Nos. 11-393 & 11-400

In The Supreme Court of the United States

NATIONAL FEDERATION OF INDEPENDENT BUSINESS ET AL., *Petitioners*,
v.
KATHLEEN SEBELIUS ET AL., *Respondents*.

STATE OF FLORIDA ET AL., *Petitioners,*
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES ET AL., *Respondents.*

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF OF *AMICI CURIAE* AARP, CENTER FOR MEDICARE ADVOCACY, INC., MEDICARE RIGHTS CENTER, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE, NATIONAL COUNCIL ON AGING, AND NATIONAL SENIOR CITIZENS LAW CENTER IN SUPPORT OF RESPONDENTS ON SEVERABILITY

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STATEMENTS OF INTEREST[1]

AARP is a nonpartisan, nonprofit organization dedicated to addressing the needs and interests of people aged 50 and older. Since its founding in 1958, AARP has advocated for affordable, accessible health care, as well as improved quality of care and controlled health care costs. In response to the growing number of older people forgoing health care services and facing financial ruin because of health care and insurance becoming increasingly unaffordable and unavailable, AARP sought legislative solutions that would protect Medicare benefits; reduce insurance rate disparities based on age or pre-existing conditions; reduce the rate of health care cost increases, including for prescription drugs; and eliminate waste, fraud, and abuse. When Congress was debating health reform legislation, AARP's advocacy focused on six key priorities: (1) Guaranteeing access to affordable coverage in the individual market for Americans ages 50 to 64 with pre-existing and chronic conditions; (2) Closing the Medicare Part D prescription drug coverage gap ("donut hole"); (3) Lowering drug costs by increasing availability of generic biologics; (4) Reducing costly hospital readmissions through a Medicare Transitional Care

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amici* represent that no counsel for a party authored this brief in whole or in part and that none of the parties or their counsel, nor any other person or entity other than *amici*, their members or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented to the filing of *amicus* briefs and have filed letters reflecting their blanket consent with the Clerk.

Benefit; (5) Increasing funding and eligibility for home-and community-based services for people with chronic conditions; and (6) Helping low-income Americans afford premiums and out-of-pocket health costs.

The **Center for Medicare Advocacy, Inc.** provides information, education, and representation to older people and people with disabilities regarding fair access to Medicare and health care. The Center's work involves responding to over 7,000 calls and e-mails annually, producing educational materials, pursuing Medicare coverage for beneficiaries, and engaging in litigation of national significance − with a particular emphasis on issues of import to people with low incomes and long-term conditions. The Center has a substantial interest and expertise in ensuring that due process and access to necessary health care are available to people with Medicare, Medicaid, and disabilities.

The **Medicare Rights Center** is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through direct counseling and advocacy, educational programs and public policy initiatives. Since 1989, Medicare Rights has been helping people with Medicare understand their benefits, navigate the health care system and secure the health care to which they are entitled. Medicare Rights connects real beneficiary experiences to education and policy advocacy — making sure that people with Medicare and their families understand coverage rules and policies, all

the while pursuing reforms to systemically improve the Medicare program as a whole. The Medicare Rights Center stresses the importance of Medicare reforms included in the Affordable Care Act and the potential implications the Court's decision could have on access to and the affordability of quality health care for this population.

The **National Committee to Preserve Social Security and Medicare** ("NCPSSM") is a nonprofit organization with more than 3 million members and supporters. Our 30 years of legislative advocacy, policy expertise and educational outreach have focused on the preservation, protection, and strengthening of programs and benefits that ensure access to adequate economic and health care security during retirement or disability. These include, but are not limited to, Social Security, Medicare, Medicaid, and the Older Americans Act. Through a national network of grassroots staff and volunteers, NCPSSM has helped millions of older Americans and their families understand their rights as beneficiaries. NCPSSM leverages its diverse resources to mobilize public support for the creation or defense of laws that protect seniors, the disabled, and their families.

The **National Council on Aging** ("NCOA") is a nonprofit service and advocacy organization that seeks to improve the lives of millions of older adults, especially those who are vulnerable and disadvantaged. NCOA coordinates with thousands of nonprofit organizations, businesses, and governments across the country to improve the

wellbeing of older individuals. NCOA strives to better the health of older adults by improving their access to government programs such as Medicare and Medicaid. Along with this, NCOA works hard to strengthen and protect these programs, so that more individuals receive the services that enable them to remain healthy and independent in their communities. The Court's holding will have an enormous impact on the quality and accessibility of healthcare services that are available under Medicare and Medicaid, and NCOA is accordingly concerned with the effects the Court's decision will have on the older population.

The **National Senior Citizens Law Center** ("NSCLC") is a non-profit organization that advocates nationwide to promote the independence and well-being of low-income older persons. NSCLC seeks to ensure that low-income older adults have access to high quality, affordable health care benefits from programs such as Medicare and Medicaid. NSCLC works to advance coordination of care and improve consumer protections for the nine million people who have both Medicare and Medicaid, commonly called "dual eligibles." NSCLC also seeks to expand the use of home and community based services as an alternative to nursing homes or other forms of institutionalization for low-income older adults. For 40 years, NSCLC has served low-income older persons through advocacy, litigation, and the education and counseling of local advocates nationwide. NSCLC's *Federal Rights Project* works to ensure that courts uphold rights provided and protected by federal laws. NSCLC is profoundly

concerned about the impact that the Court's decision may have on both the availability and the quality of care and services received by its clients under Medicare and Medicaid.

SUMMARY OF ARGUMENT

The Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), is designed to address numerous inadequacies in America's multifaceted health care system, in which individuals secure access to services and medicines primarily through insurance. Prior to the ACA's enactment, insurance was obtained predominantly via employer-sponsored health insurance, direct purchase of health insurance, Medicare, Medicaid, and/or military health benefits. The vast majority of people age 65 and older have Medicare coverage, but tens of millions of people under age 65 do not have any health insurance. Congress enacted the ACA to address this problem by, among other things, expanding access to affordable coverage for all Americans regardless of an individual's health condition, age, or gender.

