10 Year Check-Up:

The Affordable Care Act Has Enhanced Access to Quality Health Care for Low-Income Older Adults

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) was designed to improve the quality of health care and expand access to critical services for everyone across the health care system. It is well-known for creating brand new health coverage options through the Marketplace, protecting against insurance exclusions due to pre-existing conditions, and expanding Medicaid to low-income adults under age 65. All of these major provisions benefit older adults; but the ACA did much more than that. It improved Medicare, Medicaid, and the coordination of programs for people who are dually eligible for both. Furthermore, it enhanced the ability of seniors to age in place and created more protections for seniors who live in nursing facilities. Almost ten years after its enactment, the ACA has been so ingrained into our health care system that the system would collapse without it.

This issue brief takes a look at the ACA's vast accomplishments through the lens of low-income older adults and individuals dually eligible for Medicare and Medicaid. Many of the law's coverage expansions, care coordination improvements, consumer protections, and elder justice and healthcare rights provisions that are not as well-known are nonetheless revolutionary.

> **Almost ten years after its enactment, the ACA has been so ingrained into our health care system that the system would collapse without it.**

In December 2018, a Federal District Court issued a decision in *Texas v. U.S.* declaring the entire ACA unconstitutional.[1] The twenty Republican state attorneys general and governors brought the lawsuit after Congress eliminated the ACA's tax penalty for individuals who do not maintain minimum essential coverage. While the individual mandate to maintain health coverage still exists, the plaintiff states argued that the individual mandate without the tax penalty is unconstitutional and that the entire ACA is thereby unconstitutional because it relies on the individual mandate.[2] The district court's decision has not taken effect and legal scholars opine that it will not stand. However, if ultimately upheld on appeal, the decision would dismantle the health care system on which older adults rely and be even more devastating than Congress' mostly failed attempts to repeal parts of the sweeping healthcare law. Without the ACA, at least 4.5 million older adults would become uninsured,[3] fewer seniors would be able to age at home and in their communities, Medicare costs would increase and financing would be threatened, and successful efforts to improve care for individuals dually eligible for Medicare and Medicaid would be halted.[4]

COVERAGE EXPANSION

The ACA has improved overall health care coverage for many older Americans with limited income and resources. Shortly after the ACA's Medicaid expansion and reforms to the individual and group health insurance markets were implemented, the uninsured rate for older adults ages 50-64 was cut in half.[5]

New Medicaid Programs & Initiatives

Medicaid Expansion

One of the ACA's most well-known provisions, Medicaid expansion, extended coverage to more older adults ages 50-64 who are too young to qualify for Medicare and had no health coverage options pre-ACA.[6] Before the ACA, older adults could only qualify for Medicaid if they had dependent children, were age 65 or older, or had a disability meeting strict Social Security criteria, in addition to having income and assets below strict limits.[7] The

1 *Texas v. United States*, 340 F. Supp.3d 579 (2018).

2 Katie Keith, *Texas v. United States Oral Arguments in July*, Health Affairs (Apr. 12, 2019), healthaffairs.org/do/10.1377/hblog20190412.997469/full/.

3 Linda J. Blumberg et al., Urban Institute, *Implications of Partial Repeal of the ACA through Reconciliation* (Dec. 2016), urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf.

4 As of 2018, ninety-three percent of persons age 65 and over are Medicare beneficiaries and another seven percent are Medicaid beneficiaries. Administration on Community Living, *2018 Profile of Older Americans,* 13 (2018), acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/2018OlderAmericansProfile.pdf.

5 Laura Skopec et al., The Urban Institute & the AARP Public Policy Institute, *Monitoring the Impact of Health Reform on Americans Ages 50–64: Uninsured Rate Dropped by Nearly Half between December 2013 and March 2015* (Oct. 2015), aarp.org/content/dam/aarp/ppi/2015/uninsured-rate-dropped-by-nearly-half-between-december-2013-march-2015.pdf.

6 Rachel Garfield et al., Kaiser Family Foundation, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,* 1 (2019), files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid.

7 Prior to the ACA, the median income limit across states was sixty-four percent of the federal poverty level for parents under age 65. Steven A. Sass, Ctr. for Retirement Research, *How Medicaid Helps Older Americans* (Mar. 2018), crr.bc.edu/wp-content/

ACA effectively eliminated those categories and the asset test for adults under age 65 in states that chose to expand Medicaid coverage to adults without dependent children up to 138% of the federal poverty level (FPL) using new authority and federal funding.[8]

> **Shortly after the ACA's Medicaid expansion and reforms to the individual and group health insurance markets were implemented, the uninsured rate for older adults age 50-64 was cut in half.**

The ACA's provision of enhanced federal funding for expansion has led thirty-six states[9] and the District of Columbia to expand coverage. As a result, by 2018, over thirteen million Americans in expansion states had gained Medicaid coverage.[10] The older adults who have gained coverage through Medicaid expansion have very limited income and cannot afford to purchase health insurance. They are not yet eligible for Medicare and are unlikely to have jobs that offer insurance.[11]

Not only has Medicaid expansion contributed to sharp drops in the uninsured rate,[12] it has helped beneficiaries become more financially stable[13] and helped decrease disparities in access to and affordability of care.[14] For example, the ACA requires states to cover mental health and substance use disorder treatment services at parity with other medical benefits.[15] These improvements in access to care have also led to increases in diagnoses and consistent treatment for chronic conditions such as cancer.[16] States that have expanded Medicaid have also had greater improvements in access to behavioral and mental health treatment and increased utilization of smoking cessation medications.[17] And Medicaid

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STATES & D.C. EXPANDED MEDICAID

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uploads/2018/02/IB_18-5.pdf.

