over 50 at social and economic risk	DC	501 (c)(3)	509(a)(1)	AARP
AARP Institute 601 E Street NW Washington, DC20049 52-0788550	Supporting organization of AARP Foundation	DC	501 (c)(3)	509(a)(3)	AARP Foundation
Legal Counsel for the Elderly 601 E Street NW Washington, DC20049 52-1194743	Provides free or lost cost legal assistance and education to DC elderly	DC	501 (c)(3)	509(a)(1)	AARP

Part III **Identification of Related Organizations Taxable as a Partnership**

(A) Name, address, and EIN of related organization	(B) Primary activity	(C) Legal domicile (state or foreign country)	(D) Direct controlling entity	(E) Predominant income(related, investment, unrelated)	(F) Share of total income	(G) Share of end-of-year assets	(H) Disproprtionate allocations? Yes	(H) No	(I) Code V—UBI amount on Box 20 of K-1	(J) General or managing partner? Yes	(J) No

Part IV **Identification of Related Organizations Taxable as a Corporation or Trust**

(A) Name, address, and EIN of related organization	(B) Primary activity	(C) Legal domicile (state or foreign country)	(D) Direct controlling entity	(E) Type of entity (C corp, S corp, or trust)	(F) Share of total income	(G) Share of end-of-year assets	(H) Percentage ownership
AARP Financial Services Corporation 601 E Street NW Washington, DC20049 52-1367607	Real Estate Holding Company	DE	AARP	C	1,171,749	10,624,957	100 000 %
AARP Services Inc (consolidated) 650 F Street NW Washington, DC20004 52-2141065	Marketing and Research	DE	AARP	C	180,257,830	75,618,198	100 000 %
AARP Insurance Plan 601 E Street NW Washington, DC20049 52-6069387	Grantor Trust	DC	AARP	T	23,913,515		100 000 %

Part V Transactions with Related Organizations

Note. Complete line 1 if any entity is listed in Parts II, III or IV

		Yes	No
1	During the tax year, did the organization engage in any of the following transactions with one or more related organizations listed in Parts II-IV?		
a	Receipt of (i) interest (ii) annuities (iii) royalties (iv) rent from a controlled entity	1a Yes	
b	Gift, grant, or capital contribution to other organization(s)	1b Yes	
c	Gift, grant, or capital contribution from other organization(s)	1c Yes	
d	Loans or loan guarantees to or for other organization(s)	1d Yes	
e	Loans or loan guarantees by other organization(s)	1e	No
f	Sale of assets to other organization(s)	1f	No
g	Purchase of assets from other organization(s)	1g	No
h	Exchange of assets	1h	No
i	Lease of facilities, equipment, or other assets to other organization(s)	1i	No
j	Lease of facilities, equipment, or other assets from other organization(s)	1j	No
k	Performance of services or membership or fundraising solicitations for other organization(s)	1k Yes	
l	Performance of services or membership or fundraising solicitations by other organization(s)	1l Yes	
m	Sharing of facilities, equipment, mailing lists, or other assets	1m Yes	
n	Sharing of paid employees	1n	No
o	Reimbursement paid to other organization for expenses	1o Yes	
p	Reimbursement paid by other organization for expenses	1p Yes	
q	Other transfer of cash or property to other organization(s)	1q	No
r	Other transfer of cash or property from other organization(s)	1r Yes	

2 If the answer to any of the above is "Yes," see the instructions for information on who must complete this line, including covered relationships and transaction thresholds

	(A) Name of other organization(s)	(B) Transaction type(a-r)	(C) Amount involved
(1)	See Additional Data Table		
(2)			
(3)			
(4)			
(5)			
(6)			

Part VI **Unrelated Organizations Taxable as a Partnership**

Provide the following information for each entity taxed as a partnership through which the organization conducted more than five percent of its activities (measured by total assets or gross revenue) that was not a related organization See instructions regarding exclusion for certain investment partnerships

(A) Name, address, and EIN of entity	(B) Primary activity	(C) Legal domicile (state or foreign country)	(D) Are all partners section 501(c)(3) organizations?		(E) Share of end-of-year assets	(F) Disproportionate allocations?		(G) Code V—UBI amount on Box 20 of K-1	(H) General or managing partner?	
			Yes	No		Yes	No		Yes	No

ditional Data

Return to Form

Software ID:
Software Version:
EIN: 95-1985500
Name: AARP

n 990, Schedule R, Part I - Identification of Disregarded Entities

(A) Name, address, and EIN of disregarded entity	(B) Primary Activity	(C) Legal Domicile (State or Foreign Country)	(D) Total Income ($)	(E) End-of-year assets ($)	(F) Direct Controlling Entity
:P Properties LLC E Street NW hington, DC 20049 1985500	Real Estate Holding Company	DE	204,802	142,457,670	AARP
:P 650 F 2-3 LLC E Street NW hington, DC 20049 1985500	Real Estate Holding Company	DE	45,147	18,647,527	AARP
:P 650 F 4-5 LLC E Street NW hington, DC 20049 1985500	Real Estate Holding Company	DE	45,783	18,462,805	AARP
:P Carson Place LLC E Street NW hington, DC 20049 1985500	Real Estate Holding Company	DE	0	21,477,609	AARP
:P Watson Plaza LLC E Street NW hington, DC 20049 1985500	Real Estate Holding Company	DE	0	10,199,695	AARP
:P Global Network LLC E Street NW hington, DC 20049 4499050	Cooperates with organizations representing people 50+ in other countries	DC	908,943	939,329	AARP
:P Andrus Insurance Fund LLC E Street NW hington, DC 20049 1985500	Insurance captive	DC	3,776,862	5,193,694	AARP

m 990, Schedule R, Part V - Transactions with Related Organizations

(A) Name of other organization	(B) Transaction type(a-r)	(C) Amount Involved ($)
) AARP Services Inc Consolidated	A	3,286,690
) AARP Foundation (cash contributions)	B	21,624,609
) Legal Counsel for the Elderly (cash contributions)	B	1,897,159
) AARP Foundation	C	3,093,441
) AARP Foundation	D	26,550,000
) Legal Counsel for the Elderly (in-kind rent)	M	82,755
) AARP Foundation (in-kind contributions)	L	10,116,428
) AARP Services Inc Consolidated	L	108,424,067
) Legal Counsel for the Elderly (in-kind contributions)	L	1,263,206
0) AARP Services Inc Consolidated	P	67,892
1) AARP Foundation	P	1,406,492
2) Legal Counsel for the Elderly	P	60,505
3) - AARP Insurance Plan (see Schedule O for explanation)	R	261,111,468
4) AARP Services Inc Consolidated	K	6,689,920
5) AARP Services Inc Consolidated (dividend payment)	R	5,000,000
6) AARP Services Inc Consolidated	L	11,362,417
7) AARP Foundation (dual employee reimbursement)	O	333,307

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n 4562 — ‹artment of the asury ‹rnal Revenue vice

Depreciation and Amortization
(Including Information on Listed Property)

▶ See separate instructions. ▶ Attach to your tax return.

OMB No 1545-0172

2008

Attachment Sequence No 67

ne(s) shown on return RP	Business or activity to which this form relates	Identifying number
	Form 990 Page 10	95-1985500

art I Election To Expense Certain Property Under Section 179

Note: If you have any listed property, complete Part V before you complete Part I.

Maximum amount See the instructions for a higher limit for certain businesses	1	250,000
Total cost of section 179 property placed in service (see instructions)	2	
Threshold cost of section 179 property before reduction in limitation (see instructions)	3	800,000
Reduction in limitation Subtract line 3 from line 2 If zero or less, enter -0-	4	
Dollar limitation for tax year Subtract line 4 from line 1 If zero or less, enter -0- If married filing separately, see instructions	5	

(a) Description of property	(b) Cost (business use only)	(c) Elected cost

Listed property Enter the amount from line 29	7	
Total elected cost of section 179 property Add amounts in column (c), lines 6 and 7	8	
Tentative deduction Enter the smaller of line 5 or line 8	9	
Carryover of disallowed deduction from line 13 of your 2007 Form 4562	10	
Business income limitation Enter the smaller of business income (not less than zero) or line 5 (see instructions)	11	
Section 179 expense deduction Add lines 9 and 10, but do not enter more than line 11	12	
Carryover of disallowed deduction to 2009 Add lines 9 and 10, less line 12 ▶	13	

ıte: *Do not use Part II or Part III below for listed property. Instead, use Part V.*

rt II Special Depreciation Allowance and Other Depreciation (Do not include listed property.) (See instructions.)

Special depreciation allowance for qualified property (other than listed property) placed in service during the tax year (see instructions)	14	
Property subject to section 168(f)(1) election	15	
Other depreciation (including ACRS)	16	20,155,805

rt III MACRS Depreciation (Do not include listed property.) (See instructions.)

Section A

MACRS deductions for assets placed in service in tax years beginning before 2008	17	
If you are electng to group any assets placed in service during the tax year into one or more general asset accounts, check here ▶ ☐		

Section B—Assets Placed in Service During 2008 Tax Year Using the General Depreciation System

(a) Classification of property	(b) Month and year placed in service	(c) Basis for depreciation (business/investment use only—see instructions)	(d) Recovery period	(e) Convention	(f) Method	(g) Depreciation deduction
a 3-year property						
b 5-year property						
c 7-year property						
d 10-year property						
e 15-year property						
f 20-year property						
g 25-year property			25 yrs		S/L	
h Residential rental property			27 5 yrs	MM	S/L	
			27 5 yrs	MM	S/L	
i Nonresidential real property			39 yrs	MM	S/L	
				MM	S/L	

Section C—Assets Placed In Service During 2008 Tax Year Using the Alternative Depreciation System

a Class life					S/L	
b 12-year			12 yrs		S/L	
c 40-year			40 yrs	MM	S/L	

art IV Summary (See instructions)

Listed property Enter amount from line 28	21	
Total. Add amounts from line 12, lines 14 through 17, lines 19 and 20 in column (g), and line 21 Enter here and on the appropriate lines of your return Partnerships and S corporations—see instr	22	20,155,805
For assets shown above and placed in service during the current year, enter the portion of the basis attributable to section 263A costs	23	

m 4562 (2008) Page 2

art V **Listed Property** (Include automobiles, certain other vehicles, cellular telephones, certain computers, and property used for entertainment, recreation, or amusement.)

Note: *For any vehicle for which you are using the standard mileage rate or deducting lease expense, complete only 24a, 24b, columns (a) through (c) of Section A, all of Section B, and Section C if applicable.*

ction A—Depreciation and Other Information (Caution: *See the instructions for limits for passenger automobiles.*)

a Do you have evidence to support the business/investment use claimed? ☐ Yes ☐ No | 24b If "Yes," is the evidence written? ☐ Yes ☐ No

(a) ype of property (list vehicles first)	(b) Date placed in service	(c) Business/ investment use percentage	(d) Cost or other basis	(e) Basis for depreciation (business/investment use only)	(f) Recovery period	(g) Method/ Convention	(h) Depreciation/ deduction	(i) Elected section 179 cost
Special depreciation allowance for qualified listed property placed in service during the tax year and used more than 50% in a qualified business use (see instructions)						25		
Property used more than 50% in a qualified business use								
		%						
		%						
		%						
Property used 50% or less in a qualified business use								
		%				S/L -		
		%				S/L -		
		%				S/L -		
Add amounts in column (h), lines 25 through 27 Enter here and on line 21, page 1						28		
Add amounts in column (i), line 26 Enter here and on line 7, page 1								29

Section B—Information on Use of Vehicles

mplete this section for vehicles used by a sole proprietor, partner, or other "more than 5% owner," or related person
ou provided vehicles to your employees, first answer the questions in Section C to see if you meet an exception to completing this section for those vehicles

	(a) Vehicle 1		(b) Vehicle 2		(c) Vehicle 3		(d) Vehicle 4		(e) Vehicle 5		(f) Vehicle 6	
Total business/investment miles driven during the year (do not include commuting miles)												
Total commuting miles driven during the year												
Total other personal(noncommuting) miles driven												
Total miles driven during the year Add lines 30 through 32												
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Was the vehicle available for personal use during off-duty hours?												
Was the vehicle used primarily by a more than 5% owner or related person?												
Is another vehicle available for personal use?												