Access to health insurance for people under age 65 was not the only goal of the ACA. There are extensive provisions in the ACA of vital importance to the health and well-being of people 65 and older. Nothing in the text or history of the ACA suggests that Congress wanted these significant changes to

health care for people 65 and older to be contingent on the constitutionality of the minimum coverage provision. To the contrary, these ACA provisions address long-recognized, deep-seated problems plaguing health care for people 65 and over, including cost-sharing that discouraged the use of prescription medications and preventive care, the lack of accountability for low-quality managed care plans, the high-cost of treating individuals with chronic illnesses, the unnecessary institutionalization of individuals needing long-term care services, and abuse and neglect in nursing homes.

There is no reason to believe Congress, in passing the ACA, wanted older people capable of receiving care in the community to languish in institutions or be subject to abuse and neglect if the minimum coverage provision was invalidated. Similarly, it is not credible to suggest Congress wanted the implementation of the ACA's requirement that brand-name drug companies contribute to the lowering of prescription drug costs for Medicare beneficiaries to hinge on the constitutionality of the minimum coverage provision.

This brief highlights parts of the ACA that greatly benefit people 65 and older and are not related to the minimum coverage provision. To begin with, the ACA reduces cost-sharing for Medicare beneficiaries by substantially reducing the coverage gap for prescription medications (commonly known as the "donut hole"), eliminating cost-sharing for preventive services such as an annual wellness

visit and numerous screening services, and prohibiting Medicare Advantage plans from charging higher cost-sharing for chemotherapy and dialysis than permitted under traditional Medicare. These reductions in cost-sharing improve access to specific services under Medicare, of tremendous value to beneficiaries, but have no impact on expanding insurance coverage for uninsured individuals. The ACA further improves the quality of care for Medicare beneficiaries by providing higher bonus payments for Medicare Advantage plans that achieve high ratings for quality, requiring Special Needs Plans to meet quality standards, and limiting Medicare Advantage plan spending on administrative expenses. In addition, Medicare beneficiaries with chronic conditions benefit from several ACA initiatives that target improved and affordable care for this high-cost and high need insured population.

Moreover, the ACA decreases the unnecessary institutionalization of Medicaid beneficiaries by providing financial incentives to states to shift their spending away from institutional care, moving beneficiaries out of nursing homes and back into the community. Likewise, the ACA contains provisions designed to prevent individuals who need long-term care from being institutionalized by improving services in the community. The ACA improves the quality of life for individuals already receiving Medicaid coverage in institutions, allowing them to receive appropriate care in a less restrictive environment for a lower cost.

The ACA also improves the coordination of care for people receiving both Medicare and Medicaid, who have not one, but two forms of government-sponsored health insurance.

Finally, the ACA improves quality and safety in nursing facilities and prevents abuse and neglect of elderly and disabled individuals in nursing and other residential care facilities.

ARGUMENT

Petitioners contend that all of the ACA should fall if the minimum coverage provision, 26 U.S.C. § 5000A (Supp. 2010), is invalidated. State Petitioners Br. on Severability, at 51-59. This argument ignores Congress' clear intent to pursue numerous independent objectives through the ACA. If this Court holds that the individual mandate is not constitutional,[2] all unrelated provisions of the ACA should be left "in force." *Ayotte v. Planned Parenthood of N. New Eng.,* 546 U.S. 320, 328-29 (2006). While the Eleventh Circuit's Appendix supplied a cursory list of provisions in the ACA unrelated to the minimum coverage provision, *Florida ex rel. Att'y Gen. v. U.S. Dep't of Health and Human Servs.*, 648 F.3d 1235, 1365-71 (11th Cir. 2011), *cert. granted*, 132 S. Ct. 604 (2011), this *amicus* brief provides a detailed explanation of many

[2] Many of the *amici* joining this brief regarding severability have submitted separate amicus briefs to this Court supporting the constitutionality of the minimum coverage provision. This brief does not address the constitutionality of the minimum coverage provision.

ACA provisions that are of great importance to persons age 65 and over. These include improvements in the quality of coverage provided to people already insured by Medicare and Medicaid, improvements to conditions and safety for older and disabled individuals who reside in nursing homes or receive care at home, and protection of the elderly from abuse and neglect.

A careful review demonstrates that the "policies Congress sought to advance by enacting" these provisions affecting people age 65 and older can be effectuated without any reliance on the minimum coverage provision. *See Regan v. Time, Inc.,* 468 U.S. 641, 653 (1984). These provisions are "fully operative" regardless of the fate of the minimum coverage provision. *See Alaska Airlines Inc. v. Brock,* 480 U.S. 678, 684 (1987) (quoting *Buckley v. Valeo*, 424 U.S. 1, 108 (1976)) (internal quotation marks omitted).

This *amicus* brief is submitted in support of Respondents' position that only the pre-existing conditions provision, 42 U.S.C. § 300gg-3 (Supp. 2010), the community rating provision, § 300gg, and the guaranteed issue provision, § 300gg-1, are dependent upon the minimum coverage provision. The rest of the ACA, including, but in no way limited to the provisions highlighted in this *amicus* brief, should remain intact. There is no basis in the "statute's text or historical context" for concluding that "Congress, faced with" the invalidation of the minimum coverage provision, "would have preferred" not to improve the quality of Medicare, Medicaid,

and nursing homes. *See Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010) (citing *Alaska Airlines, Inc*, 480 U.S. at 684).