8 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

9 Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision* (May 13, 2019), kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act.

10 Mediaid & CHIP Payment & Access Commission, *Medicaid enrollment changes following the ACA*, macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/#ftn1.

11 Rachel Garfield et al., Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work,* 3 (2018), files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

12 *See* George L. Wehby and Wei Lyu, The Impact of the ACA Medicaid Expansions on Health Insurance Coverage through 2015 & Coverage Disparities by Age, Race/Ethnicity, and Gender, 53:2, HSR: Health Svcs. Research 1248, 1258 (Apr. 2018); *see also* AARP Public Policy Institute, *Breaking Through the Noise: The Facts About the Medicaid Program,* 4 (2018), aarp.org/content/dam/aarp/ppi/2018/10/breaking-through-the-noise.pdf.

13 Kyle J. Caswell and Timothy A. Waidmann, *The Affordable Care Act Medicaid Expansions and Personal Finance*, 1 Medical Care Research & Review 2-3 (2017), journals.sagepub.com/doi/pdf/10.1177/1077558717725164; Ctr. on Budget & Policy Priorities, *Chart Book: The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion 11 (2018)*, cbpp.org/sites/default/files/atoms/files/10-2-18health.pdf.

14 Larisa Antonisse et al., Kaiser Family Foundation, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review,* 3 (2018), files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review.

15 Kaiser Family Foundation, *Potential Impact of Texas v. U.S. Decision on Key Provisions of the Affordable Care Act* (Mar. 26, 2019), kff.org/health-reform/fact-sheet/potential-impact-of-texas-v-u-s-decision-on-key-provisions-of-the-affordable-care-act [hereinafter *Kaiser Texas v. U.S. and the ACA*].

16 *Id.* at 5.

17 *Id.*

patients in expansion states have experienced shorter hospital stays.[18] In addition, by covering more individuals age 50–64, Medicaid expansion decreases health care costs for these individuals when they turn 65 and begin Medicare because they are likely to be healthier.

Home and Community-Based Services (HCBS)

The ACA expanded options for older adults to age in place and for people with disabilities to live in the community. Nearly all adults aged 65 or older report that they wish to remain in their homes as they age, as opposed to moving to a nursing facility.[19] The right to live in the community is codified in the Americans with Disabilities Act (ADA), which mandates states to provide long-term care services (LTSS) in the most integrated setting.[20] Prior to the ACA, states spent most of their Medicaid LTSS dollars on institutional care; the ACA changed that. States now spend over half of their LTSS dollars on home-and community-based services (HCBS).[21] The ACA created and expanded several optional programs that shifted the focus of Medicaid LTSS from institutional care toward more integrated settings. These programs not only help states comply with their obligations under the Americans with Disabilities Act, but they have also improved the quality of life for older adults and people with disabilities who rely on Medicaid LTSS.

> States now spend **over half of their LTSS dollars on home and community-based services.**

The **Community First Choice Option**[22] provides participating states a six-percentage point increase in federal Medicaid matching funds for personal care services to persons living in the community who require an institutional level of care. Thus, states are financially incentivized to provide services that keep older adults and persons with disabilities in their homes and communities instead of segregating or isolating them in nursing facilities.[23] As of 2016, eight states had elected to provide personal care aide services to over 353,000 beneficiaries through the Community First Choice Option.[24]

Another optional program, **Section 1915(i)**,[25] gives states the opportunity to provide HCBS to people who do not meet an institutional level of care. The ACA abolished some of Section 1915(i)'s original restrictions: states can now tailor services to specific populations, include individuals with up to 300% of the SSI federal benefit rate, and

18 *Id.* at 6.

19 AARP, *2018 Home and Community Preferences Survey: A National Survey of Adults Age 18-Plus,* 15 (2018), aarp.org/content/dam/aarp/research/surveys_statistics/liv-com/2018/home-community-preferences-chartbook.doi.10.26419-2Fres.00231.002.pdf (finding that nearly ninety percent of the oldest adults, i.e. the "silent" generation, wished to age in place).

20 42 U.S.C. § 12132; 28 C.F.R. § 35.130(d); Olmstead v. L.C., 527 U.S. 581 (1999).

21 Steve Eiken, *et al*, *Medicaid Expenditures for Long-Term Services and Supports in FY 2016 6 (2018)*, medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf.

22 42 U.S.C. § 1396n(k).

23 For example, Texas was the fifth state to implement the Community First Choice Option, covering home and community-based attendant services and supports to assist individuals with activities and instrumental activities of daily living, health-related related tasks, voluntary management training, emergency response services, and support services. *NORC at the Univ. of Chi., ACA Section 2401, Community First Choice Option (Section 1915(k) of the Social Security Act); Texas State Plan Amendment Summary 1 (2015)*, medicaid.gov/medicaid/hcbs/downloads/tx-cfc-spa-matrix.pdf. Seven other states use the Community First Choice Option to provide in-home long-term care: California, Connecticut, Maryland, Montana, New York, Oregon, and Washington. Straight Talk for Seniors: Nat'l Council on Aging, *The Affordable Care Act and Long-Term Care*, (Dec. 19, 2016), ncoa.org/blog/straight-talk-affordable-care-act-long-term-care.

24 *Kaiser Texas v. U.S. and the ACA*, *supra* note 15.