Section C—Questions for Employers Who Provide Vehicles for Use by Their Employees

swer these questions to determine if you meet an exception to completing Section B for vehicles used by employees who are not more than owners or related persons (see instructions)

	Yes	No
Do you maintain a written policy statement that prohibits all personal use of vehicles, including commuting, by your employees?		
Do you maintain a written policy statement that prohibits personal use of vehicles, except commuting, by your employees? See the instructions for vehicles used by corporate officers, directors, or 1% or more owners		
Do you treat all use of vehicles by employees as personal use?		
Do you provide more than five vehicles to your employees, obtain information from your employees about the use of the vehicles, and retain the information received?		
Do you meet the requirements concerning qualified automobile demonstration use? (See instructions)		
Note: If your answer to 37, 38, 39, 40, or 41 is "Yes," do not complete Section B for the covered vehicles		

art VI **Amortization**

(a) Description of costs	(b) Date amortization begins	(c) Amortizable amount	(d) Code section	(e) Amortization period or percentage	(f) Amortization for this year
Amortization of costs that begins during your 2008 tax year (see instructions)					
Amortization of costs that began before your 2008 tax year				43	52,846
Total. Add amounts in column (f) See the instructions for where to report				44	52,846

Form 4562 (2008)

KPMG

AARP℠

CONSOLIDATED FINANCIAL STATEMENTS

December 31, 2008 and 2007

(With Independent Auditors' Report Thereon)

AARP

Consolidated Financial Statements

December 31, 2008 and 2007

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KPMG LLP
2001 M Street, NW
Washington, DC 20036

Independent Auditors' Report

The Board of Directors
AARP, Inc.:

We have audited the accompanying consolidated statements of financial position of AARP, Inc. and affiliates (collectively, AARP) as of December 31, 2008 and 2007, and the related consolidated statements of activities and cash flows for the years then ended. These consolidated financial statements are the responsibility of AARP management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of AARP's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of AARP as of December 31, 2008 and 2007, and the changes in its net assets and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

As discussed in note 2 to the consolidated financial statements, AARP adopted Financial Accounting Standards Board Statement No. 157, *Fair Value Measurements*, in 2008.

KPMG LLP

March 30, 2009

AARP

Consolidated Statements of Financial Position

December 31, 2008 and 2007

(In thousands)

	2008	2007
Assets:		
Cash and cash equivalents (note 2(c))	$ 472,006	325,154
Accounts receivable, net (note 5)	70,419	79,122
Prepaid expenses and other assets (note 8)	26,013	34,805
Prepaid pension asset (note 10)	—	4,789
Investments (note 4)	916,146	1,087,082
Property and equipment, net (note 6)	315,166	304,778
Total assets	$ 1,799,750	1,835,730
Liabilities:		
Accounts payable and accrued expenses	$ 100,030	143,680
Insurance premiums payable (note 3)	711,242	662,974
Deferred revenue and other liabilities	31,701	25,057
Deferred membership dues	435,597	388,280
Accrued pension liability (note 10)	113,764	—
Accrued postretirement health benefits (note 11)	69,823	67,808
Notes payable (note 7)	230,069	230,053
Total liabilities	1,692,226	1,517,852
Net assets:		
Unrestricted:		
Undesignated	17,186	101,481
Board designated (note 14)	81,348	205,461
Total unrestricted net assets	98,534	306,942
Temporarily restricted (note 15)	8,990	10,936
Total net assets	107,524	317,878
Total liabilities and net assets	$ 1,799,750	1,835,730

See accompanying notes to consolidated financial statements.

AARP

Consolidated Statement of Activities

Year ended December 31, 2008

(In thousands)

	Unrestricted	Temporarily restricted	Total
Operating revenues:			
Membership dues	$ 249,314	—	249,314
Royalties (note 3)	652,701	—	652,701
Publications advertising	119,696	—	119,696
Grant revenue (note 9)	89,649	—	89,649
Program income	82,114	—	82,114
Contributions	41,113	879	41,992
Other operating income	19,683	—	19,683
Net assets released from restrictions	2,825	(2,825)	—
Operating revenue before investment loss	1,257,095	(1,946)	1,255,149
Investment loss (notes 3 and 4)	(175,063)	—	(175,063)
Total operating revenues	1,082,032	(1,946)	1,080,086
Operating expenses:			
Program services:			
Programs and field services	298,310	—	298,310
Publications	177,638	—	177,638
Member services	284,086	—	284,086
Legislation and research	58,844	—	58,844
Total program services	818,878	—	818,878
Supporting services:			
Membership development	114,096	—	114,096
Management and general	204,879	—	204,879
Total supporting services	318,975	—	318,975
Total operating expenses	1,137,853	—	1,137,853
Change in net assets from operations	(55,821)	(1,946)	(57,767)
Other income (expenses):			
Investment loss from sinking fund (notes 4 and 7)	(22,513)	—	(22,513)
Income taxes (note 8)	(17,427)	—	(17,427)
Charges other than net periodic benefit cost (notes 10 and 11)	(106,239)	—	(106,239)
Change in net assets before effect of adoption of measurement provisions of FASB Statement No. 158	(202,000)	(1,946)	(203,946)
Effect of adoption of measurement provisions of FASB Statement No. 158 (note 2)	(6,408)	—	(6,408)
Change in net assets	(208,408)	(1,946)	(210,354)
Net assets, beginning of year	306,942	10,936	317,878
Net assets, end of year	$ 98,534	8,990	107,524

See accompanying notes to consolidated financial statements.

AARP

Consolidated Statement of Activities

Year ended December 31, 2007

(In thousands)

	Unrestricted	Temporarily restricted	Total
Operating revenues:			
Membership dues	$ 249,353	—	249,353
Royalties (note 3)	497,635	—	497,635
Publications advertising	121,518	—	121,518
Grant revenue (note 9)	82,431	—	82,431
Program income	90,850	—	90,850
Contributions	42,353	6,878	49,231
Other operating income	2,938	—	2,938
Net assets released from restrictions	888	(888)	—
Operating revenue before investment income	1,087,966	5,990	1,093,956
Investment income (notes 3 and 4)	79,951	—	79,951
Total operating revenues	1,167,917	5,990	1,173,907
Operating expenses:			
Program services:			
Programs and field services	302,518	—	302,518
Publications	184,572	—	184,572
Member services	294,631	—	294,631
Legislation and research	60,581	—	60,581
Total program services	842,302	—	842,302
Supporting services:			
Membership development	112,960	—	112,960
Management and general	204,079	—	204,079
Total supporting services	317,039	—	317,039
Total operating expenses	1,159,341	—	1,159,341
Change in net assets from operations	8,576	5,990	14,566
Other income (expenses):			
Investment income from sinking fund (notes 4 and 7)	4,479	—	4,479
Income taxes (note 8)	(8,902)	—	(8,902)
Change in net assets before effect of adoption of recognition provisions of FASB Statement No. 158	4,153	5,990	10,143
Effect of adoption of recognition provisions of FASB Statement No. 158 (note 2)	(580)	—	(580)
Change in net assets	3,573	5,990	9,563
Net assets, beginning of year	303,369	4,946	308,315
Net assets, end of year	$ 306,942	10,936	317,878

See accompanying notes to consolidated financial statements.

AARP

Consolidated Statements of Cash Flows

Years ended December 31, 2008 and 2007

(In thousands)

	2008	2007
Cash flows from operating activities:		
Change in net assets	$ (210,354)	9,563
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	27,606	24,846
Reserve for uncollectible accounts	248	(22)
Effect of adoption of FASB Statement No.158	6,408	580
Charges other than net periodic benefit cost	106,239	—
Net loss (gain) on investments	258,420	(19,554)
Deferred income taxes	1,447	(327)
Amortization of premium on investments	18	120
Changes in operating assets and liabilities:		
Cash and cash equivalents held as collateral	—	41,506
Accounts receivable	8,455	(24,173)
Prepaid expenses and other assets	7,345	1,325
Prepaid pension asset	4,789	4,570
Accounts payable and accrued expenses	(43,650)	2,139
Insurance premiums payable	48,268	50,331
Securities loan payable	—	(41,506)
Deferred revenue and other liabilities	6,644	2,484
Deferred membership dues	47,317	29,629
Accrued pension liability	(1,408)	—
Accrued postretirement health benefits	4,540	5,336
Total adjustments	482,686	77,284
Net cash provided by operating activities	272,332	86,847
Cash flows from investing activities:		
Purchases of property and equipment	(37,978)	(31,350)
Proceeds from sale and maturities of investments	995,414	1,304,705
Purchases of investments	(1,082,916)	(1,358,527)
Investment in joint venture	—	(33)
Net cash used in investing activities	(125,480)	(85,205)
Net increase in cash and cash equivalents	146,852	1,642
Cash and cash equivalents, beginning of year	325,154	323,512
Cash and cash equivalents, end of year	$ 472,006	325,154
Supplemental disclosures:		
Cash paid for interest	$ 12,979	14,623
Cash paid for income taxes	17,928	6,646

See accompanying notes to consolidated financial statements.

(1) Description of Organizations and Activities

(a) AARP, Inc.

AARP, Inc. was organized in 1958 as a District of Columbia not-for-profit corporation for the purpose of promoting the interests of older persons. AARP, Inc. is qualified as a tax-exempt social welfare organization under Section 501(c)(4) of the Internal Revenue Code (IRC). The mission of AARP, Inc. is to meet the needs and promote the independence, dignity, and purpose of persons 50 and older. The programs and activities of AARP, Inc. and its affiliates include education, advocacy, research, service programs, other social welfare activities, and charitable programs serving the needs of older persons.

AARP, Inc.'s programs, activities and operations are managed and supported primarily from its National Headquarters in Washington, D.C. AARP, Inc. and its affiliates also have offices in all fifty U.S. states, Washington, D. C., Puerto Rico, and the U. S. Virgin Islands, as well as a membership processing center located in Lakewood, California, and an advertising sales office in New York City.

(b) AARP Services, Inc. and AARP Financial, Inc.

AARP Services, Inc. (AARP Services) is a wholly owned taxable subsidiary of AARP, Inc., and was incorporated in Delaware in 1998. AARP, Inc. contracts with AARP Services to provide quality control of AARP intellectual property and other services relating to AARP, Inc. branded products and services available to AARP, Inc. members as part of their membership benefits.

AARP Services receives fees from AARP, Inc. for specific services including new product development, membership development, quality control services, and AARP Webplace design and maintenance. At the direction of AARP, Inc., AARP Services also receives a service provider relationship management fee, computed as a percentage of the royalty received by AARP, Inc.

AARP Financial, Inc. (AARP Financial) was incorporated in Delaware in September 2005, as a wholly owned taxable subsidiary of AARP Services. AARP Financial was formed to design, develop and manage AARP, Inc. branded financial services and related products. AARP Financial is also a Securities and Exchange Commission (SEC) registered investment adviser to the AARP family of mutual funds.

(c) AARP Insurance Plan

The AARP Insurance Plan (the Plan) is a grantor trust established by an Agreement and Declaration of Trust for the purpose of making group health insurance and other health-related products and services available to AARP, Inc. members. Insurance premiums collected by the Plan are paid directly by participants. At the direction of the third party insurance carriers, certain agreed upon deductions from the premiums are made for royalties payable to AARP, Inc. The Plan is administered by a board of trustees appointed by the Board of Directors of AARP, Inc. For the years ended December 31, 2008 and 2007, the Plan processed $6.3 billion and $5.9 billion, respectively, of premium payments from member participants.

 (Continued)

(d) AARP Foundation and AARP Institute

The AARP Foundation was organized in 1961 as a District of Columbia not-for-profit corporation. The goals of the AARP Foundation are to lead positive social change, enhance the quality of life for all and deliver value to those 50 and older with emphasis on those at social and economic risk. The AARP Foundation, an AARP affiliate, is a qualified nonprofit organization under Section 501(c)(3) of the IRC and is therefore exempt from federal income taxes on its charitable operations. In addition, the AARP Foundation is a public charity as defined in Section 509(a)(1) of the IRC. The AARP Foundation receives funding principally from the federal government, AARP, Inc., foundations, corporations and individuals. The AARP Foundation's Board of Directors is composed of members appointed by AARP, Inc.'s Board of Directors.