I. Congress' Goal Of Improving The Quality Of Medicare And Medicaid For Already Insured People Aged 65 And Over Is Wholly Unrelated To Efforts To Decrease The Number Of Uninsured Individuals Under Age 65

The vast majority of Americans aged 65 and older received their health insurance coverage through Medicare prior to the passage of the ACA. In 2010, 98% of people 65 and older had health insurance coverage and 95% of those were covered by Medicare. Ke Bin Wu, AARP Pub. Policy Inst., *Income, Poverty, and Health Insurance Coverage of Older Americans, 2010* at 8-9 (2011), *available at* http://www.aarp.org/content/dam/aarp/research/public_policy_institute/econ_sec/2011/fs232v2.pdf. Only 3.6% of insured individuals under age 65 had Medicare. *Id*. at 10 fig.12.

Medicare Part A covers inpatient care in hospitals, skilled nursing facility care, hospice care, and home health care. Medicare Part B covers doctors' care, including preventive health services, as well as outpatient care, durable medical equipment, and home health care. Medicare Part C covers the same services as Parts A and B, but the insurance is provided by private insurance companies, known as Medicare Advantage Plans. Part C covers managed

care, such as health maintenance organizations. Medicare Part D covers prescription drugs. *See* Ctrs. for Medicare & Medicaid Servs., *Medicare and You, 2012*, at 14 (2011), *available at* http://www.medicare.gov/publications/pubs/pdf/10050.pdf.

Low-income older persons who need long-term care services, which are often not covered by Medicare, may obtain additional government-sponsored health insurance through Medicaid. Kaiser Comm'n on Medicaid & Uninsured, *Medicaid and Long-Term Care Services and Supports* 1 (2011), *available at* http://www.kff.org/medicaid/upload/2186-08.pdf. Long-term care services are extremely expensive, with an average yearly cost of $72,000 for nursing home care and an average hourly rate of $21 per hour for home health services. *Id*. Medicaid provides a long-term care services safety net, either in nursing homes or in the community, for those who become impoverished by high medical bills. *Id*. at 1-2. For persons with health insurance age 65 and older, 8.8% had Medicaid coverage. Ke Bin Wu, *supra*, at 9.

In 2010, people 65 years of age and older comprised 12.8% of the total population but only 2% of the uninsured.[3] Carmen Denavas-Walt et al., U.S. Census Bureau, *Income, Poverty, and Health*

[3] Just under half of the elderly individuals without health insurance are not United States citizens, and half of those individuals had not been in the United States for five years. James W. Mold, et al., *Who are the Uninsured Elderly in the United States?*, J. of American Geriatrics Society, Vol. 52, Issue 4, at 603 (2004). Medicare has citizenship and residency requirements. *See Medicare and You, 2012*, at 28.

Insurance Coverage in the United States: 2010, at 27 tbl.8 (2011), *available at* http://www.census.gov/prod/2011pubs/p60-239.pdf; *USA QuickFacts*, U.S. Census Bureau, http://quickfacts.census.gov/qfd/states/00000.html (last updated Dec. 23, 2011). The lack of uninsured individuals over 65 demonstrates that the efforts to decrease the number of uninsured through the minimum coverage provision were not directed at elderly people.

The minimum-coverage provision is an important component of Congress' efforts to reduce the number of uninsured individuals, 42 U.S.C. § 18091(a)(2)(C)-(D) (Supp. 2010), but that goal is inapplicable to older individuals who were already covered under government-sponsored health insurance. The minimum coverage provision does not affect the quality of health insurance offered under Medicare and Medicaid. *See id.* Therefore, Congress did not intend for the ACA's improvements to those programs to be contingent on the validity of the minimum coverage provision.

Similarly, the minimum coverage provision is crucial for preventing the denial of insurance to people with pre-existing conditions, *see* 42 U.S.C. § 18091(a)(2)(I), but Medicare and Medicaid have never denied coverage for pre-existing conditions. Thus, neither the ACA's minimum coverage provision nor the ban on exclusions for pre-existing conditions in private and employer-sponsored health insurance will alter coverage for people age 65 and older under Medicare and Medicaid.

Instead, insurance coverage for persons 65 and over was improved by wholly unrelated provisions in the ACA, which make substantial changes to the quality of Medicare and Medicaid coverage by enhancing access to specific medical services and products and promoting innovation in the development of targeted services. As discussed below, these changes include reducing Medicare beneficiary cost-sharing to improve access to prescription medications and preventive care; rewarding Medicare managed care organizations for providing high-quality care; facilitating the development of model programs to improve the quality of care for Medicare beneficiaries with chronic conditions; encouraging states to provide Medicaid coverage for long-term care services in the community rather than in institutions; and improving coordination of care for individuals who have both Medicare and Medicaid.

The above-described improvements in the quality of care provided under government sponsored health insurance programs are fully functional, with or without the minimum coverage provision, and hence entirely severable from that provision.

II. The ACA's Reductions Of Cost-Sharing For Medicare Beneficiaries Are Fully Operative Regardless Of The Constitutionality Of The Minimum Coverage Provision

The ACA made significant reductions to the amounts Medicare beneficiaries must pay in co-insurance, thus improving access to specific health services and reducing the financial burden on older persons to obtain these services. Research shows that older people and those with chronic illness may experience more negative health outcomes from cost-sharing than younger, healthier individuals. *See* Sarah Goodell & Katherine Swartz, Robert Wood Johnson Found., *Cost Sharing: Effects on Spending and Outcomes* 3 (2010), *available at* http://www.rwjf.org/files/research/121710.policysynthesis.costsharing.brief.pdf. Congress' reduction of Medicare cost-sharing, targeted to the older population, is not dependent on its efforts to increase health insurance coverage for younger persons. Moreover, because some costs are picked up by drug manufacturers and managed care insurers, these substantive changes in Medicare law cannot be linked to the "delicate fiscal balance" that Petitioners claim was at the "core" of every ACA provision. *See* State Petitioners Br. on Severability, at 53.