25 42 U.S.C. § 1396n.

incorporate additional services. To date, eighteen states have used Section 1915(i) to provide home- and community-based services to their residents.[26] Several states use Section 1915(i) to target services to specific populations, including older adults.[27]

The ACA also reauthorized the optional **Money Follows the Person** demonstration program, which provides enhanced federal funding to states and allows Medicaid to pay for items and services such as home modifications and first month's rent that enable individuals to transition from institutions to community living. The program has helped almost 90,000 seniors and people with disabilities voluntarily move out of institutions and back into their communities.[28]

Finally, the ACA made a critical change to financial eligibility rules that decreases Medicaid's bias towards institutional care by **extending Medicaid's "spousal impoverishment protection" to eligibility for HCBS.** This protection makes it possible for an individual who needs an institutional level of care to qualify for Medicaid while allowing their spouse to retain a modest amount of income and resources to pay for rent, food, and medication. Federal Medicaid law has required states to apply this protection to spouses of individuals needing institutional long-term care since 1988, but the ACA extended this protection to eligibility for HCBS in all states to ensure that married couples have the same financial protections whether care is provided in a facility or in the community.

Simplified Eligibility, Enrollment & Renewal

The ACA created opportunities for states to implement streamlined enrollment and renewal processes:

- Prior to the ACA, many states used burdensome enrollment procedures—such as face-to-face interviews and assets tests—but now every state has an **online and telephone Medicaid application**, and all have eliminated face-to-face interviews.[29] As a result, many states are reporting faster processing of applications, and 21 states report automatically completing at least half of renewals.[30]

- Many states have **expanded presumptive eligibility** to allow hospitals and other entities to make preliminary eligibility determinations for individuals to receive Medicaid-covered services while a full eligibility determination is pending.[31]

- The ACA also created a new financial eligibility standard in every state for Medicaid expansion and certain other eligibility categories, such as low-income parents and children, as well as Marketplace subsidies. **Modified Adjusted Gross Income (MAGI)[32]** is much more straightforward than traditional eligibility

26 *Kaiser Texas v. U.S. and the ACA*, *supra* note 15.

27 *Id.*

28 Medicaid Innovation Accelerator Program, *Medicaid Expenditures for Long-Term Services and Supports in FY 2016* (May 2018), medicaid.gov/medicaid/ltss/downloads/reports-and-evaluations/ltssexpenditures2016.pdf.

29 Kaiser Family Foundation, Tricial Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019L Findings from a 50-State Survey* (Mar. 27, 2019), kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/; *Kaiser Texas v. U.S. and the ACA*, *supra* note 15.

30 Kaiser Family Foundation (Mar. 27, 2019), Tricial Brooks et al., *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019L Findings from a 50-State Survey*, kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2019-findings-from-a-50-state-survey/.

31 Note that presumptive eligibility does not apply to aged, blind, disabled populations.

32 The ACA and federal regulations establish three separate definitions of MAGI: 26 U.S.C. § 1.36B(e)(2), 26 C.F.R. §1.36B-1(e) (for Marketplace subsidy eligibility determinations), 42 C.F.R. § 435.603(e)(for Medicaid eligibility determinations); and 26 U.S.C. § 1.5000A1(d)(10)(ii)(for calculating the Individual Shared Responsibility Payment (ISRP)). Insurance Affordability Programs (IAPs) include Medicaid, CHIP, Basic Health Plan (a state option), Advance Premium Tax Credits and cost-sharing assistance for enrollees in

criteria in that it uses household size, income, and a standard 5% disregard. It does not count assets or use deductions.[33]

New Affordable Coverage Options Through the Marketplace

Before the ACA, many people age 50 to 64 could not afford private health insurance and lacked access to employer coverage. The ACA gave them a new option by establishing the Health Insurance Marketplace (HealthCare.gov) and income-based subsidies that reduce or eliminate premiums and cost-sharing.[34] In 2017, **premium tax credits** helped over 3 million low and moderate-income adults ages 50 to 64 purchase health insurance coverage in the Marketplace.[35]

The Marketplace also makes coverage available to noncitizens who previously had no options,[36] as well as eliminates cost sharing for American Indians and Alaska Natives with income not exceeding 300% of FPL.[37]

In addition, the ACA created the navigator program to provide free assistance to people using the Marketplace and funded state Consumer Assistance Programs (CAP) to advocate for individuals with private health coverage—thirty-six CAPs are still active today.[38]

Health Insurance Reforms

The ACA contained numerous broad health insurance reforms that particularly benefit low-income older adults.

Age Rating Limits & Protections for People with Pre-existing Conditions

Prior to the ACA, insurance companies denied coverage to more than 1 in 5 pre-Medicare older adults who applied.[39] Moreover, there was no limit on how much an insurer could charge a person based on their age, and women had to pay higher premiums than men. The ACA prohibits all non-grandfathered health plans from charging older adults more than three times what they charge a young adult and from discriminating against individuals on the basis of their sex or health status. Large, small, and non-group health plans are prohibited from applying any pre-existing conditions exclusions and small and non-group insurers may not alter their premiums

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Qualified Health Plans (QHPs) through the health insurance Marketplaces (also known as Exchanges).

33 National Health Law Program, *The Advocate's Guide to MAGI* (Aug. 2018), 9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/MAGI-Guide-8.22.18.-UPDATE-FINAL-docx.pdf

34 *See* 42 U.S.C. § 18031(b); 26 U.S.C. § 36B(b)(3)(A) (Premium tax credits are available to people with income between 100% and 400% of the federal poverty level); 42 U.S.C. § 18071(c)(2) (Individuals and families with incomes below 250% FPL can enroll in plans with reduced deductibles and cost-sharing.)