The AARP Institute (the Institute), a wholly owned subsidiary of the AARP Foundation, was organized in 1963 as a District of Columbia not-for-profit corporation. The Institute qualifies as a tax-exempt organization under Section 501(c)(3) of the IRC. The AARP Foundation and the Institute are collectively referred to as the Foundation.

(e) Legal Counsel for the Elderly

Legal Counsel for the Elderly (LCE) was incorporated in the District of Columbia in 1980 for the purpose of providing free legal assistance and education to the elderly, primarily in the District of Columbia. LCE publishes manuals, conducts seminars on issues affecting the elderly, and operates legal services and long-term care ombudsman programs. LCE qualifies as a tax-exempt charitable organization under Section 501(c)(3) of the IRC. Funding for LCE is obtained primarily through contributions from AARP, Inc., foundations, corporations and individuals. LCE's Board of Directors is comprised of seven members appointed by AARP, Inc.'s Chief Executive Officer.

(f) Other Affiliates

AARP Global Network is a limited liability company (LLC) formed to promote and deliver social change through a joint international commitment to assure that people 50 and older are better able to live fulfilling lives with dignity and purpose. AARP Andrus Insurance Fund LLC, a single-member LLC with AARP, Inc. as its sole member, was formed in 2007 to serve as a self-funding mechanism for the deductible portion of certain AARP, Inc. insurance coverages with third party insurance carriers. Various special purpose taxable affiliated entities own and operate the AARP headquarters building located in Washington, D.C., the related parking garage facilities and buildings in California. These properties are primarily occupied by AARP, Inc. and its affiliates.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

These consolidated financial statements are prepared on the accrual basis of accounting and include the accounts of the entities listed in note 1, collectively referred to as AARP.

(Continued)

All significant intercompany transactions have been eliminated in consolidation. The consolidated financial statements do not include the operations and accounts of over 2,500 local chapters of AARP that are organized and operated as separate entities. AARP neither controls nor derives beneficial economic interest from these organizations, as defined by U.S. generally accepted accounting principles.

AARP summarizes the costs of providing and managing its various programs and supporting activities on a functional basis in the accompanying consolidated statements of activities. Accordingly, certain operating costs are allocated among the benefiting program and supporting services based on specific identification or reasonable allocation methodologies.

Net assets and changes in net assets are classified based on the existence or absence of donor-imposed restrictions. Accordingly, net assets are classified and reported as follows:

Unrestricted – net assets that are not subject to donor-imposed stipulations including amounts designated by the Board of Directors for specific purposes.

Temporarily restricted – net assets subject to donor-imposed stipulations that will be met by actions of AARP and/or the passage of time.

(b) Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect reported amounts and disclosures in the financial statements. Although actual results could differ from these estimates, management does not believe that such differences will be material.

(c) Cash Equivalents

Investments with original maturities of three months or less are reported as cash equivalents. As of December 31, 2008 and 2007, $284,000,000 and $183,000,000, respectively, were held by the AARP Insurance Plan for the payment of member insurance premiums.

(d) Accounts Receivable

AARP estimates uncollectible accounts based on the aging of outstanding accounts receivable and management's estimate of their net realizable values.

(e) Investments

Investments in debt securities, institutional mutual funds, equity securities and derivative financial instruments are measured and reported at fair value. The fair value of debt securities, institutional mutual funds, and equity securities with a readily determinable fair value is based on quotations obtained from national security exchanges.

Debt securities, institutional mutual funds, equity securities and derivative financial instruments with fair values that are not readily determinable are carried at estimated fair values as provided by the investment managers. AARP management reviews and evaluates the values provided by the investment managers and agrees with the valuation methods and assumptions used in determining their estimated fair value. Due to the inherent uncertainties of these estimates, these values may differ from the values that would have been reported had a ready market for such investments existed. In 2008 and 2007, the estimated fair values represented approximately 63% and 71%, respectively, of total investments. Changes in fair value are reported as investment income (loss) in the accompanying consolidated statements of activities.

All investment securities are exposed to various risks such as interest rate, market, and credit risks. Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and such changes could materially affect the amounts reported in the consolidated statements of financial position.

(f) Property and Equipment

Property and equipment are stated at cost. Computer software is composed of external and certain qualifying internal costs related to software development. Management periodically evaluates whether events or circumstances have occurred indicating that the carrying amount of long-lived assets may not be recovered. If the sum of the undiscounted expected future cash flows is less than the carrying amount of an asset, AARP recognizes an impairment loss based on the amount by which the carrying amount of the asset exceeds the fair value of the asset. Depreciation and amortization are calculated using the straight-line method over the lesser of the estimated useful lives of the assets or the lease term. The useful lives range from three to 30 years. Maintenance and repair costs are expensed as incurred.

(g) Membership Dues

Membership dues are deferred upon receipt and recognized as revenue ratably over the membership term of one, two, three or five years.

(h) Royalties

Royalties are received from AARP branded third party providers of member benefit programs, in return for the rights to use AARP's intellectual property (including name, logo and mailing list) in offering programs. These royalties are recognized as revenue as earned.

During 2008 and 2007, the service provider United Healthcare Corporation accounted for 63% and 57%, respectively, of total royalties earned.

(i) Publications Advertising

AARP sells advertising space in its major publications, which are provided to members without additional charge as part of their membership benefits. Advertising revenue is recognized as earned in the month of each publication's issue date.

(j) Grant Revenues

The Foundation and LCE report activities under grant agreements as exchange transactions. Accordingly, grant-related revenue is recognized to the extent that allowable expenses are incurred under program agreements. Amounts reported as grants receivable represent grant program expenses incurred in advance of the receipt of funds. Funds received in advance of incurred grant program expenses are reported as deferred revenue. Federal funds are only received by the Foundation and LCE.

The Foundation and LCE receive a majority of their revenue from government grants, which are subject to audit by various federal and state agencies. The ultimate determination of amounts received under these grants generally is based upon allowable costs reported to and audited by the governments or their designees. The liabilities, if any, arising from such compliance audits cannot be determined at this time. In the opinion of management, adjustments resulting from such audits, if any, will not have a significant effect on the financial position of the Foundation or LCE.

(k) Program Income

AARP receives service fees from providers of and participants in member programs, for consulting and specific program services. These fees are recognized as earned.

(l) Contributions and Fundraising Expense

AARP reports contributions as revenue when received or pledged by the donor. Contributions are reported as temporarily restricted revenue if such gifts are restricted by the donor to a specific program or include an explicit or implied time restriction.

Expirations of temporary restrictions on net assets (i.e. the donor-stipulated purpose has been fulfilled and/or the stipulated time period has elapsed) are reported as net assets released from restrictions. Gifts whose donor-stipulated purposes are met in the same year as received are reported as unrestricted revenue.

Contributions include cash received in support of both charitable and advocacy program activities. Charitable contributions are only received by the Foundation and LCE, while advocacy contributions are only received by AARP, Inc. Contributions also include in-kind contributed professional services totaling $14,920,000 and $14,283,000 for the years ended December 31, 2008 and 2007, respectively.

Fundraising expenses, which are reported as part of management and general expenses, were $25,972,000 and $27,448,000 for the years ended December 31, 2008 and 2007, respectively.

(m) Volunteer Services

AARP and its members benefit from the efforts of many volunteers. These in-kind contributions by volunteers are not recorded as revenue in the consolidated financial statements because they do not meet the requirements for recognition under U. S. generally accepted accounting principles.

(Continued)

(n) Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to the differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carry-forwards. Deferred tax assets and liabilities are measured using enacted rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in other income (expenses) in the period that includes the enactment date.

AARP adopted the provisions of Financial Accounting Standards Boards (FASB) Interpretation No. 48, *Accounting for the Uncertainty in Income Taxes* (FIN 48) on January 1, 2007. FIN 48 prescribes a threshold of more-likely-than-not for recognition and derecognition of tax positions taken or expected to be taken in a tax return. The implementation of FIN 48 had no impact on AARP's consolidated financial statements. AARP does not believe that there are any unrecognized tax benefits/liabilities that should be recorded.

(o) Financial Instruments

At December 31, 2008 and 2007, the carrying value of financial instruments such as cash equivalents, accounts receivable, accounts payable and variable rate debt approximated their fair value, based on the short-term maturities or floating interest rates of these instruments. The fair values of investments, notes payable and fixed rate debt (with related swap agreements) are discussed in notes 4 and 7, respectively.

(p) Measure of Operating Results

AARP reports as operating all activities except for any required provision for federal and state income taxes, investment income earned on debt sinking funds and pension and post-retirement related charges other than net periodic benefit cost. Additionally, the effect of the adoption of FASB Statement No. 158, *Employers' Accounting for Defined Benefit Pension and Other Post Retirement Plans,* is excluded from operating results.

(q) Advertising Expenses

AARP expenses advertising costs as incurred except to the extent of any direct response marketing costs that qualify for capitalization. These costs include brand awareness, member acquisition and retention, member program marketing, and advocacy advertising. For the years ended December 31, 2008 and 2007, advertising expense was $156,867,000 and $157,674,000, respectively, and no costs were capitalized.

(r) New Accounting Standards

Benefit Plans

In 2006, the FASB issued Statement No. 158 providing new accounting requirements for pension plans and other post-retirement benefits (see notes 10 and 11). The statement requires an employer to recognize in its statement of financial position the overfunded or underfunded status of its benefit

(Continued)

plans. The recognition of an asset or liability related to the funded status position is effective for fiscal years ending after June 15, 2007. AARP adopted the recognition of the funded status provisions at December 31, 2007. The effect of adoption of Statement No. 158's recognition provisions was a decrease in net assets of $580,000 in 2007.

The following table reflects the incremental effect of applying Statement No. 158 as of December 31, 2007:

	Before adoption	Adjustments		After adoption
		Pension	Postretirement	
		(In thousands)		
Prepaid pension asset	$ 21,735	(16,946)	—	4,789
Total assets	1,852,676	(16,946)	—	1,835,730
Accrued postretirement benefit	84,174	—	(16,366)	67,808
Total liabilities	1,534,218	—	(16,366)	1,517,852
Total net assets	318,458	(16,946)	(16,366)	285,146

In 2008, AARP changed its measurement date for plan assets and plan liabilities from September 30 to December 31 to comply with the measurement date provisions of Statement No. 158. This change in measurement date resulted in a decrease in net assets of $6,408,000 in 2008.

The following table reflects the incremental effect of applying the change in measurement date under Statement No. 158 as of December 31, 2008 (in thousands):

	Before adoption	Adjustments		After adoption
		Pension	Postretirement	
		(In thousands)		
Accrued pension liability	$ 108,919	4,845	—	113,764
Accrued postretirement benefit	68,260	—	1,563	69,823
Total liabilities	1,685,818	4,845	1,563	1,692,226
Total net assets	113,932	(4,845)	(1,563)	107,524

(Continued)

Fair Value Measurements

In September 2006, the FASB issued Statement No. 157, *Fair Value Measurements*. Statement No. 157 defined fair value, established a framework for measuring fair value, and enhances the disclosures about fair value measurements. This statement does not require any new fair value measures. Statement No. 157 defines fair value as the exchange price that would be received on the measurement date to sell an asset or the price paid to transfer a liability in the principal or most advantageous market available to the entity in an orderly transaction between market participants. Statement No. 157 also establishes a three level fair value hierarchy that describes the inputs that are used to measure assets. The three levels of the hierarchy are as follows:

Level 1 – Unadjusted quoted market prices for identical assets or liabilities in active markets.

Level 2 – Other observable inputs, either directly or indirectly, including:

- Quoted prices for similar assets/liabilities in active markets;
- Quoted prices for identical or similar assets in nonactive markets;
- Inputs other than quoted prices that are observable for the asset/liability; and
- Inputs that are derived principally from or corroborated by other observable market data.

Level 3 – Unobservable inputs that cannot be corroborated by observable market data.