A. Access to Prescription Medications is Improved by the ACA's Reduction of the Medicare "Donut Hole"

The Medicare Part D prescription medication benefit contains a coverage gap, commonly known as the Part D "donut hole." Part D covers the cost of medications up to an initial coverage limit, but then leaves the enrollee without coverage until the enrollee has spent enough on drugs to reach the catastrophic coverage threshold. When in the donut hole, the enrollee must pay out-of-pocket for the entire cost of medications. In 2010, a consumer had to pay $3,610 to get out of the donut hole. Leigh Purvis, AARP Pub. Policy Inst., Health Care Reform Legislation Closes the Medicare Part D Coverage Gap 1 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs182-doughnut-hole-reform.pdf. Approximately one-quarter of Medicare Part D beneficiaries who utilize Medicare to pay for prescription drugs fell into the donut hole, exceeding the initial coverage limit for prescription medications. *See* Jack Hoadley et al., Henry J. Kaiser Family Found., *The Medicare Part D Coverage Gap: Costs and Consequences in 2007*, at ii (2008), *available at* http://www.kff.org/medicare/upload/7811.pdf. Research demonstrates that Medicare beneficiaries reduce their purchases of prescribed medications in anticipation of reaching the donut hole and then cut their purchases of prescription drugs by 14% after they enter the donut hole, raising concerns about an increased risk of more costly hospitalization and physician services.

Yuting Zhang et al., *The Effects of the Coverage Gap on Drug Spending: A Closer Look at Medicare Part D*, 28 Health Affairs w317, w322 (2009), *available at* http://www.pitt.edu/~ytzhang/zhang_healthaffairs2009.pdf.

The ACA substantially reduces the donut hole, thereby improving access to prescription drugs for Medicare enrollees. By 2020, Part D enrollees will be responsible for only 25% of donut hole prescription drug costs. Purvis, *supra*, at 2. Rather than relying entirely on government expenditures, the ACA requires drug manufacturers to reduce prices for Medicare enrollees in the donut hole. Beginning in 2011, brand-name drug manufacturers must provide a 50% discount on brand-name and biologic drugs for Part D enrollees in the donut hole. *Id.* at 2. Starting in 2013, the Medicare program will begin providing an additional discount on brand-name and biologic drugs for enrollees who are in the donut hole, starting at 2.5% and gradually increasing until it reaches 25% in 2020. 42 U.S.C. § 1395w-102(b)(2)(D)(ii) (Supp. 2010); *see also id.* The Medicare program started picking up a greater share of costs for generic drugs in 2011, gradually increasing until in 2020, the beneficiary receives a 75% discount. 42 U.S.C. § 1395w-102(b)(2)(C)(ii). Thus, by 2020, for both brand-name and generic drugs, enrollees will be responsible for only 25% of the costs they previously had to cover in full.

Moreover, the donut hole as originally enacted was slated to increase the out-of-pocket threshold—the point at which enrollees enter catastrophic

coverage—over time, but the ACA changes that as well. Between 2014 and 2019, the ACA adjusts the indexing of the out-of-pocket threshold to help slow its growth. 42 U.S.C. § 1395w-102(b)(4)(B)(i).

The ACA's closing of the donut hole was the culmination of extensive efforts by Congress. Several bills had been previously introduced in Congress to remedy this gap in Medicare Part D coverage, demonstrating that Congress was committed to solving the problem of inadequate Medicare prescription drug coverage, regardless of the minimum coverage provision. The Medicare Part D Coverage Gap Elimination Act of 2006, S. 3764, 109th Cong. (2006), had the purpose of completely eliminating the donut hole. Likewise, the Medicare Prescription Drug Improvement Act, H.R. 1626, 109th Cong. (2005), would have eradicated the coverage gap. This important congressional goal is independent of the minimum coverage provision, and Congress sought the fulfillment of this goal, regardless of the constitutionality of the minimum coverage provision.

B. Access to Preventive Health Services is Improved by the ACA's Reduction of Cost-Sharing for Medicare Beneficiaries

Prior to the passage of the ACA, for many preventive health services, Medicare Part B required the beneficiary to pay a deductible and 20% co-insurance. In 2011, the Part B deductible was $162. Ctrs. for Medicare & Medicaid Servs., *Your Guide to*

Medicare's Preventive Services 7 (2011) [hereinafter *Services Guide*], *available at* http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf. The ACA eliminated cost-sharing for many preventive-care services, including an annual wellness visit during which beneficiaries receive a comprehensive health risk assessment and health care providers take vital signs and basic body measurements to inform a plan for preventive and screening services. 42 U.S.C. § 1395x(s)(2)(FF), (hhh) (Supp. 2010); *see also* Lynda Flowers, AARP Pub. Policy Inst., *Improvements to Medicare's Preventive Services Under Health Reform* 1-2 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs180-preventive.pdf. The ACA also eliminated cost-sharing for numerous screening services, such as mammograms, Pap smears, bone mass measurement for those with osteoporosis, depression screening, diabetes screening, HIV screening, and obesity screening and counseling. § 1395*l*(a)(1)(T); *see Services Guide*, *supra*; *see also* Nat'l Council on Aging, Nat'l Ctr. for Benefits Outreach & Enrollment, *Quick Reference Chart: Medicare's Preventive Benefits* 1-7 (2012), *available at* http://www.ncoa.org/assets/files/pdf/center-for-benefits/medicare-preventive-benefits-chart.pdf. Other preventive health services that no longer require cost-sharing include medical-nutrition therapy for people with diabetes and kidney disease and smoking-cessation counseling. *Id.*