35 *See,* Jane Sung et al., AARP Pub. Policy Inst., *Adequate Premium Tax Credits are Vital to Maintain Access to Affordable Health Coverage for Older Adults* (Mar. 2017), aarp.org/content/dam/aarp/ppi/2017-01/adequate-premium-tax-credits-are-vital-to-maintain-access-to-affordable-health-coverage-for-older-adult.pdf.

36 *See Immigration status and the Marketplace*, HealthCare.gov, healthcare.gov/immigrants/immigration-status/; National Immigration Law Center, *Lawfully Present' Individuals Eligible Under the Affordable Care Act*, nilc.org/issues/health-care/lawfullypresent (last revised July 2016).

37 42 U.S.C. § 18071(d)(1). Moreover, cost sharing for items or services furnished through a qualified Indian health organization is eliminated. *Id.* § 18071(d)(2).

38 *Kaiser Texas v. U.S. and the ACA*, *supra* note 15.

39 Gerry Smolka et al., AARP Public Policy Institute, *Health Costs and Coverage for 50-to 64-Year-Olds* (Feb. 2012), aarp.org/content/dam/aarp/research/public_policy_institute/health/Health-Insurance-Coverage-for-50-64-year-olds-fact-sheet-AARP-ppi-health.pdf.

based on health status.[40] Nearly 85% of adults ages 55 to 64 have at least one pre-existing condition.[41] By banning pre-existing conditions exclusions, the ACA opened coverage to all of them.

> **Nearly 85% of adults ages 55 to 64 have at least one pre-existing condition.** By banning pre-existing conditions exclusions, the ACA opened coverage to all of them.

Minimum Essential Coverage Standards

The ACA also improved the quality of health insurance by establishing minimum standards that most plans have to meet. One such standard requires health plans in the individual and small group market to cover ten essential health benefits (EHB): hospitalization, emergency services, outpatient care, maternity care, **mental health** and substance abuse treatment, **prescription drugs**, laboratory services, **habilitative and rehabilitative** services, **preventive services without cost-sharing**, and pediatric oral and vision care.[42] Prior to the EHB mandate, health plans often left out key services, such as prescription drug coverage and habilitative services, and most people had to pay cost-sharing for preventive services like cancer screenings and flu shots.[43] Moreover, the ACA provides financial protection by capping out-of-pocket cost sharing for EHBs.[44] These standards ensure that older adults can get comprehensive coverage that meets their needs and provide a backstop for catastrophic medical costs.

CARE COORDINATION FOR PEOPLE DUALLY ELIGIBLE FOR MEDICARE & MEDICAID

In addition to the millions of older adults under age 65 who benefit from the ACA's Medicaid expansion, twelve million older adults and people with disabilities who have very low incomes are dually enrolled in both Medicare and Medicaid through eligibility pathways that existed prior to the ACA.[45] These individuals, often referred to as "duals," typically have high health and long-term care needs, multiple chronic conditions, and several social risk factors.[46] As a result, spending for this population accounts for a third of both Medicare and Medicaid spending.[47] The ACA launched a number of initiatives that place long-overdue and much greater emphasis on serving the duals population.

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40 *Kaiser Texas v. U.S. and the ACA*, *supra* note 15.

41 HHS ASPE, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Jan. 5, 2017), aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

42 Ctrs. For Medicare & Medicaid Servs., *Information on Essential Health Benefits (EHB) Benchmarks*, cms.gov/cciio/resources/data-resources/ehb.html (last visited June 6, 2019). This requirement only applies to non-grand-fathered health plans. *Id.*

43 Ctr. on Budget & Pol'y Priorities, *Essential Health Benefits Under Threat*, cbpp.org/essential-health-benefits-under-threat (last visited June 6, 2019).

44 *Kaiser Texas v. U.S. and the ACA*, *supra* note 15.

45 CMS Medicare-Medicaid Coordination Office, *Data Analysis: Medicare-Medicaid Dual Enrollment from 2006 through 2017,* 1 (Dec. 2018), cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/MedicareMedicaidDualEnrollmentEverEnrolledTrendsDataBrief2006-2017.pdf.

46 CMS Medicare-Medicaid Coordination Office, *People Dually Eligible for Medicare and Medicaid* (2019), cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DuallyEligibleIndividualsFactSheet03112019.pdf. In fact, over forty percent of duals have at least one mental health condition, nearly fifty percent require long-term care services, and sixty percent have more than one chronic condition. *Id.*

47 *Id.*

Before the ACA created the MMCO there was very little oversight at the federal level to ensure that QMBs were in fact protected. The result was that the practice of improper billing was common nationwide, due largely to providers and consumers being unaware of or confused about when the protections apply.

Medicare-Medicaid Coordination Office

Prior to the ACA, no federal office focused on the duals population or coordination between Medicare and Medicaid despite the same agency, CMS, administering both programs. There were also few care options that integrated Medicare and Medicaid services or means for duals to get help with care coordination. The ACA changed that starting with creation of the Federal Health Care Coordination Office (also known as the Medicare-Medicaid Coordination Office or MMCO) to **address duals' unique and complex needs and promote cost-effective care**.[48]

For nearly a decade, the MMCO has been working to improve health and long-term care quality, care continuity, and the integration of Medicare and Medicaid benefits as described below. The office serves as the dedicated point of contact for states, overseeing new projects to integrate care and providing technical assistance and support, as well training and education for providers serving the duals population.