AARP uses quoted values and other data provided by a nationally recognized independent pricing service (pricing service) as inputs into its process for determining fair value of its investments. The pricing service obtains market quotations and actual transaction prices for securities that have quoted prices in active markets. For securities that do not trade on a daily basis, the pricing service prepares estimates of fair value measurements for these securities based upon its proprietary pricing applications which include available relevant market information, benchmark curves, benchmarking of like securities, sector groupings and matrix pricing.

Securities with fixed maturities (debt securities) other than U.S. Treasury securities generally do not trade on a daily basis. The fair value estimates of such fixed maturity investments are based on observable market information rather than market quotes. Accordingly, the estimates of fair value for such fixed maturity investments as provided by the pricing service are included in the debt securities amount disclosed in Level 2 of the hierarchy. The estimated values of U.S. Treasury securities are included in the debt securities amount disclosed in Level 1 as the estimates are based on unadjusted market prices.

AARP's equity securities trade on a major exchange. Accordingly, such equity securities are disclosed in Level 1.

AARP invests in several institutional mutual funds. These funds are not available to retail investors. These funds do not usually have daily purchases and redemptions. The fair value estimates of such institutional mutual funds are based on observable market information rather than market quotes. Accordingly, the estimates of fair value for such funds as provided by the pricing service are included in the amount disclosed in Level 2.

(Continued)

AARP has two interest rate swaps (swaps) covering the variable notes payable. These swaps are not traded on a daily basis, and are included in accounts payable and accrued expenses in the consolidated statements of financial position. The fair value of such swaps is based on observable market information rather than any market quotes. Accordingly, the estimates of fair value for such swaps as provided by an outside valuation firm are included in the amounts disclosed in Level 2.

AARP does not currently hold any Level 3 financial instruments.

The following is a summary of the fair value measurements of AARP's assets and liabilities within the fair value hierarchy as of December 31, 2008:

	December 31, 2008	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)
		(In thousands)	
Assets:			
Equity securities	$ 91,083	91,083	—
Debt securities	244,791	32,331	212,460
Institutional mutual funds	580,272	—	580,272
	$ 916,146	123,414	792,732
Liabilities:			
Swaps	$ 979	—	979

The fair value of other financial instruments, principally cash and cash equivalents, accounts receivable and accounts payable approximates their carrying value at December 31, 2008 and 2007 because of the short maturity of these items.

In February 2008, the FASB issued FASB Staff Position (FSP) FAS 157-2, *Effective Date of FASB Statement No. 157*. FSP FAS 157-2 delayed, for one year, the effective date of Statement No. 157 for all nonfinancial assets and liabilities, except those recognized or disclosed in the financial statements on at least an annual basis. Consequently, Statement No. 157 will be effective for nonfinancial assets and liabilities for 2009.

In February 2007, the FASB issued Statement No. 159, *Fair Value Option for Financial Assets and Financial Liabilities*. Statement No. 159 permits entities to measure many financial instruments and certain other items at fair value. Under this statement an entity is permitted to measure eligible items at fair value at specified election dates. This statement, which does not require any new fair value measures, is effective for fiscal years beginning after November 15, 2007. Management has chosen not to elect the fair value option for eligible assets and liabilities.

(Continued)

(s) Reclassifications

Certain reclassifications have been made to the 2007 reported amounts to conform to the 2008 presentation.

(3) Member Insurance Program

AARP makes certain types of insurance available to its members through third party insurance carriers. Agreements between AARP, Inc., AARP Services, United HealthCare Corporation (United), Metropolitan Life Insurance Company (MetLife), Genworth Life Insurance Company (Genworth), and Aetna Life Insurance Company (Aetna) make certain types of insurance available to AARP members.

The Plan, a grantor trust, collects insurance premiums from participating members and is required to remit such payments to third party insurance carriers within a contractually specified period of time. These transactions are classified as agency transactions and, as such, are not recorded as either revenue or expenses on the accompanying consolidated statements of activities.

The premiums are collected from insured members and are subsequently remitted to the third party insurance carriers, and are invested and recorded with an offsetting liability "Insurance Premiums Payable." For the years ended December 31, 2008 and 2007, the Plan experienced a net investment loss of $69,274,000 and earned net investment income of $40,422,000, respectively, which is included in investment income (loss) in the accompanying consolidated statements of activities.

At the direction of the third party insurance carriers, the Plan pays AARP, Inc. a portion of the total premiums collected for the use of its intellectual property, which is reported as royalties in the consolidated statements of activities. AARP derived 47% and 58% of total royalties from the Plan for the years ended December 31, 2008 and 2007, respectively.

At December 31, 2008 and 2007, insurance premiums payable were comprised of the following:

	2008	2007
	(In thousands)	
Premiums payable to the insurance carriers	$ 514,186	485,546
Payments received in advance	180,128	162,066
Partial and unprocessed payments	16,928	15,362
Total insurance premiums payable	$ 711,242	662,974

(Continued)

(4) Investments

AARP's investments by type of security were as follows at December 31, 2008 and 2007:

	2008	2007
	(In thousands)	
U.S. government and agency obligations	$ 21,787	34,389
Mortgage-backed securities	134,593	164,487
Fixed income securities	88,411	87,270
Equity securities	91,083	90,999
Institutional mutual funds:		
Various equity index funds	219,049	300,489
Short term bond fund	10,610	17,174
U.S. bond market funds	17,556	16,641
U.S. government portfolio	52,564	60,700
Mortgage portfolio	159,190	183,885
Municipal portfolio	6,354	3,648
Real return bond fund	3,148	2,121
Private emerging markets bond fund	14,549	34,949
International bond portfolio	25,309	47,784
High yield bond portfolio	20,595	31,195
Investment grade corporate bond portfolio	46,007	25,659
Asset backed fund	5,341	7,251
Book value wrapper contract	—	(21,559)
Total investments	$ 916,146	1,087,082

Investment (loss) income for the years ended December 31, 2008 and 2007 was as follows:

	2008	2007
	(In thousands)	
Interest and dividend income	$ 60,844	64,876
Net (loss) gain	(258,420)	19,554
Total	$ (197,576)	84,430

Investment (loss) income as reported on the consolidated statements of activities was as follows:

	2008	2007
	(In thousands)	
Investment (loss) income – operations	$ (175,063)	79,951
Investment (loss) income – Sinking Fund	(22,513)	4,479
Total	$ (197,576)	84,430

(Continued)

As of December 31, 2008 and 2007, $431,000,000 and $484,000,000 of consolidated investments, respectively, is held by the AARP Insurance Plan for the payment of member insurance premiums.

(a) Book Value Wrapper Contract

The synthetic Book Value Wrapper Contract (BV Wrapper) with AIG Financial Products Corporation and AEGON Institutional Markets was entered into to provide a higher degree of predictability for overall investment returns and to reduce the short-term impact of significant fluctuations in the financial markets.

The BV Wrapper has two components – a portfolio of investment securities and a third-party book value "put" feature. The agreement establishes, on a quarterly basis, a specific guaranteed return based on the nature of the underlying portfolio, historical gains and losses of the portfolio, and certain other factors. AARP retains legal title to the underlying investment portfolio and controls investment related risks by setting investment guidelines. In early 2008, management decided to terminate the BV Wrapper for strategic reasons. As of December 31, 2008 and 2007, the market value of the investment portfolio underlying the BV Wrapper was $0 and $314,443,000, respectively, and the value of the BV Wrapper as a whole was $0 and $292,884,000, respectively. The market value of the investment portfolio as determined by AARP's investment managers, and the market value of the BV Wrapper as determined by AIG and AEGON, have been netted to determine the reported value of the total position. The associated gain (loss) amounted to $21,559,000 and $(3,194,000) for the years ended December 31, 2008 and 2007, respectively, and is included as a component of investment income (loss) in the accompanying consolidated statements of activities.

(b) Futures Contracts

The cash position on futures contracts settles daily for changes in their fair value. Realized and unrealized gains and losses based on changes in market values of open futures contracts were fully recognized in the accompanying consolidated statements of activities for the years ended December 31, 2008 and 2007. AARP had no direct exposure to futures contracts at December 31, 2008 and 2007, although they were used in several commingled funds.

(Continued)

(5) Accounts Receivable

Accounts receivable as of December 31 were as follows:

	2008	2007
	(In thousands)	
Royalties	$ 37,442	43,312
Program fees	4,931	5,198
Publication advertising	10,434	8,124
Interest and dividends	2,070	2,186
Grants	7,488	8,881
Other	8,505	11,624
Gross accounts receivable	70,870	79,325
Allowance for doubtful accounts	(451)	(203)
Accounts receivable, net	$ 70,419	79,122

(6) Property and Equipment

Property and equipment as of December 31 were as follows:

	2008	2007
	(In thousands)	
Land	$ 55,110	55,110
Buildings and improvements	249,899	239,957
Furniture and equipment	101,927	96,526
Computer software	74,275	59,596
Leasehold improvements	6,775	4,622
Less accumulated depreciation and amortization	(172,820)	(151,033)
Property and equipment, net	$ 315,166	304,778

(Continued)

(7) **Notes Payable**

The carrying amounts of notes payable and other long-term debt as of December 31 were as follows:

	2008	2007
	(In thousands)	
Fixed rate notes, maturing May 2031, net of discount of $931 in 2008 and $947 in 2007	$ 124,069	124,053
Variable rate notes, maturing May 2031	50,000	50,000
District of Columbia Variable Rate Revenue Bonds, maturing October 2034	25,000	25,000
Revolving credit facility, maturing November 2009	15,000	15,000
Revolving credit facility, maturing November 2009	16,000	16,000
Total notes payable	$ 230,069	230,053

The maturity dates of notes payable were as follows (in thousands):

2009	$ 31,000
2031	175,000
2034	25,000
	$ 231,000

Total interest expense incurred for the years ended December 31, 2008 and 2007 was $13,146,000 and $14,983,000, respectively.

(a) Fixed Rate Notes

On May 1, 2001, AARP, Inc. issued unsecured fixed rate notes in the aggregate amount of $125,000,000 for permanent financing of the AARP Headquarters Building and bearing interest at 7.5%. Interest is payable monthly. Based on the borrowing rates currently available to AARP for fixed rate bonds with similar terms and average maturities, the fair value of the $125,000,000 fixed rate debentures is approximately $117,125,000 and $151,973,000 as of December 31, 2008 and 2007, respectively.

(b) Variable Rate Notes

On May 1, 2001, AARP, Inc. issued unsecured variable rate notes in the amount of $75,000,000, for permanent financing of the AARP Headquarters Building. The variable rates were effectively changed to approximately 5.40% fixed annual rates by AARP entering into two interest rate swap agreements with JP Morgan and Bank of America. Interest is payable monthly. On December 1, 2004, AARP made debt repayments of $25,000,000 on the unsecured variable notes.

(Continued)

(c) District of Columbia Variable Rate Revenue Bonds

On October 21, 2004, the Foundation issued 30 year District of Columbia Variable Rate Revenue Bonds Series 2004 in the amount of $25,000,000 to finance the purchase of two condominium units located within the AARP Headquarters Building. The bonds bear interest at a variable rate determined by the Remarketing Agent, based upon market conditions of reselling the bonds in a secondary market sale. Accrued interest is payable monthly. The Foundation may elect at any time to convert to a fixed interest rate. As of December 31, 2008 and 2007, the notes had an interest rate of 1.20% and 3.48%, respectively.

The Foundation has obtained a letter of credit to secure repayment of the bond financing of its office space. The letter of credit constitutes an irrevocable obligation to pay the bond trustee up to an amount equal to the sum of the principal amount of the Series 2004 Bonds outstanding, plus an amount equal to interest for 35 days on the principal amount of each bond outstanding.

(d) Revolving Credit Facility

On January 3, 2005, AARP, Inc. obtained an unsecured revolving credit facility with a maximum principal amount of $15,000,000 from a commercial bank. The credit facility bears interest at a floating LIBOR rate plus 16 basis points. As of December 31, 2008 and 2007, the credit facility had an interest rate of 0.62% and 5.03%, respectively. Interest on the credit facility is payable quarterly, and the credit facility expires November 29, 2009.