The impact of cost-sharing may differ according to the patient's age and medical needs. A study of people (who are not poor) under age 62 found that some increased cost-sharing may not

adversely affect health outcomes; in contrast, studies of the elderly and chronically ill found that higher cost-sharing can lead to increased emergency-department services, hospitalizations, and nursing-home admissions. Katherine Swartz, Robert Wood Johnson Found., *Cost-sharing: Effects on Spending and Outcomes* 11-12 (2010), *available at* http://www.rwjf.org/files/research/121710.policysynthesis.costsharing.rpt.pdf; Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 Am. Econ. Rev. 193, 211 (2010), *available at* http://dspace.mit.edu/openaccess-disseminate/1721.1/61694; *see also* Amanda Cassidy, *Health Policy Brief: Preventive Services Without Cost Sharing*, Health Affairs (Dec. 28, 2010), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=37. The reduction of Medicare cost-sharing for preventive services improves the quality of health care obtained by persons over age 65, increasing access to preventive care to minimize more expensive and restrictive services such as hospitalizations and nursing-home admissions. Chandra, *supra*. This worthy goal of increasing the use of preventive care by Medicare beneficiaries is separate from the minimum coverage provision.

C. Access to Chemotherapy, Dialysis and Other Services is Improved by the Limitation of Cost-Sharing for Medicare Beneficiaries Participating in Medicare Advantage Plans

In contrast to the fixed deductible and co-payments of Part B, Medicare Part C allows greater flexibility for Medicare Advantage plans to impose cost-sharing. Managed care plans are encouraged to compete with one another for members by offering different cost-sharing options. The Medicare Payment Advisory Commission reported to Congress in December 2004 that for many services, most Medicare Advantage plans do not require higher cost-sharing than Part B's fee-for-service plan. Medicare Payment Advisory Comm'n, *Report to the Congress: Benefit Design and Cost Sharing in Medicare Advantage Plans* 1-2 (2004), *available at* http://www.medpac.gov/documents/Dec04_CostSharing.pdf. However, in recent years, some Medicare Advantage plans have significantly increased cost-sharing for specific services needed by less-healthy patients, including chemotherapy and renal dialysis. *Id*. at 1. For instance, some plans charge a 20% co-insurance for chemotherapy, which would cost approximately $5,600 for one year of treatment. *Id*. at 12. Plans that did not increase cost-sharing for these services complained that they were disadvantaged when sicker beneficiaries switched their enrollment out of the higher cost-sharing plans to the lower cost-sharing plans. *Id*. at 2. The Commission recommended "limitations on

disproportionate cost sharing for services that are less discretionary in nature." *Id*. at 40.

The ACA pursues this worthy goal of limiting exorbitant cost-sharing for specific services needed by less healthy Medicare beneficiaries in Medicare Advantage plans. The ACA prevents Medicare Advantage plans from imposing higher cost-sharing for chemotherapy and dialysis than permitted under Medicare Parts A and B. 42 U.S.C. § 1395w-22(a)(1)(B)(iii)-(iv). The prohibition on disproportionate cost sharing is totally unrelated to the minimum coverage provision. Since this ACA provision addresses competition among managed care plans, it has no overall impact on the costs of the Medicare program.

III. The ACA's Other Provisions Designed To Improve The Quality Of Health Care For Medicare And Medicaid Beneficiaries Do Not Depend Upon The Minimum Coverage Provision

In addition to provisions addressing cost-sharing, the ACA improves the quality of care for Medicare beneficiaries through multiple additional measures. The ACA targets Medicare Part C, rewarding high-quality care provided by Medicare Advantage plans, requiring Medicare Advantage Special Needs Plans to meet quality standards, and limiting spending on administrative expenses. In addition, the ACA establishes several new programs that explore means to best serve Medicare beneficiaries with chronic illnesses. The minimum

coverage provision does not impact these Medicare initiatives.

A. The ACA Contains Incentives and Requirements to Improve the Quality of Care in Medicare Advantage Plans

In 2010, 11.1 million people, comprising 24% of all Medicare beneficiaries, were enrolled in Medicare Advantage plans. Kaiser Family Found., Explaining Health Reform: Key Changes in the Medicare Advantage Program 1 ex.1 (2010), *available at* http://www.kff.org/healthreform/upload/8071.pdf. A large majority of beneficiaries in Medicare Advantage plans, 65%, were enrolled in a health maintenance organization ("HMO"). *Id.*

The ACA includes both financial rewards for high-quality plans and requirements designed to improve quality of care for all Medicare Advantage plans. Congress' goal of improving the quality of services provided by Medicare managed-care plans is wholly independent from the ACA's efforts to increase the number of uninsured individuals under age 65.

The Centers for Medicare and Medicaid Services ("CMS") created a quality-rating system for Medicare Advantage plans. Gretchen Jacobson, et al., Kaiser Family Found., *Reaching for the Stars: Quality Ratings of Medicare Advantage Plans*, 2011, at 1 (2011) [hereinafter *Reaching for the Stars*], *available at* http://www.kff.org/medicare/upload/

8151.pdf. The ACA establishes that the ratings will be used to award quality-based payments to Medicare Advantage plans starting in 2012. 42 U.S.C § 1395w-23(n)-(o) (Supp. 2010). Plans with the highest quality ratings qualify for bonus payments and in some counties are eligible for double bonuses. *Id.*, § 1395w-23(o). The bonuses must be used either to provide extra benefits or to lower premiums for enrollees. *Reaching for the Stars*, *supra*, at 2.

The ACA also targets improvement in the quality of care provided by Medicare Advantage plans for beneficiaries with special needs. Medicare Advantage Special Needs Plans ("SNPs") serve individuals who have certain serious chronic diseases and conditions; who have specialized needs, such as people dually eligible for Medicare and Medicaid; or who live in nursing facilities and other institutions. *Overview: Special Needs Plans*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/SpecialNeeds Plans (last modified July 5, 2011). While SNPs were created to improve the quality of care for people with complex health needs, the plans have had inadequate standards of care. Cmty. Catalyst, *Medicare Special Needs Plans: A Critical Need for Quality Standards of Care* 1 (2008), *available at* http://www.communitycatalyst.org/doc_store/publications/medicare_special_needs_plans_a_report.pdf ("[w]ithout quality standards tailored to the specific needs of the populations enrolled in SNPs, too many plans fail to offer a model of care that adequately addresses the difficulties

beneficiaries encounter in the current fragmented system.").