Protections from Improper Billing

The MMCO has implemented policies and mechanisms to protect the lowest-income duals, known as Qualified Medicare Beneficiaries (QMBs), from improper billing. Although federal law prohibits Medicare providers from billing QMBs for cost-sharing for any Medicare-covered service,[49] before the ACA created the MMCO there was very little oversight at the federal level to ensure that QMBs were in fact protected. The result was that the practice of improper billing was common nationwide, due largely to providers and consumers being unaware of or confused about when the protections apply.[50] Improper billing causes tremendous financial strains on low-income seniors who may not understand that they are not legally required to pay it and may ultimately limit their use of critical services because of their inability to pay.[51]

The MMCO has led the efforts to: implement new computer system flags that notify providers in real-time when a patient is a QMB and cannot be billed; change the notices Medicare sends to providers and QMB beneficiaries to clearly indicate that they cannot be billed; set up a pathway to empower beneficiaries to confirm their QMB

48 42 U.S.C. § 1315b(a). The Medicare-Medicaid Coordination Office (MMCO) aims to provide duals with full access to the benefits they are entitled to by simplifying application procedures, eliminating regulatory conflicts between Medicare and Medicaid, improving safe continuity of care, eliminating cost-shifting between Medicare and Medicaid providers, and improving the quality of services. Ctrs. For Medicare & Medicaid Servs., *About the Medicare-Medicaid Coordination Office*, cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html (last modified Mar. 21, 2019).

49 42 U.S.C. § 1396a(n)(3)(B). CMS also requires that all Medicare Advantage plans accept the capitated rate from the plan as payment in full—meaning dual eligible cannot be billed for Medicare cost sharing. 42 C.F.R. § 422.504(g)(1)(iii); Georgia Burke and Denny Chan, Justice in Aging, *Fighting Improper Billing of Dual Eligibles: New Strategies 4 (Feb. 2017),* justiceinaging.org/wp-content/uploads/2017/02/Fighting-Improper-Billing-of-Dual-Eligibles-New-Strategies.pdf.

50 Ctrs. for Meidcare & Medicaid Svcs., *Access to Care Issues Among Qualified Medicare Beneficiaries (QMB) 2 (2015)*, cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf.

51 *Id.* at 5.

status and report and receive help with improper billing through 1-800-MEDICARE; and conduct ongoing provider education and training.[52] In the short time since these changes were fully implemented in 2018, Justice in Aging has seen decreases in both providers improperly billing QMBs and in QMBs paying improperly billed cost-sharing.

Demonstration enrollees have experienced lower nursing facility and hospital admissions and long-term nursing facility stays, as well as cost savings. Enrollees also report high rates of satisfaction with access to care and care coordination.

Integrated Care Demonstrations

The ACA also includes numerous authorities for states to start, expand, and extend demonstrations, pilots, and waivers aimed at integrating both care for duals and financing between Medicare and Medicaid. For example, the ACA created the authority for the Financial Alignment Initiative, which allows states to administer demonstration projects to improve the integration and coordination of care and services for duals, ensuring beneficiaries are actively involved in their care planning and that care is person-centered.[53] Through this new ACA authority, thirteen states[54] have engaged in demonstrations, achieving measurable improvements in outcomes and care coordination.[55] Demonstration enrollees have experienced lower nursing facility and hospital admissions and long-term nursing facility stays,[56] as well as cost savings.[57] Enrollees also report high rates of satisfaction with access to care and care coordination.[58]

The demonstrations are still testing models and contributing valuable learning to improve care and service delivery, not only for duals but across our health care system.[59] Many of the programs that older adults and their families rely on, such as adult day care centers, are integrated into these models.

MEDICARE IMPROVEMENTS

While Medicare provides health coverage to the vast majority of seniors age 65 and older, it has gaps and can require

52 *See* Ctrs. For Medicare & Medicaid Servs., *Qualified Medicare Beneficiary (QMB) Program*, cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html (last modified May 29, 2019).

53 *See* Letter from Centers for Medicare & Medicaid Services Administrator to State Medicaid Directors 2-4 (Apr. 24, 2019), medicaid.gov/federal-policy-guidance/downloads/smd19002.pdf [hereinafter MMCO Letter] (reporting that Financial Alignment Initiative enrollees gave high ratings to the integrated plans and that states achieved an average of 4.4% savings).

54 These states are: California, Colorado, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, Virginia, and Washington. Ctrs. For Medicare & Medicaid Servs., *Financial Alignment Initiative (FAI)*, cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html (last modified May 29, 2019).

55 CMS Medicare-Medicaid Coordination Office, *Medicare-Medicaid Financial Alignment Initiative Care Coordination Data Snapshot for the Capitated Model*, cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CapitatedModelCareCoordinationDataSnapshot_05092018.pdf (last visited June 10, 2019).

56 *E.g.*, RTI International, *Financial Alignment Initiative MyCare Ohio: First Evaluation Report,* Table ES-1 (2018), innovation.cms.gov/Files/reports/fai-oh-firstevalrpt.pdf; RTI International, *Financial Alignment Initiative Washington Health Homes MFFS Demonstration: Second Evaluation Report,* 29 (2018), innovation.cms.gov/Files/reports/fai-wa-secondevalrpt.pdf.

57 *Id.* at 15.

58 Ctrs. For Medicare & Medicaid Servs., *Enrollee Experiences in the Medicare-Medicaid Financial Alignment Initiative: Results through the 2017 CAHPS Surveys,* 5, 16 (2017), cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FAICAHPSResultsDec2017.pdf.