On December 5, 2006, AARP, Inc. obtained an unsecured revolving credit facility with a maximum principal amount of $16,000,000 from a commercial bank. The credit facility bears interest at a floating LIBOR rate plus 50 basis points. As of December 31, 2008 and 2007, the credit facility had an interest rate of 0.96% and 5.03%, respectively. Interest on the credit facility is payable quarterly and the credit facility expires November 29, 2009.

(e) Swap Agreements

AARP Inc. has two interest rate swap agreements (swaps), each covering $25,000,000 of the variable rate notes, which were executed to manage the variability of the interest expense associated with the floating rate debt. Under the swap agreements, AARP pays fixed annual rates of approximately 5.40% and receives an amount based on the notional amount of each swap at an interest rate equal to LIBOR. The terms of the swaps provide for net receipt or payment on the first of each month. The swaps are reported at their fair value on the accompanying consolidated statements of financial position.

The net interest accrual, which is the difference between the monthly fixed payment on the swap and the variable receipt from the swap counter-party, is recorded as interest expense together with the interest expense on the fixed rate and other variable rate debt in the accompanying consolidated statements of activities. For the years ended December 31, 2008 and 2007, AARP recorded a loss on the change in fair value of the swaps of $979,000 and $541,000, respectively, within management and general expenses on the accompanying consolidated statements of activities.

(Continued)

(f) Board Designated Sinking Fund

In 2001, the AARP Board of Directors authorized the creation and funding of a Sinking Fund for the purpose of repayment of outstanding notes and bonds payable. The designated minimum funding is $3,600,000 per year, to be transferred on or about January 1 of each year. The balance in the Sinking Fund as of December 31, 2008 and 2007 was $50,348,000 and $69,260,000, respectively, and the Sinking Fund assets were included in investments in the accompanying consolidated statements of financial position. The net investment loss on the Sinking Fund investments for the year ended December 31, 2008 was $22,513,000 and the net investment income on the Sinking Fund investments for the year ended December 31, 2007 was $4,479,000.

(8) Income Taxes

The significant components of the provision for income taxes were as follows for the years ended December 31, 2008 and 2007:

	2008	2007
	(In thousands)	
Current:		
Federal income tax	$ 12,293	6,986
State income tax	3,674	2,243
Current income tax expense	15,967	9,229
Deferred:		
Federal income tax	1,074	(208)
State income tax	386	(119)
Deferred income tax benefit	1,460	(327)
Total income tax expense	$ 17,427	8,902

(Continued)

The significant components of the deferred tax asset, which were included in prepaid expenses and other assets at December 31, 2008 and 2007, were as follows:

	2008	2007
	(In thousands)	
Deferred income tax assets:		
Employee benefits	$ 1,492	2,744
Accrued expenses	2,214	2,356
Depreciation	(47)	70
Bad debt allowance	99	2
Partnership income	—	35
Total deferred income tax assets	3,758	5,207
Deferred income tax liability:		
Property tax expense	(21)	(23)
Total deferred income tax liability	(21)	(23)
Net deferred income tax asset	$ 3,737	5,184

Income taxes paid by AARP, Inc., Financial Services Corp., and AARP Services during 2008 and 2007 totaled $17,928,269 and $6,645,506, respectively, and consisted entirely of estimated federal and state income tax payments.

(9) **Grant Revenue**

The Foundation and LCE administer grants received from federal agencies and private organizations. The two largest grant programs are described below.

(a) Senior Community Service Employment Program (SCSEP)

SCSEP provides subsidized assignments and job training for persons 55 and older whose income is at or below 125% of the federal poverty level. The SCSEP project is primarily funded by the U.S. Department of Labor totaling approximately $79 million and $73 million for the years ended December 31, 2008 and 2007, respectively. The current commitment expires in June 2009.

(b) Tax Counseling for the Elderly (Tax-Aide)

Tax-Aide provides volunteer assistance for federal income tax preparation assistance to low and moderate income persons throughout the country, with special attention to those 60 and older. The Tax-Aide grant is primarily funded by AARP and the Internal Revenue Service totaling approximately $4 million and $3 million for the years ended December 31, 2008 and 2007, respectively. The current commitment expires in September 2009.

The continuation of all grant programs beyond expiration of the current agreements is subject to future commitment of funds by sponsoring agencies.

(Continued)

(10) Defined Benefit Pension Plan

Eligible employees of AARP participate in a noncontributory defined benefit pension plan called the AARP Employees' Pension Plan (the Plan). The Plan covers all employees meeting eligibility service requirements. AARP's funding policy is to contribute an amount equal to or greater than the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as actuarially determined, calculated on a level percentage of payroll costs basis, but not greater than the maximum tax deductible limit. Plan assets are invested in equity and fixed income securities managed by outside fund managers.

In 2008 and 2007, employer contributions to the Plan were $16,000,000 and $20,000,000, respectively. AARP was not required to make a contribution to the Plan in 2008. However, AARP plans to make a discretionary $16,000,000 contribution in 2009.

The net periodic pension expense for the years ended December 31, 2008 and 2007 was $19,380,000 and $20,570,000, respectively. The components of net periodic benefit cost for the years ended December 31, 2008 and 2007 were as follows:

	2008	2007
	(In thousands)	
Service cost	$ 17,500	16,812
Interest cost	22,133	19,726
Expected return on plan assets	(23,399)	(21,163)
Amortization of actuarial loss	2,870	4,892
Amortization of prior service cost	276	303
	$ 19,380	20,570

(Continued)

The following sets forth the funded status of the Plan and accrued pension liability and prepaid pension asset shown in the accompanying consolidated statements of financial position at December 31:

	2008	2007
	(In thousands)	
Change in benefit obligation:		
Benefit obligation at beginning of year	$ (337,657)	(315,488)
Service cost	(17,500)	(16,812)
Interest cost	(22,133)	(19,726)
Effect of eliminating early measurement date	(7,957)	—
Actuarial gain	17,872	7,131
Benefits paid	9,763	7,238
Benefit obligation at end of year	(357,612)	(337,657)
Change in plan assets:		
Fair value at beginning of year	338,446	291,669
Actual return on plan assets	(108,732)	38,015
Contribution to the plan	16,000	16,000
Effect of eliminating early measurement date	7,897	—
Benefits paid	(9,763)	(7,238)
Fair value at end of year	243,848	338,446
Funded status	(113,764)	789
Fourth quarter contribution	—	4,000
(Accrued pension liability) prepaid pension asset	$ (113,764)	4,789

The assumptions used to determine the benefit obligation in the actuarial valuations at the December 31, 2008 and September 30, 2007 measurement dates were as follows:

	2008	2007
Discount rate	6.15%	6.30%
Future salary increases	4.00	4.00

The assumptions used to determine net periodic benefit cost in the actuarial valuations at December 31, 2008 and September 30, 2007 measurement dates were as follows:

	2008	2007
Discount rate	6.30%	6.00%
Expected long-term rate of return on plan assets	8.00	8.00
Future salary increases	4.00	4.00

(Continued)

In order to determine an appropriate return on plan assets, AARP considers its current asset allocation along with historical and expected returns that can be achieved with the various asset types in the Plan. As of December 31, 2008, the returns on plan assets from 2004 to 2008 were as follows: 7.4%, 4.4%, 10.8%, 6.6% and (29.1)%, respectively. Management believes that the current asset allocation justifies an expected long-term rate of return on plan assets of 8%.

The weighted average asset allocation for plan assets was as follows at December 31:

	2008	2007
Asset categories:		
Equity securities	57%	67%
Debt securities	37	28
Alternatives	4	4
Cash equivalents	2	1
	100%	100%

The targeted allocation of the investment assets in the Plan is for equities to comprise 65% of the investment portfolio, debt securities to comprise 30%, and alternatives to comprise the remaining 5%. These targets are not intended to serve as a rigid constraint on the investment allocation. The following chart sets out the minimum and maximum positions for the various asset classes in the Plan:

	Minimum	Target	Maximum
Asset class:			
Equity securities	61%	65%	71%
Debt securities	24	30	32
Alternatives	—	5	7
Cash equivalents	—	—	7

AARP notes that at December 31, 2008, its asset allocation for the pension plan was outside of the targeted range shown above. The value of the pension assets suffered a significant decline in the fourth quarter of 2008. AARP opted not to rebalance its portfolio in the fourth quarter due to unprecedented volatility in the investment markets. AARP plans to rebalance its asset portfolio in 2009 in order to return to the targeted asset mix.

The following benefit payments, which reflect expected future service, are expected to be paid (in thousands):

2009	$ 10,171
2010	11,469
2011	12,920
2012	14,661
2013	16,580
Years 2014 – 2018	114,229

(Continued)

Amounts for 2008 not yet recognized as components of net periodic benefit cost under the provisions of Statement No. 158 (in thousands):

Net actuarial loss	$ 109,313
Prior service cost	1,014
Total	$ 110,327

Estimated amounts to be amortized into net periodic benefit cost in 2009 are $3,803,000 from actuarial loss and $212,000 from prior service cost.

(11) Postretirement Health Benefits

All employees of AARP and its affiliates may become eligible for continuing health care benefits after retirement if they meet minimum age and service requirements and are covered by an AARP employee health insurance plan at the date of retirement. Healthcare benefits are provided through the AARP Employees' Welfare Plan (the Welfare Plan).

The net postretirement health benefits expense for the Welfare Plan for the years ended December 31, 2008 and 2007 was $6,251,000 and $6,803,000, respectively. The components of net periodic benefit cost for the years ended December 31, 2008 and 2007 are as follows:

	2008	2007
	(In thousands)	
Service cost	$ 2,464	2,498
Interest cost	4,400	4,184
Amortization of actuarial gain	(830)	(467)
Amortization of prior service cost	217	588
	$ 6,251	6,803

(Continued)

The following sets forth the changes in benefit obligations, changes in plan assets, and the composition of accrued postretirement benefit cost shown in the accompanying consolidated statements of financial position at December 31:

	2008	2007
	(In thousands)	
Change in benefit obligation:		
Benefit obligation at beginning of year	$ (68,283)	(68,217)
Effect of eliminating early measurement date	(1,214)	—
Service cost	(2,464)	(2,498)
Interest cost	(4,400)	(4,184)
Actuarial (loss) gain	(3,721)	5,017
Participant contributions	(250)	(207)
Benefits paid	2,167	2,063
Plan amendments	8,549	—
Other	(207)	(257)
Benefit obligation at end of year	$ (69,823)	(68,283)
Change in plan assets:		
Fair value at beginning of year	$ —	—
Employer contribution	1,917	1,856
Plan participants' contributions	250	207
Benefits paid	(2,167)	(2,063)
Fair value at end of year	$ —	—
Funded status:		
Unfunded benefit obligation	$ (69,823)	(68,283)
Unrecognized prior service cost	—	—
Unrecognized actuarial gain	—	—
Fourth quarter contribution	—	475
Accrued postretirement benefit cost	$ (69,823)	(67,808)

As of December 31, 2008 and September 30, 2007, the weighted average discount rates used in the actuarial valuation were as follows:

	2008	2007
End of year benefit obligation	6.15%	6.30%
Net periodic benefit cost	6.30	6.00

For measurement purposes, the health care cost trend rate was 9% for 2008 (the rate was assumed to decrease gradually to 5.5% through 2012 and remain level thereafter).

(Continued)

The following benefit payments are expected to be paid (in thousands):

2009	$ 2,501
2010	2,695
2011	2,922
2012	3,158
2013	3,411
Years 2014 – 2018	20,664

Amounts at December 31, 2008 not yet recognized as components of net periodic benefit cost under the provisions of Statement No. 158 (in thousands):

Net actuarial loss	$ 3,630
Prior service credit	(7,718)
Total	$ (4,088)

Estimated amounts to be amortized into net periodic benefit cost in 2009 are $0 from actuarial loss and $764,000 from prior service credit.

The healthcare cost trend rate assumption has a significant impact on the postretirement benefit costs and obligations. The effect of a 1% change in the assumed healthcare cost trend rate at December 31, 2008, would have resulted in an $11,817,000 increase or a $9,568,000 decrease in the accumulated postretirement benefit obligation, and a $1,435,000 increase or a $1,131,000 decrease in the 2008 aggregate service and interest cost.