Starting in 2012, the ACA requires SNPs to be certified by the National Committee for Quality Assurance (NCQA) and meet standards promulgated by the federal government. § 1395w-28(f)(7). SNPs will be evaluated on, among other things, the plan's (1) specific target population; (2) measurable goals; (3) staffing structure and care-management goals; (4) care management for the most vulnerable subpopulations; and (5) performance and health-outcome measurements. *See id.* (5). The ACA's certification requirement will strengthen efforts to improve health outcomes for SNP beneficiaries, who tend to be Medicare's sickest and most vulnerable.

In another effort to improve care, the ACA limits the amount Medicare Advantage plans are allowed to spend on administrative expenses. Starting in 2014, plans must spend at least 85% of revenues from premiums on medical benefits or activities that improve quality. § 1395w-27(e)(4). If a plan fails to meet the required target for medical spending for three consecutive years, HHS will suspend new enrollment in the plan for one year. If a plan fails to meet the lower administrative costs for five years, the plan's Medicare contract will be terminated. Joyce Dubow, AARP Pub. Policy Inst., *How Health Reform Adjusts Medicare Advantage Payments and Rewards Quality of Care* 2 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs181-ma.pdf.

B. The ACA Creates Programs to Improve the Quality of Care for People Suffering With Chronic Conditions and Illnesses

Almost 95% of healthcare expenditure for persons 65 years of age and older is for the treatment of chronic illnesses. Ctrs. for Disease Control, Merck Inst. of Aging & Health, *The State of Aging and Health in America in 2004*, at 2 (2004), *available at* http://www.cdc.gov/aging/pdf/State_of_Aging_and_Health_in_America_2004.pdf. Three chronic diseases, heart disease, cancer, and stroke, accounted for 60% of the deaths of people age 65 and over in 2000. *Id.* at 1. Chronic illnesses are also responsible for years of pain, disability, loss of function, and loss of independence. *Id.* at 2. At least 80% of Americans age 65 and over have one chronic illness, and 50% have at least two chronic illnesses. *Id.*

The ACA has several provisions targeted to improving the quality of care for patients with chronic illness and reducing the costs to Medicare and Medicaid for serving these beneficiaries. These provisions promote innovation and improvement in the delivery of care to already insured individuals with chronic illnesses and are not in any way linked to the minimum coverage provision.

The Medicare Community-Based Care Transitions Program targets beneficiaries in traditional fee-for-service Medicare who are hospitalized and are at high risk for readmission

based on risk factors including chronic diseases, depression, and cognitive impairments. 42 U.S.C. § 1395b-1 note (Supp. 2010) (Community-Based Care Transitions Program). The program provides grants to hospitals, who work in collaboration with community-based organizations, to provide transitional care interventions, such as arranging post-discharge services, providing patient self-management support or caregiver support, or conducting medication management review. *Id.*; *see also* Keith D. Lind, AARP Pub. Policy Inst., *Health Reform Initiatives to Improve Care Coordination and Transitional Care for Chronic Conditions*, 1-3 (2011), *available at* http://assets.aarp.org/rgcenter/ppi/health-care/fs191-health-reform.pdf.

The Independence at Home program, a demonstration project created by the ACA, similarly targets Medicare beneficiaries who have chronic illnesses and have been hospitalized. 42 U.S.C. § 1395cc–5. This program pays physicians and nurse practitioners to provide primary care services in the home for up to 10,000 fee-for-service Medicare beneficiaries. *Id.* The Demonstration's goal is to improve overall quality of care and quality of life for patients served, while lowering health care costs by avoiding the need for care in institutional settings. Dep't of Health & Human Servs., *Fact Sheet, Independence at Home Demonstration* 1 (2011), *available at* https://www.cms.gov/DemoProjects EvalRpts/downloads/IAH_FactSheet.pdf.

In addition, the ACA establishes an Innovation Center within CMS that is tasked with

exploring how to improve delivery of health care to Medicare and Medicaid beneficiaries who suffer with chronic and multiple illnesses because they tend to be the sickest and most vulnerable beneficiaries and the most costly to treat. 42 U.S.C. § 1315a. The Innovation Center's goal is to explore new health care delivery and payment methods that will improve the quality of care for patients, the affordability of coverage and reduce costs to Medicare and Medicaid programs. *Center for Medicare and Medicaid Innovation*, Ctrs. for Medicare & Medicaid Servs., http://innovations.cms.gov (last visited Jan. 22, 2012).

IV. The ACA's Shifting Of Medicaid Long-Term Care Expenditures From Institutions To The Community Improves The Quality Of Life For Older Persons, Pursuing A Policy Unrelated To The Minimum Coverage Provision

Medicaid is "a cooperative federal-state program that provides federal funding for state medical services to the poor." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433 (2004). The federal government pays between 50% and 83% of the costs of Medicaid, varying across states according to factors such as state unemployment rates. Barbara S. Klees, Office of the Actuary, Ctrs. for Medicare & Medicaid Servs., *Brief Summaries of Medicare & Medicaid as of November 1, 2011*, at 28 (2011), *available at* http://www.cms.gov/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2011.pdf.