59 In fact, the Centers for Medicare & Medicaid Services (CMS) has shown interest in continuing these innovative projects and is actively seeking proposals from states to test better approaches to integration. In addition, CMS has expressed openness to testing new approaches to improve integrated care for duals. MMCO Letter, *supra* note 53, at 6.

significant cost-sharing. The ACA implemented several reforms that help reduce those costs that can strain low and middle-income seniors' budgets and even prevent access.[60] For example, the ACA **eliminated beneficiary cost-sharing for preventive services such as mammograms, pap smears, bone mass measurement for those with osteoporosis, depression screening, diabetes screening, HIV screening, obesity screening and counseling, and annual wellness visits.**[61]

The ACA also **expanded funding for State Health Insurance Assistance Programs** (SHIPs), which educate and assist Medicare-eligible adults in making informed decisions about their health insurance and access the benefits to which they are entitled.[62] SHIPs play an especially important role in raising awareness and enrolling low-income seniors in the Medicare Savings Programs and Part D Extra Help.

Part D Prescription Drug Coverage

The ACA also made several important improvements to prescription drug coverage for seniors:

- The ACA was instrumental in **closing the Medicare Part D "donut hole".** Part D was originally designed so that after incurring a certain amount of costs each year, Part D enrollees effectively lost coverage (though they continued to pay premiums) until their out-of-pocket spending hit the so-called "catastrophic threshold" at which point coverage kicked back in.[63] Although beneficiaries eligible for the Low-Income Subsidy do not face a coverage gap, more than five million Part D enrollees reached the "donut hole" in 2016.[64] The ACA created a plan to gradually reduce and close the donut hole.[65] This plan is responsible for saving nearly 12 million Medicare beneficiaries almost $27 billion on out-of-pocket prescription drug costs.[66]
- The ACA changed the Part D true out-of-pocket (TrOOP) cost calculation to include costs incurred by the AIDS Drug Assistance Program and the Indian Health Service. Because TrOOP is used to determine whether an individual is in the donut hole, including these costs helps **beneficiaries with high prescription drug needs move through the donut hole more quickly**.[67]
- The ACA further shields the **six protected classes of drugs** by requiring all Part D plans to cover all drugs in each of the classes and the classes to remain in place until CMS establishes criteria for editing the list.[68]

60 *See, e.g.,* Sukyung Chung et al., *Medicare Annual Preventive Care Visits: Use Increased among Fee-For-Service Patients, But Many Do Not Participate*, Health Affairs (Jan. 2015), healthaffairs.org/doi/full/10.1377/hlthaff.2014.0483.

61 42 U.S.C. §1395l(a)(1)(T).

62 Administration for Community Living, *State Health Insurance Assistance Program (SHIP)*, acl.gov/programs/connecting-people-services/state-health-insurance-assistance-program-ship (last modified Apr. 25, 2019).

63 Low income Subsidy (LIS) recipients are not subject to the coverage gap.

64 Juliette Cubanski et al., *Closing the Medicare Part D Coverage Gap: Trends, Recent Changes, and What's Ahead*, (Aug. 21, 2018), kff.org/medicare/issue-brief/closing-the-medicare-part-d-coverage-gap-trends-recent-changes-and-whats-ahead/. This number has increased from 3.8 million in 2007. *Id.*

65 The donut hole is considered closed once the cost to Part D enrollees is twenty-five percent of prescription drugs' cost. Dena Bunis, *Medicare 'Doughnut Hole' Will Close in 2019*, AARP (Feb. 9, 2018), aarp.org/health/medicare-insurance/info-2018/part-d-donut-hole-closes-fd.html. A 2018 budget deal moved the plan up by one year, setting the donut hole to close in 2019. *Id.* The donut hole closed in 2019, a year earlier than the ACA planned due to the Bipartisan Budget Act of 2018. Justice in Aging, *Health Care Provisions in the Bipartisan Budget Act of 2018,* 1 (2018), justiceinaging.org/wp-content/uploads/2018/02/Health-Care-Provisions-in-the-Bipartisan-Budget-Act-of-2018.pdf.

66 CMS, Nearly 12 million people with Medicare have saved over $26 billion on prescription drugs since 2010 (Jan. 13, 2017), cms.gov/newsroom/fact-sheets/health-care-fraud-and-abuse-control-program-protects-consumers-and-taxpayers-combating-health-care

67 42 U.S.C. 1395w-102(b)(4)(C)(iii).

68 These protected drugs are: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics. Kaiser Family Foundation, *An Overview of the Medicare Part D Prescription Drug Benefit,* 3 (2018), kff.org/medicare/fact-sheet/an-

- The ACA improved CMS's system for **tracking and responding to complaints** against Part D and Medicare Advantage plans. In addition to the existing complaint mechanism, which permits beneficiaries to file their complaints through 1-800-MEDICARE, regional Medicare offices, and the Ombudsman's office, the ACA required CMS to create and post an electronic complaint form online.[69]

Extra Help Improvements

When Part D was added to Medicare, the Low-Income Subsidy (LIS or Extra Help) was created to cover premiums and lower cost-sharing for low-income Medicare beneficiaries, including those who are dually enrolled in Medicaid.[70] The ACA improved LIS coverage by:

- Extending the **LIS $0 copay on all Part D drugs to individuals receiving Medicaid home- and community-based services (HCBS)**.[71] Since the Part D program was created, dually eligible individuals residing in nursing facilities and other institutional settings have not had to pay any cost-sharing for Part D drugs. However, prior to the ACA, dually eligible individuals receiving HCBS did not have this same protection. The ACA eliminated cost-sharing for Part D drugs for duals who require an institutional level of care but receive HCBS.[72]
- **Extending LIS eligibility for an individual whose spouse dies** by one year if their death would decrease or eliminate the subsidy.[73]
- Requiring that the notices CMS sends to LIS recipients who are part of the annual reassignment process include **information about the formulary differences between the new and old plan**, and a description of the beneficiaries' right to request a coverage determination and file an appeal to get access to needed drugs.[74]
- **Increasing the number of $0 premium (or benchmark) Part D plans** available to LIS enrollees by excluding plan rebates from the "benchmark" calculation and permitting plans with premiums that are above the benchmark by an insignificant amount to waive their premiums for LIS recipients.[75]

ADDED PROTECTIONS FOR SENIORS IN NURSING FACILITIES

The ACA was the first comprehensive piece of legislation since 1987 to expand quality of care requirements for publicly funded nursing facilities.[76] Its regulations responded to rampant reports of poor health and safety

overview-of-the-medicare-part-d-prescription-drug-benefit/.