The effect of a 1% change in the assumed healthcare cost trend rate at December 31, 2007, would have resulted in an $11,722,000 increase or a $9,467,000 decrease in the accumulated postretirement benefit obligation, and a $1,501,000 increase or a $1,171,000 decrease in the 2007 aggregate service and interest cost.

(12) Employee Health Care Benefits

AARP operates under a "pay as you go" model for employee health benefits, with obligations being funded from general corporate assets. For the years ended December 31, 2008 and 2007, expenses for the AARP Welfare Plan for current health care benefits were $16,990,000 and $17,678,000, respectively. As of December 31, 2008 and 2007, AARP had a liability related to these benefits of $4,311,000 and $4,229,000, respectively, which was included in accounts payable and accrued expenses on the accompanying consolidated statements of financial position.

(13) Defined Contribution Plan

Effective January 1, 1998, AARP and certain affiliates participate in a single-employer defined contribution plan through the AARP Employees' 401(k) Plan.

(Continued)

AARP provides an employer contribution to the 401(k) Plan, which matches 100% of employee contributions up to 3% of employee compensation, and 50% of employee contributions for the next 2% of employee compensation, up to the maximum limit allowed by law. For the years ended December 31, 2008 and 2007, AARP employer contributions to this plan totaled $7,852,000 and $7,655,000, respectively.

(14) Board Designated Unrestricted Net Assets

Board designated net assets at December 31, 2008 and 2007 were available to fund the following:

	2008	2007
	(In thousands)	
Debt retirement sinking fund	$ 50,348	69,260
Investment earnings reserve	—	104,842
Foundation quasi endowment	11,115	15,148
Foundation board designated reserve	16,952	12,987
LCE quasi endowment	2,461	2,483
Other board designations	472	741
Board designated net assets	$ 81,348	205,461

(15) Temporarily Restricted Net Assets

Temporarily restricted net assets consisted primarily of net assets available for future periods.

(16) Commitments and Contingencies

(a) Lease commitments

AARP leases offices, information centers, and warehouse facilities in 93 locations in the U.S. and its territories under operating leases with various lease terms. Total rent expense incurred under operating leases was $18,708,000 and $17,978,000 in 2008 and 2007, respectively.

Future minimum lease payments, exclusive of additional operating costs, at December 31, 2008 are (in thousands):

2009	$ 16,525
2010	15,718
2011	14,549
2012	13,975
2013	12,389
2014 – 2022	56,588
Total	$ 129,744

(Continued)

(b) Contingencies

In the normal course of business, AARP is subject to various claims and lawsuits. Certain lawsuits may be covered, in full or in part, by external insurance coverage. AARP has recently been named in lawsuits relating to the benefits offered by AARP endorsed third party providers. AARP intends to vigorously defend these suits. The amount of loss from these lawsuits cannot be estimated as of December 31, 2008.

(17) Subsequent Events

Recent market conditions have resulted in an unusually high degree of volatility and increased risks related to short term liquidity of certain investments held by AARP, which could impact the value of investments after the date of these consolidated financial statements. In addition, subsequent to year-end, there has been a decline in the fair value of AARP's investments.

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6115

January 26, 2010

Rick Smith
Senior Vice President for Policy
Pharmaceutical Research and Manufacturers
of America (PhRMA)
950 F Street NW
Washington, D.C. 20004

Dear Mr. Smith:

Thank you for appearing before the Subcommittee on Health on December 8, 2009, at the hearing entitled "Prescription Drug Price Inflation: Are Prices Rising Too Fast?."

Pursuant to the Committee's Rules, attached are written questions for the record directed to you from certain Members of the Committee. In preparing your answers, please address your response to the Member who submitted the questions.

Please provide your responses by February 9, 2010, to Earley Green, Chief Clerk, in Room 2125 of the Rayburn House Office Building and via e-mail to Earley.Green@mail.house.gov. Please contact Earley Green or Jennifer Berenholz at (202) 225-2927 if you have any questions.

Sincerely,

Henry A. Waxman
Chairman

Attachment

The Honorable Bruce Bralev

1. What actions has PhRMA taken to ensure that brand manufacturers are aware their products are not properly registered with the FDA and therefore will not be covered by Medicare Part D starting January 1, 2010?

Richard I. Smith
SENIOR VICE PRESIDENT
POLICY, RESEARCH AND STRATEGIC PLANNING

PhRMA

February 3, 2010

The Honorable Bruce Braley
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Re: Questions from December 8, 2009 Hearing

Dear Congressman Braley:

This letter responds to your follow-up question from the December 8th hearing: "What action PhRMA has taken to ensure that brand manufacturers are aware their products are not properly registered with the FDA and therefore will not be covered by Medicare Part D starting 2010?"

The Centers for Medicare and Medicaid Services first announced in the 2010 Call Letter its proposed policy "to begin rejecting prescription drug event submissions on January 1, 2010 with national drug codes (NDCs) for which the FDA is unable to provide regulatory status determinations through their regular processes." This effort to match covered Part D drugs with a list of NDCs registered with the FDA was an effort to help Part D plan sponsors make determinations on which drug products are Part D drugs. When CMS released the draft 2010 Call Letter, we shared the document with our members. Throughout the year we understand that the list of unmatched NDCs has decreased significantly as a result of manufacturers, repackagers and others working with FDA to ensure NDCs are registered as appropriate.

While PhRMA is not involved in the business or compliance activities of its member companies, we have recently sent a notice to our companies reminding them of this CMS-FDA initiative and that any remaining unmatched NDCs of theirs should be remedied.

I appreciate the opportunity to respond to your question.

Sincerely,

Richard I. Smith

AARP

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February 4, 2010

The Honorable Henry A. Waxman
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515-6115

Dear Mr. Chairman:

Thank you for your letter of January 26, 2010, addressed to Bonnie Cramer, the Chair of the AARP Board of Directors, which consists of questions to Ms. Cramer's testimony at a December 8, 2009, hearing before the Energy and Commerce Committee's Subcommittee on Health. Following her testimony on various policy issues related to the cost of prescription drugs, she was asked a number of broader questions related to AARP public policy positions and operations.

Because AARP's Board is a volunteer board, and because your letter includes a number of detailed questions about AARP operations, policy, and member benefits, we thought it would be more helpful if I responded to your letter. As Chief Operating Officer, I am responsible for overseeing AARP's social impact and advocacy activities, for managing AARP's human, technical, and material resources, and, in partnership with the Chief Financial Officer, for the planning, development, and monitoring of AARP's budgets.

AARP appreciates the opportunity to clarify its position on important health care legislation, to answer questions about its positions, and to engage in a constructive dialogue on critical health care issues facing older Americans. As has been the case throughout the health care reform debate, we are fully committed to being as cooperative as possible in providing requested information.

Because a significant number of the questions relate to how AARP's positions on health care issues were developed, and the basis for those positions, we begin with an overview of AARP's policy development process. We then provide answers to the specific questions.

Public Policy Development

AARP develops its public policy positions through a process that is independent of any royalty-generating activities. This process involves input from AARP members and others, research and analysis by AARP staff of older persons' needs, review by a volunteer National Policy Council, and, ultimately, approval by the all-volunteer AARP Board of Directors. Every year, AARP publishes its public policy positions in the AARP *Policy Book*, which then forms the basis for all of AARP's advocacy efforts during the year. The attached pages from the 2009 *Policy Book* (which is also available on the AARP web site), provide additional information about the policy development process.

With respect to the current health care reform debate, the Board has engaged in extensive review and discussion of the relevant public policy issues, both at its regularly scheduled Board meetings, and in additional special meetings held for the specific purpose of developing AARP's position on healthcare reform legislation.

During both the regular and special meetings, the AARP Board developed certain criteria to evaluate the merits of health care legislation. These criteria were designed to ensure that any proposed legislation would benefit members and older Americans generally. These criteria included considerations such as whether the proposed legislation would improve Medicare (e.g., by closing the Part D "doughnut hole," by improving preventive benefits, and by attacking waste, fraud, and abuse), and whether it would provide affordable health care options to those not yet eligible for Medicare (e.g., through prohibitions on insurance denials due to pre-existing conditions and strict limits on insurance "age rating"). How well a potential piece of legislation met these principles was the guiding factor in the Board's decision whether to endorse that legislation.

These health care reform policy decisions were not formulated, motivated by, or based upon any assessment of the financial impact that such legislation might have on AARP. Rather, as with all of its public policy positions, AARP developed these health care reform positions independently, based upon what AARP believes is in the best interests of our members and all people age 50+.

Responses to Questions

We now provide responses to the specific questions in the January 26, 2010 letter.

1. **During the hearing, you confirmed that the majority of AARP's $1.3 billion, annual operating budget is funded by "royalty fees" from insurance company profits. You also committed to providing the Committee with a detailed account of the sources of these royalty fees.**

Like many other non-profit organizations (including social welfare organizations, professional associations, and universities), AARP licenses its name to a variety of companies that offer benefits to its members. Providers pay AARP a royalty in exchange for the right to use the AARP name and intellectual property.

The providers offering these member benefits include not only insurance companies, but also a wide variety of other organizations, such as financial institutions, retailers, and travel and leisure organizations.

This royalty income, along with the income from membership dues and other sources, enable us to fund a broad range of activities serving the needs of our members and all people age 50+.

In 2008, AARP received approximately $653 million in royalties from the providers of all member benefits. About $425 million of that $653 million was from providers of health-related member benefits. About $205 million of the $653 million was received from providers of financial-related member benefits. About $23 million of that $653 million was received from providers of travel, lifestyle, and other member benefits. Not all of the providers that pay royalties to AARP are insurance companies. Ms. Cramer indicated that she would get back to you about the specific royalty paid by United for the use of the AARP name on the Medicare Supplement plans, but we respectfully note that such product-specific information (like the specific royalty information for other provider benefits) is confidential and proprietary to both the providers and AARP.

a. The number of people enrolled in AARP Medicare Supplement Insurance Plans; the approximate market share of AARP-branded products in the Medicare supplemental insurance (Medigap) market; and the annual royalty fees AARP generates from the sale of AARP Medicare Supplement Insurance Plans in terms of total dollars, dollars per policy sold, and as a percentage of premiums charged to enrollees.

With respect to enrollment, United HealthCare Group ("United") has informed us that as of the end of 2008, 2,789,889 people were enrolled in Medicare Supplement products carrying the AARP name. Additionally, according to United, its AARP-branded Medicare supplement plans have a 29 percent market share.

b. The number of people enrolled in AARP-branded Medicare Part C insurance policies; the approximate market share of AARP-branded products in the Medicare Part C insurance market; and the annual royalty fees AARP generates from the sale of AARP-branded Medicare Part C insurance policies in terms of total dollars, dollars per policy sold, and as a percentage of premiums charged to enrollees.

According to United, there are approximately one million enrollees in the Medicare Advantage Plans carrying the AARP name. Please note that a person does not have to be an AARP member to be enrolled in these United Medicare Advantage plans. United also informs us that these plans have a 17 percent share of the market for non-private-fee-for-service Medicare Advantage plans.

c. **The number of people enrolled in AARP-branded Medicare Part D prescription drug plans; the approximate market share of AARP-branded products in the Medicare Part D insurance market; and the annual royalty fees AARP generates from the sale of AARP-branded Medicare Part D prescription drug plans in terms of total dollars, dollars per policy sold, and as a percentage of premiums charged to enrollees.**

United has informed us that, as of November, 2009, there were 3,920,132 people enrolled in the Part D prescription drug plans that carry the AARP name. Please note that a person does not have to be an AARP member to be enrolled in these United Part D plans. According to United, these Part D plans have a 25 percent market share.

2. **As Chair of the Board of Directors for AARP, please describe in detail the Board's responsibilities regarding the availability of adequate financial resources.**

As a non-profit social welfare organization, AARP's mission is to address the societal needs of its members and the 50+ population generally – not to make a profit. Like other non-profit organizations, the AARP Board is responsible for ensuring that AARP appropriately carries out this non-profit mission, and the Board oversees AARP strategies, plans, and budgets in order to do so. This includes oversight of financial plans, approval of the annual AARP budget, and ongoing monitoring to ensure that resources are used efficiently and effectively to further AARP's non-profit mission.