Medicaid provides funding for long-term care services both in institutions, such as nursing homes, and in the community. Most people would prefer to receive care in their homes. Enid Kassner et al., AARP Pub. Policy Inst., *A Balancing Act: State Long-Term Care Reform* 1 (2008), *available at* http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf. And the cost to Medicaid of long-term care in the home is far lower than institutions. In 2004, the average Medicaid expenditure on a beneficiary in a nursing home was $24,585 compared with only $8,440 for community based care. *Id.* at 6 fig.3.

Nevertheless, most states spend their Medicaid dollars primarily on institutional care. In 2006, 63% of Medicaid's nationwide long-term care expenditures were utilized to finance care in nursing homes or other institutions. *Id.* at 2. The amount spent on community-based care varies according to state policies. Oregon set the lead in 2006, with 55% of its Medicaid long-term care expenditures going to community care, while Tennessee was at the opposite end of the spectrum, spending 1% of its Medicaid long-term care funds in the community. *Id.* at 7 fig.4.

The ACA contains several provisions designed to encourage states to shift Medicaid long-term care spending from institutions to the community. Many of these provisions target people already receiving Medicaid coverage for long-term care services in institutions. By providing financial incentives to move people out of institutions and into the community, Congress sought to facilitate an

improved quality of life for older persons receiving Medicaid-funded long-term care services. This objective is totally distinct from the minimum coverage provision's goal of achieving universal minimum coverage. Rather than focusing on acquisition of a bare minimum of coverage, the ACA provisions promoting long-term care in the community seek to enable people needing long-term care services who already have Medicaid coverage to reside in the least-restrictive environment, wherein they can enjoy life to the fullest.

A. The ACA Provides Incentives for Shifting Medicaid Long-Term Care Funding from Institutional to Community Based Care

The Deficit Reduction Act of 2005 ("DRA"), created the Money Follows the Person program, which gave states an enhanced federal match for the first twelve months of care in the community after a person leaves a nursing home. Pub. L. No. 109-171, §6071, 120 Stat. 4, 102-10 (2005). The DRA required that persons be institutionalized for at least six months to participate, and it authorized states to impose a minimum residency requirement up to two years. *Id.* The federal government reports that from 2008 to 2010, 43 states and the District of Columbia chose to participate in the program, transitioning approximately 12,000 people out of institutions, back into the community. *Money Follows the Person*, Ctrs. for Medicare & Medicaid Servs., http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-

Support/Balancing/Money-Follows-the-Person.html (last visited Jan. 22, 2012).

The Money Follows the Person program was set to expire in 2011. Pub. L. No. 109-171, § 6071, 120 Stat. 4, 102-10. The ACA authorized the program to continue through 2016 and made the program more accessible to institutionalized persons. 42 U.S.C. § 1396a(a), (g)(2), note (Money follows the person rebalancing demonstration). The ACA reduces the minimum residency requirement to 90 days and eliminates the states' authority to require a longer minimum residency. *Id.*; *see also* Nat'l Senior Citizens Law Ctr., *The Medicaid Long-Term Services and Supports Provisions in the Health Care Reform Law* 8 (2010) [hereinafter *Long-Term Provisions*], *available at* http://www.nsclc.org/wp-content/uploads/2011/07/Medicaid-LTSS-Provisions-on-Health-Reform-Law.pdf.

In addition, the ACA establishes a new program, the Community First Choice Option program, to assist with the costs of transitioning from an institution to the community. 42 U.S.C. § 1396n(k). It enables states to provide Medicaid coverage for transition costs including rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities to facilitate the individual's transition to the community. *Long-Term Provisions*, *supra*, at 4.

The ACA also created the Balancing Incentive Payment Program, which targets increased federal matching funds to states that spent less than half

their Medicaid long-term care expenditures on community-based care, providing a financial incentive for states to shift Medicaid spending away from institutional care. 42 U.S.C. § 1396d note (Incentives for States to offer home and community-based services as long-term care alternative to nursing homes). In return for these increased federal dollars, participating states must commit to increasing their percentage of long-term care expenditures on community-based care by September 30, 2015. *Id.*; *see also Balancing Incentive Program*, Ctrs. for Medicare & Medicaid Servs., http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html (last visited Jan. 22, 2012).

These programs serve the important objective of moving people and federal dollars from institutional care to community-based care. The minimum coverage provision does not affect ACA provisions implementing this significant goal.

B. The ACA Contains Numerous Provisions Designed to Help People Needing Long-Term Care Obtain Services in the Community and Avoid Institutionalization

Not only does the ACA pursue the goal of reducing institutionalization by targeting currently institutionalized individuals, but also the ACA

strives to prevent needless institutionalization of people who could be served in the community.

The Community First Choice Option program discussed above allows states to offer individuals needing a nursing-home level of care Medicaid coverage for community-based attendant services at an enhanced federal matching rate. *Long-Term Provisions*, *supra*, at 8. The ACA also has a provision entitled, "Removal of Barriers to Providing Home and Community-Based Services," which gives states additional flexibility in the type, scope, and duration of services they offer under the Medicaid state plan amendment option. 42 U.S.C. § 1396n note (Oversight and assessment of the administration home and community-based services). Subject to federal approval, states may also offer services in addition to those set forth in the Medicaid statute. *Long-Term Provisions*, *supra*, at 6.

Under prior law, the spouse of a person who sought long-term care in an institution was protected against impoverishment, but if the person sought care in the community, the spouse would have no such protection. The ACA extends Medicaid's spousal protection provisions to spouses of individuals who seek long-term care in the community. 42 U.S.C. § 1396r-5(h)(1)-(2); *see also* Kaiser Comm'n on Medicaid & the Uninsured, *The Medicaid Long-Term Services and Supports: Key Changes in Health Reform Law* 3 (2010), *available at* http://www.kff.org/healthreform/upload/8079.pdf; Lina Walker, AARP Pub. Policy Inst., *Health Care Reform Improves Access to Medicaid Home and*

Community-Based Services, at 4 (2010), *available at* http://assets.aarp.org/rgcenter/ppi/ltc/fs192-hcbs.pdf. This will prevent the unnecessary institutionalization of individuals who can be well-served in the community.