69 *See* Medicare Complaint Form, medicare.gov/MedicareComplaintForm/home.aspx (last visited Jul. 2, 2019).

70 Social Security Administration, Program Operations Manual System HI 03001.005.

71 42 U.S.C. 1395w-114 (a)(1)(D); 42 CFR 423.782(a)(2)(ii); *see also* Nat'l Senior Citizens L. Ctr., *Information for Advocates: No Part D Copayments for Dual Eligibles Receiving Medicaid HCBS Services*, arcflorida.org/wp-content/documents/Dual%20Eligibles%20do%20not%20have%20co-pays.pdf (last visited June 19, 2019).

72 Kaiser Family foundation, *Affordable Care Act Provisions Relating to the Care of Dually Eligible Medicare and Medicaid Beneficiaries 1 (2011)*, kff.org/wp-content/uploads/2013/01/8192.pdf.

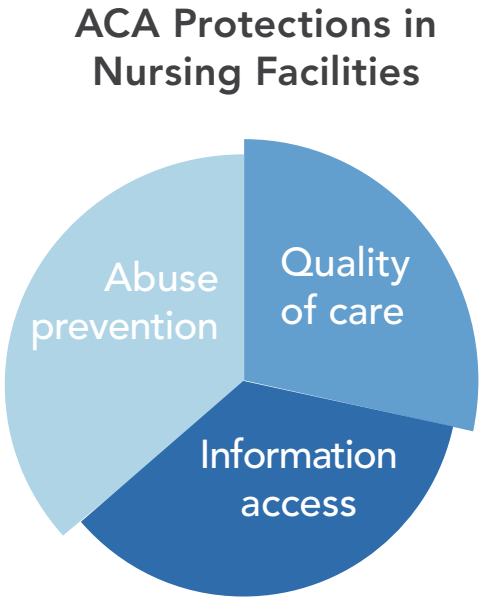
73 20 C.F.R. § 418.3123(e).

74 42 U.S.C. 1395w-114(d). These reassignment notices are sometimes the "blue notices" because they are printed on blue paper.

75 *See* 42 CFR § 423.780(b)(ii); 42 CFR § 423.780(f).

76 Kaiser Family Foundation, *Implementation of Affordable Care Act Provisions to Improve Nursing Home Transparency, and Abuse Prevention,* 3 (2013), kff.org/wp-content/uploads/2013/02/8406.pdf.

protections for nursing facility residents.[77] The ACA sought to remedy these problems by increasing transparency and improving the quality of care at nursing facilities.



Information Access

Through the Nursing Home Transparency and Improvement Act, the ACA improves accountability and ensures the safety of residents by expanding access to facilities' information. It requires facilities to disclose ownership and management information,[78] and submit information about the staff that works directly with the residents (direct patient staff).[79] It also requires states to develop standardized complaint forms and a complaint resolution process that ensures that a resident's representative is not denied access to the resident or retaliated against by the facility.[80]

Quality of Care

The ACA established quality assurance and performance improvement programs,[81] as well as compliance and ethics programs.[82] The compliance and ethics programs require nursing facilities to implement auditing systems designed to detect criminal, civil, and administrative violations by nursing facility employees.[83]

The law also spurred ongoing efforts to have more accurate and reliable data—both to inform consumers, as well as to provide greater insight into the relationship amongst staffing, quality of care, and outcomes.[84] For example, CMS uses staffing measures to calculate each nursing facility's rating as part of its "Five Star Quality Rating System."[85] Before the ACA, CMS relied on facilities' self-reported (and often inaccurate) staffing information. After CMS required facilities to submit payroll-based information, data from the third quarter of 2017 showed that "approximately 6% of facilities that submitted complete data had seven or more days where no hours for RNs [registered nurses] were reported," despite the fact that the 1987 Nursing Home Reform Law requires that a registered nurse be on site at least eight hours per day, seven days per week.[86] Given the established link between RN presence and the health and safety of residents, CMS announced that it would downgrade a facility's rating in the nurse staffing measure to one star if a facility failed to have the required RN coverage.[87] In addition to greater scrutiny of staffing levels, the ACA's effectiveness in acquiring more accurate staffing information has led to legislative proposals to improve nursing facility staff levels. Consumers and others now have a clearer picture of the ramifications of staffing levels on residents' health because of the ACA.