3. **Do members of the Board of Directors or executives of AARP use projections of annual revenue for future fiscal years in making strategic decisions regarding AARP's operations? If so, please describe how these revenue projections are produced and used.**

AARP staff develops and uses financial projections in order to align resources with the organization's strategies for carrying out its non-profit mission. The Board reviews projections as necessary to evaluate AARP's operations and approve budgets, consistent with AARP's mission.

4. **In response to a question from Congressman Buyer, you stated, "We have not, to my knowledge, had any estimate of revenues that AARP would lose or gain under House bill 3962." Please confirm that this statement is still accurate. Please detail the steps you have taken since your testimony to**

confirm that no member of the Board of Directors or employee of AARP has engaged in, requested, or received such an analysis.

The statement is still accurate. As a mission-driven social welfare organization, AARP develops its public policy positions based upon what AARP believes is in the best interests of our members and all Americans age 50 and over – and not based upon financial considerations. AARP's health care reform positions were not formulated, motivated by, or based upon any assessment of the financial impact of H.R. 3962 on AARP.

5. **Given that AARP receives a majority of its annual revenue from royalty fees from the sale of AARP-branded insurance products, why did the Board neglect to conduct or request an analysis of H.R. 3962's potential impact on the sale of such insurance products? Do you believe this failure comports with your fiduciary duties as members of the Board of Directors?**

As noted above, AARP's non-profit mission is to further the interests of all Americans age 50 and over – not to increase revenue. By reaching its health care reform conclusions based on an assessment of the needs of all older Americans, without regard to any potential financial impact on the organization, the AARP Board carried out its responsibilities appropriately and consistently with the organization's non-profit mission, as it always does.

6. **According to AARP's official filings with the IRS, United HealthCare and other insurance companies pay AARP "a portion of the total premiums collected" from any AARP-branded health insurance product. Were any of the people involved in AARP's decision to endorse H.R. 3962 aware of this fact?**

AARP staff and the AARP Board are, of course, aware that member benefit providers pay a royalty for the use of the AARP name and intellectual property. This fact is disclosed in many public documents, including annual reports, financial statements, and materials describing the member benefits.

7. **Since AARP receives "a portion of the total premiums collected" from AARP-branded health insurance products, is it therefore true that AARP revenues would increase if more higher-cost AARP-branded insurance policies were sold to seniors? Please outline how the Board believes this "contingency fee" provision meets appropriate conflict-of-interest standards set by the organization, as well as appropriate laws and regulations issued by the Centers for Medicare and Medicaid Services and other applicable State and Federal laws.**

The Board has acted consistently with AARP's non-profit mission, conflict of interest standards, and applicable laws and regulations, in developing its public policy positions

on health care reform. Again, these decisions were, appropriately, not motivated by consideration of how those public policy positions might potentially affect AARP revenue.

8. **Prior to your testimony, were you and your Board colleagues aware that AARP Medicare Supplement Insurance Plan policies limit access to coverage for seniors with pre-existing conditions? How does this policy comport with the Board's stated commitment to "end health status discrimination?"**

Consistent with AARP's non-profit mission, the AARP-branded Medicare Supplement plans from United have been designed to promote broad access to individuals with pre-existing conditions. Many other Medicare Supplement plans will not accept applicants who have various pre-existing conditions (e.g., emphysema, Parkinson's disease, multiple sclerosis, osteoporosis with fracture, COPD, mild cognitive impairment, etc.). In contrast, in 2008, the AARP-branded plans from United accepted over 99.9% of all applicants (with end stage renal disease being the only exception).

In addition, after individuals have enrolled, United also operates these plans in a way that furthers accessibility. Although permitted by law in 49 states to impose waiting periods for new enrollees with pre-existing conditions, United (unlike many other providers) only administers such waiting periods in 11 states. United does so in these limited number of states because of market conditions, and a desire to help keep premiums affordable for all enrollees, given those market conditions. These practices contrast with those of many other insurers that impose pre-existing condition waiting periods more extensively, in addition to their restrictive acceptance standards as discussed above.

Many other Medicare Supplement plans use "attained age rating," which means that premiums are more favorable at younger ages, but could become prohibitive at older ages. In contrast, and consistent with AARP's mission, the AARP-branded Medicare Supplement plans from United generally use community rating (with very few exceptions, as in the case of states, like Florida, that require Entry Age Rating) in order to help keep rates more manageable for older individuals, and to ensure that rates do not go up simply because of an individual's age.

As noted above, the laws of nearly all states permit denial of coverage for a broad range of health conditions, the imposition of waiting periods for pre-existing conditions, and the use of age rating. AARP will continue to advocate for legislative changes to improve this framework and end health status discrimination, including the elimination of exclusions based on pre-existing health conditions. If we are successful in our efforts, such improvements would apply across the board, including to those products that carry the AARP name.

9. **Prior to your testimony, were you and your Board colleagues aware that the AARP-branded major medical coverage plans offered by Aetna charge 64-year-olds premiums that are 60%-70% higher than the premiums for 50-**

year-olds? How does this policy comport with the Board's stated commitment to "end health status discrimination?"

Unlike in the Medicare Supplement market, it is more difficult, without regulatory reforms, for insurers to offer affordable products in the age 50-64 market without some adjustments to premiums based upon factors such as age. The 50-64 AARP-branded products insured by Aetna comply with current state laws that permit modified community rating adjusted for age, gender, geographic location and family status. In addition, the laws of most states permit adjustment for health status based on medical underwriting. The Aetna plans also include a number of features that align with AARP's mission. For example, Aetna revised its typical underwriting guidelines to be less restrictive when considering applicants with certain pre-existing conditions. Additionally, Aetna applies a five year "look back" period for medical conditions versus the ten-year industry standard. Other insurance plans with more restrictive underwriting policies may be less expensive for some. However, increasing accessibility to health coverage is an important feature that aligns with AARP's mission and delivers significant member value.

It is because of these market difficulties that AARP is fighting so hard for legislation that would eliminate pre-existing condition exclusions, impose limits on age rating, and make coverage affordable and accessible for people over age 50 and not yet eligible for Medicare. Again, if we are successful in our efforts, such improvements would apply across the board, including to those products that carry the AARP name.

10. **Prior to your testimony, were you and your Board colleagues aware that most AARP-branded Medicare Part D prescription drug plans do not offer enrollees any benefits in the coverage gap (or "doughnut hole")? How does this policy comport with the Board's stated commitment to "end health status discrimination?"**

AARP has strongly advocated for an end to the coverage gap, or "doughnut hole" in Part D of Medicare. While we were pleased to work with Congress and the Bush Administration to enact Medicare Part D, the lack of funding, at the time, for full prescription drug coverage in the gap has proven to be particularly harmful to beneficiaries. Many older Americans with high drug costs simply stop taking needed medications, leading to poor health and ultimately even higher heath care costs.

Today, it is our understanding that no national Part D prescription drug plan sponsor offers brand name drug coverage in the coverage gap, because doing so in the current regulatory framework would prohibitively increase premiums for all enrollees. Three Part D plans from United carry the AARP name, and these plans are available in all fifty states, the District of Columbia and the U.S. Territories. Like other provider offerings, these plans have features designed to further AARP's mission (e.g., two plans have the widest formularies allowable, covering all Medicare eligible drugs, with no annual

deductible). One of the plans provides coverage of most generic drugs in the coverage gap.

But that's not enough – we need legislative change. Because of the importance of providing drug coverage in the Part D coverage gap, and the difficulty of providing a sustainable product that covers brand name drugs in the so-called "doughnut hole," AARP continues to advocate strongly for legislation that fully closes the Part D coverage gap. Again, it is worth noting that if we are successful in our legislative advocacy efforts, the new legislation will apply to all Part D plans, including those that carry the AARP name.

11. **During the hearing, you stated, "We make sure that our members have the best policies that we can have under state and federal law." Given the facts described in Questions 7, 8, and 9 regarding AARP Medicare Supplement Insurance Plans, AARP-branded major medical coverage plans, and AARP-branded Medicare Part D prescription drug plans, do you still believe that AARP provides its members with the best possible plans as allowed by State or Federal law? If so, please cite the Federal or State law that requires insurance companies to subject their enrollees to a six-month waiting period for coverage of pre-existing conditions, the Federal or State law that requires insurance companies to charge older enrollees higher premiums than those charged to similarly situated younger enrollees, and the Federal or State law that prohibits Medicare prescription drug plans from providing benefits during the coverage gap.**

AARP works to select member benefits that have unique and distinguishing features designed to further AARP's mission, meet member needs, and hopefully move the marketplace so that other companies follow suit and introduce similar offerings to serve the 50+ population generally. We have just described a few of these examples – e.g., the broad accessibility of the AARP-branded Medicare Supplement policies from United, the less restrictive underwriting standards used in the 50-64 health plans from Aetna, and the broad formularies in the Part D plans from United.

However, without the types of legislative changes for which AARP continues to fight aggressively, there are limits to the features that can be included in the providers' products, given the current market conditions and regulatory framework. Without a change in the law, for example, coverage of brand name drugs in the doughnut hole could increase premiums to an unaffordable level. Again, this is why AARP continues to work so hard for legislation that would address these systemic issues – e.g., the doughnut hole, pre-existing condition exclusions, and unfair age rating – in order to ensure that accessible and affordable coverage is available to all older Americans. We would welcome the opportunity to work with you on changing any of the above for the better.

12. **In response to a question asked by Congressman Shimkus, you confirmed that the AARP could not continue its current operations without the $653**

million in annual revenue it receives from its business relationships with insurance companies. Given the vital importance of this revenue stream to your organization and H.R. 3962's significant potential impact on this revenue stream, did the AARP Board of Directors and AARP's executive staff members recuse themselves from the decision to endorse H.R. 3962? Did anyone who receives financial compensation from AARP participate in the decision to endorse H.R. 3962? Did anyone who receives financial compensation from AARP attempt to influence the organization's decision to endorse H.R. 3962?

We would like first to clarify that Ms. Cramer was asked whether AARP operations "would change" if AARP lost $653 million in royalty revenue, and she replied that "obviously it would change." We also note that about $228 million of the $653 million in royalties was not received from providers of health-related member benefits.

Again, the decision to endorse the House health care reform legislation was in no way based upon any potential impact of that legislation on AARP's income. Consistent with AARP's non-profit mission, this decision was instead based upon an assessment of whether the proposed legislation was beneficial to older Americans. In making these decisions, AARP's all-volunteer Board carried out its responsibilities appropriately.

13. **Please describe how AARP determines the compensation packages for AARP officers. Is the compensation, including salary, bonus, and any other compensation, of any officer or employee of AARP dependent on the amount of revenue received by AARP from the royalty fees of the sale of insurance products?**

As noted above, the AARP Board is composed entirely of volunteers who are not compensated for their service (other than receiving reimbursement for travel and other expenses incurred in connection with their duties, including travel and subsistence costs of spouses/companions accompanying them to Association functions, as explained in AARP's Form 990).

As in other non-profit organizations, AARP employees' compensation is based on a number of factors, such as external labor market data (where available), the use of independent, third-party consulting firms, internal criteria, and individuals' performance. Internal criteria are based on a standard approach that measures the internal value of positions, including: complexity and scope of responsibility, skill set and competencies, education and experience, and the reporting relationship of the position.

In recent years, AARP employees have been eligible for an annual bonus based in part on their individual performance, and in part on the organization's performance. The organizational-performance component has been based on a number of high-level measurements of AARP's social impact, member value, employee satisfaction, and

financial operation. This bonus program was not operational for calendar years 2008 and 2009.

14. **In discussing AARP's relationship with the insurance companies from which it annually collects over $650 million in royalty fees, former AARP executive Marilyn Moon is quoted in a Bloomberg.com article as stating, "There's an inherent conflict of interest." Do you or any of your fellow Board members agree with your former executive that AARP's mission to help seniors has been compromised by its reliance on royalty fees from insurance company profits?**

Again, as noted above, we would like to clarify that AARP does not receive over $650 million in royalties from insurance companies.