77 *Id.*
78 42 U.S.C. § 1320a-3 (2012).
79 42 U.S.C. § 1320a-7j(g).
80 42 U.S.C. § 1320a-7j(f).
81 42 U.S.C. § 1320a-7j(c).
82 42 U.S.C. § 1320a-7j(b).
83 42 U.S.C. § 1320a-7j (b)(4)(E).
84 Ctrs. for Medicare & Medicaid Servs., "Transition to Payroll-Based Journal (PBJ) Staffing Measures on the Nursing Home Compare tool on Medicare.gov and the Five Star Quality Rating System," QSO-18-17-NH, at 1 (Apr. 6, 2018), cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO18-17-NH.pdf.
85 *Id.* at 1-2.
86 *Id.* at 4.
87 *Id.*

Abuse Prevention

The Nursing Home Transparency and Improvement Act established a program for nursing facilities to conduct background checks on direct patient staff.[88] CMS has awarded over $64 million to twenty-six states under National Background Check Program.[89]

PROTECTING SENIORS' RIGHTS AND WELFARE

Nondiscrimination Protections

The ACA's Section 1557, also known as the Health Care Rights Law, provides landmark nondiscrimination protections in health programs or activities based on race, ethnicity, age, sex, and disability.[90] It is a powerful tool to address health disparities, including among older adults enrolled in Medicare, Medicaid, or private health insurance.

Section 1557 affords older adults valuable protections unique to the ACA, such as protection against intersectional discrimination (on the basis of multiple protected classes) in the provision of healthcare.[91] It also gives individuals a new avenue to enforce their rights by filing an administrative complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

Through implementing regulations, HHS established explicit protections from discrimination based on gender identity and sex stereotyping.[92] This means insurers and state Medicaid programs cannot limit or deny medically necessary services related to gender transition.[93] Since the ACA was enacted, the number of state Medicaid programs and private health plans that explicitly cover gender affirming care has increased, although many are still violating federal law.[94]

Section 1557 and its implementing regulations also require that services, facilities, and health information be fully accessible for persons with disabilities and persons with limited English proficiency—including Medicare beneficiaries, nearly eight million of whom are deaf or hard of hearing, four million of whom have blindness or low vision, and four million of whom are limited English proficient.[95]

The regulations prohibit health plans from designing their benefit structures in a way that discriminates or discourages enrollment by individuals in a protected class, such as placing all medications to treat a specific

88 42 U.S.C. § 1320a-7I (a).

89 *CMS National Background Check* Program, Ctrs. For Medicare & Medicaid Servs., cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/BackgroundCheck.html (last modified June 5, 2018). For a breakdown of the amounts awarded and the time of the award, *see* cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/NBCP-State-Award-Chart.pdf.

90 42 U.S.C. § 18116.

91 81 Fed. Reg. 31405.

92 45 C.F.R. § 92.4.

93 Georgia Burke and Denny Chan, Justice in Aging, *Section 1557*: *Strengthening Civil Rights Protections in Health Care* (Jan. 2017), justiceinaging.org/wp-content/uploads/2017/01/Section-1557_Strengthening-Civil-Rights-Protections-in-Health-Care.pdf

94 *See* Movement Advancement Project, *Healthcare Laws and Policies: Medicaid Coverage for Transition-Related Care* (Apr. 2019), lgbtmap.org/img/maps/citations-medicaid.pdf.

95 CMS Office of Minority Health, *Understanding Communication and Language Needs of Medicare Beneficiaries,* 8, 10 (2017), cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.

condition in the highest cost sharing tiers or applying age limits to services that have been found clinically effective at all ages.[96]

Section 1557 is facing another threat in addition to the *Texas v. U.S.* case. In June 2019, the Trump Administration issued a proposed rule that would extensively revise the 2016 regulations implementing Section 1557. In particular, the Administration is proposing to eliminate definitions and requirements and narrow the applicability of the rules in ways that would severely undermine the rights of LGBTQ individuals and individuals with limited English proficiency as well as limit the ways victims of discrimination can seek redress.

Elder Abuse Protections

The Elder Justice Act[97] was passed as part of the ACA and is the first comprehensive federal law fighting elder abuse, neglect, and exploitation. Its sweeping provisions include: funding for adult protective services; establishment of forensic centers focused on elder abuse, neglect, and exploitation; grants for Long-Term Care Ombudsman Programs; grants to enhance long-term care; and mandatory reporting for crimes committed in federally funded long-term care facilities and state demonstration grants for testing methods for detecting and preventing elder abuse. The Elder Abuse Prevention Interventions Program has provided states and their partners grants to test community-based elder abuse prevention practices.[98] For example, in Texas, one grantee received funds to explore the use of a screening tool to identify at-risk elders in clinical care settings, while another grantee received funds to address medication adherence in older adults who may neglect themselves.[99]

Moreover, the ACA increased and extended funding for Area Agencies on Aging and Aging and Disability Resource Centers, both of which administer elder abuse prevention programs.[100]

CONCLUSION

As described above, the ACA included many momentous provisions that improved access, decreased costs, and increased quality of coverage, care, and services across the health care system for older adults. In addition to expanding Medicaid and creating many new coverage options, the law also accomplished countless little known, yet important reforms that improve the health and well-being of older adults. After 10 years, we can see that the ACA is woven deeply into every health care program on which older adults rely. It has become part of the foundation that we must strengthen and continue to build on in working towards Justice in Aging.

96 81 Fed. Reg. 31434.
97 42 U.S.C. § 1305 *et seq*.
98 Administration for Community Living, *Elder Abuse Prevention Intervention Demonstrations* (Apr. 14, 2017), acl.gov/programs/elder-justice/elder-abuse-prevention-intervention-demonstrations.
99 *Id.*
100 Administration for Community Living, *Prevention of Elder Abuse Neglect, and Exploitation*, acl.gov/programs/elder-justice/prevention-elder-abuse-neglect-and-exploitation (last modified Jan. 31, 2019) (noting that states have discretion in allocating funds to Area Agencies on Aging for abuse prevention programs).