For the reasons outlined in this letter, we absolutely disagree with Ms. Moon's incorrect allegation. As explained above, AARP has developed its health care reform positions in furtherance of its non-profit mission to help all Americans over age 50, and not based upon any perceived financial interests.

15. **The Congressional Budget Office has projected that H.R. 3962 will result in $160 in cuts to Medicare Part C plans and 3 million seniors who have chosen to enroll in Medicare Part C plans losing such coverage. Using the best available data regarding the percentage of Part B enrollees enrolled in AARP Medicare Supplement Insurance Plans and the royalty fees AARP receives from the sale of such insurance products, how much additional revenue could AARP expect to receive from an additional 3 million Americans becoming enrolled in Medicare Part B?**

As we have explained, the decision to support H.R. 3962 was not based upon any financial considerations, and AARP has not analyzed this question.

With respect to private plan options within Medicare, AARP has long been supportive of providing genuine choices to Medicare beneficiaries, but has raised questions about the appropriateness of Medicare payments to such plans stretching back to the beginning of this decade. With respect to Medicare Advantage plans specifically, which were renamed and provided new financial incentives in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, AARP has taken the position, since 2005, that Medicare should not pay more to private health plans for providing service to Medicare beneficiaries than it expends on the same beneficiaries in the traditional Medicare program. Currently, Medicare Advantage insurers have been unnecessarily costing taxpayers billions of dollars and driving up the cost of overall Medicare premiums. Despite the promise of cost efficiencies, those insurers now receive an average of fourteen percent more per person than the cost of traditional Medicare benefits.

AARP believes that by reducing these subsidies, we can save money, lower Medicare costs, and help ensure that seniors, their children and grandchildren will receive the guaranteed health benefits they have earned.

AARP wants to see savings from Medicare Advantage used, in part, to strengthen Medicare, such as by closing the Part D coverage gap or "doughnut hole," to lower drug costs for millions of seniors; ensuring Medicare pays doctors fairly so seniors can keep the doctor of their choice or more easily find a doctor if they don't have one; lowering out-of-pocket costs for important preventive services; improving the coordination of care for people with chronic health conditions; and strengthening the long-term financial security of the Medicare program.

16. **Did the Board decide to endorse legislation that would allow AARP-branded Medicare Supplement Insurance Plans to continue to limit access to coverage for seniors with pre-existing conditions? If not, how was the endorsement decision made and who made it?**

AARP's decision to endorse health care reform legislation in the House was based upon the factors outlined previously in this letter, including provisions that would close the doughnut hole, prohibit pre-existing condition exclusions, and limit unfair age-rating practices. The proposed legislation's failure to extend the pre-existing condition exclusion to Medicare Supplement plans was not a reason for AARP's endorsement decision, and the legislation's failure to do so was not the result of lobbying by AARP. AARP would be pleased to support the addition of a similar prohibition on pre-existing condition exclusions to the Medicare laws governing Medicare Supplement plans.

17. **H.R. 3962 requires every major type of health insurance product to have a medical loss ratio of at least 85%. However, this legislation, was drafted in such a way as to allow Medigap insurance policies, such as AARP Medicare Supplement Insurance Plans, to have a medical loss ratio of just 65%. In response to a question by Dr. Gingrey, you stated you were not aware of this special exemption given to Medigap insurance policies, such as the AARP Medicare Supplement Insurance Plans. If AARP and its Board of Directors were as thorough in their review of the legislation as you claim, how do you explain the fact that you were unaware of the special exemption given to an insurance product that produces such a significant portion of your organization's annual revenues?**

As explained above, AARP staff and the Board were indeed thorough in their work on health care reform. After the meetings and reviews described above, the Board agreed upon criteria by which proposed legislation would be evaluated in order to ensure that the needs of older Americans would be met. It was on this basis that AARP decided to endorse the proposed House legislation.

The failure of the currently proposed legislation to extend loss ratio requirements to Medicare Supplement plans was not a reason for AARP's endorsement decision, and the legislation's failure to do so was not the result of lobbying by AARP. AARP would support the extension of similar requirements for Medicare Supplement plans under the Medicare law.

18. **Why did the Board decide to endorse legislation that would require every other form of health insurance to retain only 15 cents of every premium dollar in administrative overhead and profit—while allowing AARP-branded Medicare Supplement Insurance Plans to retain 35 cents of every dollar for profit and royalty fees provided to the organization?**

Again, AARP endorsed the proposed legislation based upon its assessment that it would further the interests of members and all Americans age 50 and over, for the reasons explained previously. As also noted above, AARP would support an extension of similar loss-ratio requirements on Medicare Supplement plans.

19. **What steps did members of the Board take to exercise their own due diligence before issuing AARP's endorsement? Does the Board have documentation (e.g., e-mails, meeting minutes, etc.) it can provide to demonstrate that trustees exercised their independent governance before deciding to endorse the legislation? How many members of the Board read the 1,990 pages of H.R. 3962 in their entirety before voting to give it the organization's endorsement?**

As described in the introduction to this letter, the AARP Board engaged in extensive review and deliberation related to health care reform. In addition, AARP staff reviewed the entirety of H.R. 3962 and provided appropriate reports to the Board.

20. **On November 17, several Republican Members of Congress wrote to AARP asking the organization to reconsider its endorsement of H.R. 3962. Did the Board meet to consider this request—and if not, why not?**

As explained above, the decision to endorse the proposed House legislation was based upon the review and criteria discussed above, and the Board remains committed to that position. AARP responded to the November 17, 2009 letter, on December 2nd, indicating that AARP would welcome an opportunity to meet and discuss these important issues further.

21. **What is the average medical loss ratio (i.e., the percentage of premiums paid out in the form of medical claims) for AARP-branded Medicare Supplement Insurance Plans?**

United has informed us that the average national loss ratio for the AARP-branded Medicare Supplement plans was approximately 84.1% in 2008, according to NAIC data,

and that these plans provided either the highest or second highest return among the top Medicare Supplement carriers in benefits for every $1 of premium in 42 states in 2008.

22. **In response to a question by Dr. Gingrey, you committed to letting the Committee know if and when AARP receives any contact from the Department of Justice regarding the royalty fees AARP receives from the sale of AARP Medicare supplemental insurance plans. As you are aware, at a hearing on H.R. 3962 on November 6, 2009, Chairman Rangel of the House Ways and Means Committee suggested that he would call for a Justice Department investigation into AARP's insurance activities with respect to its royalty fee collections? Have you received any such inquiries? Please outline the actions taken by the Board – both before and after your testimony – to exercise your fiduciary duties with respect to this potential pending federal investigation.**

AARP has not received any such inquiries from the Department of Justice.

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We hope that this information is helpful in answering the questions presented. AARP has been, and will continue to be, actively engaged in ongoing efforts to improve our health care system. Throughout this debate we have fought to protect and improve guaranteed Medicare benefits for seniors and to ensure future generations have the health coverage they need.

We are committed to meaningful dialogue with you and other Members of Congress on these important health care issues, which are of unique importance to older Americans. We look forward to working with you in the future.

Respectfully,

Thomas C. Nelson
Chief Operating Officer

INTRODUCTION

The Policy Book: AARP Public Policies 2009–2010

AARP's membership comprises 40 million Americans age 50 and over. Our members include workers and retirees, individuals in their 50s at the peak of their earning years and those over 80 living alone, people with comfortable standards of living and those struggling with minimal resources. And of course, older Americans have many of the same concerns as younger members of our society—particularly about jobs, health care, and the neighborhoods in which they live.

Developing public policy recommendations that serve the interests of a group as diverse as older Americans is a formidable task. But we concentrate on the issues of most interest to our members as they age: economic security; health care; access to affordable, quality long-term care; creating and maintaining livable communities; and ensuring that our democracy works better for us all.

The Policy Book integrates input the association gathers from members and others through communications, policy forums, surveys, and polls. With this input, and after analyzing policy options, AARP's National Policy Council recommends specific public policies to the association's board of directors (see Setting Public Policies for a detailed description of this process). The board approved the policies in this edition on February 26, 2009. AARP intends the Policy Book as a guide for volunteers and staff in advocating for change over the next two years.

The 2009–2010 edition of the Policy Book is available on paper, CD-ROM, and the Internet (www.aarp.org/policybook). In 2010, AARP will update the Policy Book only electronically.

This edition of the Policy Book comes just after AARP itself turned 50. Through the Policy Book Modernization Project, we revised the book to make the information more concise and accessible for staff and volunteers, so they can get the information they need as quickly as possible. Another example of how life can begin again after 50.

AARP and Its Members in Dialogue

As one of the leading voices for an aging America, AARP regularly monitors its members' needs, concerns, and opinions. AARP develops its public policies through a consistent, ongoing process that begins with member input and policy analysis. The *Policy Book* presents the association's approved policies and forms the basis for all its advocacy efforts.

AARP's Board of Directors and National Policy Council—Founded 50 years ago by Dr. Ethel Percy Andrus, AARP is governed by its volunteer board of directors. AARP's board-appointed National Policy Council (NPC) helps the board formulate national, state, and local policy.

An advisory committee to the AARP board, the NPC is composed of individuals who represent a diverse cross section of AARP members and have a proven record of public policy experience and interest. In making public policy recommendations for the board's consideration and approval, the NPC studies public policy options and weighs the opinions of members and guidance from nationally renowned policy experts and staff.

Member input—Throughout the year AARP seeks input on public policy issues from many sources. The association receives tens of thousands of calls, letters, and e-mails from members, and surveys members and the general public on a broad range of issues. The board of directors and the NPC also host national policy forums and actively solicit policy input from state volunteers on a continuing basis.

Implementing policy—Once the board of directors finalizes federal, state, and local policy recommendations, the association disseminates them in a variety of formats. The *Policy Book* provides the basis for advocacy efforts by AARP volunteers and staff. Under the guidance of the association's chief executive officer, volunteers and staff work together to implement the association's policy goals.

At the federal level AARP works to affect legislation that reflects these policies. The association's staff in Washington, DC, lobbies the administration, Congress, and regulatory agencies, while members of the board of directors, along with other association volunteers, regularly testify on Capitol Hill on behalf of older Americans.

AARP's advocacy efforts in the states, the District of Columbia, Puerto Rico, and the US Virgin Islands also reflect the board-approved policies. The policies recognize that laws, regulations, and political realities differ widely from state to state: Legislation absent but critically needed in one state may have been enacted in another state years ago. AARP leadership in each state develops specific strategies after researching the views and needs of volunteers and members. Based on the association's annual policy priorities, and within the parameters articulated in the *Policy Book*, state AARP leaders interpret the association's goals for local leaders and guide them in selecting policy issues and creating strategies to pursue them.

The association bolsters its federal and state advocacy with grassroots and elections activities—including urging AARP members to contact legislators and regulators on key issues and educating the public on important policy matters and candidates' positions. AARP also works for change through the courts.

How AARP decides on legislative and regulatory proposals—The *Policy Book* offers policy approaches and principles but does not endorse specific legislation or regulatory proposals. The association uses board-approved policy to determine whether to support a specific bill or regulation. On far-reaching proposals that will have a major impact on older Americans and their families, the board carefully considers AARP policy, as well as feedback from members through surveys, e-mails, letters, and telephone calls; input at policy forums and meetings; public polling; and policy analysis. The board uses all this information in deciding whether to support specific legislation or regulatory proposals.

Ongoing policy analysis—Formation of AARP's public policy positions is an ongoing process. Following AARP's annual public policy meeting, the association holds forums and conducts research and policy studies throughout the year and updates its policies as necessary to stay current. The publication of the 2009-2010 *Policy Book* marks the first time that AARP's policy book is designed to cover a two-year period. Electronic updates will be available periodically.

The association's Office of Policy Integration (OPI) facilitates development, implementation, and oversight of the policy development process, coordinating the direct involvement of AARP's volunteer leadership in creating the *Policy Book*. The association's Public Policy Institute (PPI) takes responsibility for drafting the policies. Other staff throughout the association, including advocacy staff in Washington, DC and from AARP's 53 state offices, contribute to the formulation of AARP's policy.