V. ACA Provisions Improving The Coordination Of Services For Individuals Already Insured Under Both Medicare And Medicaid Are Independent Of The Minimum Coverage Provision, Which Is Directed At Currently Uninsured Persons

Approximately 9 million individuals, commonly known as "dual eligibles," have both Medicare and Medicaid coverage. Kaiser Comm'n on Medicaid & the Uninsured, *Dual Eligibles: Medicaid's Role for Low Income Medicare Beneficiaries* 1 (May 2011), *available at* http://www.kff.org/medicaid/upload/4091-08.pdf. They tend to be very low income with substantial health needs, including significant limitations in activities of daily living. They are also more likely than other Medicare beneficiaries to have multiple chronic conditions and live in nursing homes. *Id*. As a result, they are a high-cost population. Spending on individuals who are dually eligible averages five times the cost of other Medicare beneficiaries. *Id*. The issues impacting this high-need and high-cost population who have two sources of health insurance are totally distinct from the minimum coverage provision's effort to reduce the number of uninsured individuals.

The ACA created the Federal Coordinated Health Care Office ("Duals Office") to ensure that dual eligibles have high-quality, cost-effective care. 42 U.S.C. § 1315b(a) (Supp. 2010). The goals of the Duals Office include improving the health and long-term-care quality, care continuity, and the integration of Medicare and Medicaid benefits. *Overview: About the Medicaid-Medicare Coordinated Office*, Ctrs. for Medicare & Medicaid Servs., http://www.cms.gov/medicare-medicaid-coordination (last modified January 19, 2012). In addition, several ACA provisions encourage the federal government and states to explore demonstrations, pilots, and waivers to integrate both the care of dual eligibles and the financing of that care. Nat'l Senior Citizens Law Ctr., *Health Care Reform, Dual Eligibles, and Coverage Expansion* 2 (2010) [hereinafter *Dual-Eligible Coverage Expansion*], *available at* http://www.nsclc.org/wp-content/uploads/2011/07/Health-Reform-Duals-and-Coverage-Expansions.pdf.

Dual eligibles have available to them annually a number of Medicare Part D prescription drug plans, identified as "benchmark" plans, that they may join without paying any premiums. *Low-Income Subsidy*, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/States/03_lowincomesubsidy.asp (last modified August 25, 2009). The ACA changes the formula for determining benchmark plans, which should increase the number of zero-premium plans in which dual eligibles can enroll, 42 U.S.C. § 1395w-114(b)(2)(B)(iii), thereby giving them increased options for obtaining

prescription medications. *Dual-Eligible Coverage Expansion*, *supra*, at 3.

VI. The ACA'S Provisions Improving Quality And Safety In Nursing Facilities And Preventing Abuse And Neglect Of Elderly And Disabled People Are Unrelated To The Minimum Coverage Provision

The ACA's Nursing Home Transparency, Elder Justice Act and Patient Safety and Abuse Prevention Act provisions are vitally important to older and disabled people. These provisions will dramatically improve conditions and safety in nursing homes and prevent abuse and neglect of elderly and disabled people residing in nursing homes and other residential care facilities. These critically important provisions are wholly unrelated to the minimum coverage and underwriting reform provisions.

> Each of these sections would have been considered landmark legislation if enacted on its own. The first, the Elder Justice Act, seeks to combat crimes committed against older people, including financial exploitation and physical and mental abuse. Its companion, the Patient Safety and Abuse Prevention Act, goes a long way toward ensuring that the people who provide care to our seniors and people with disabilities provide a safe

> environment and do not abuse or neglect them. And, finally, the Nursing Home Transparency and Improvement Act will increase transparency and accountability in nursing homes so people will have the information they need to evaluate and compare facilities.

Families USA, *In Perspective: A Closer Look at How the Affordable Care Act Helps Everyone, Better Safety and Quality For Seniors and People with Disabilities* 1 (2010), *available at* http://familiesusa2.org/assets/pdfs/health-reform/in-perspective/Seniors-and-People-with-Disabilities.pdf.

The ACA 's "Nursing Home Transparency and Improvement" provisions include provisions from prior bills that Senators Grassley (R-IA) and Kohl (D-WI) had introduced as the Nursing Home Transparency and Improvement Act of 2009. Senator Grassley noted that "[i]mproving nursing home care requires constant vigilance. … Some problems keep coming up. They need to be fixed so nursing home quality continues to improve and stay improved. More transparency, enforcement, and staff training are all needed. That's what our bill addresses." Press Release, U.S. Sen. Spec. Comm. on Aging, *Grassley, Kohl Work to Improve Care In Nursing Homes, Introduce Nursing Home Transparency and Improvement Act of 2008* (February 14, 2008), *available at* http://aging.senate.gov/record.cfm?id=295572; *See also* Lawrence R. Siegel et al., *Nursing Home Transparency Act, Despite Uncertainty of*

Consequences, Finally Becomes Law 22 (2010), *available at* http://www.williamsmullen.com/files/Publication/6510b2a5-28c9-454c-bc11-5388d820d6f6/Presentation/PublicationAttachment/578d8055-023b-44c0-91f1-551c73e48341/Siegel-Nied_AHLA_07-2010.pdf. These requirements improve transparency of and access to nursing home information with the intention of improving accountability in nursing homes. Among other things, the ACA requires (1) nursing homes to disclose their owners, operators and financers so they are accountable to residents; (2) nursing homes to establish a Quality Assurance and Performance Improvement Program to improve quality standards; and (3) HHS to collect and report nursing home staffing information. 42 U.S.C. § 1320a-7j(c), (g) (Supp. 2010). In addition, the ACA establishes a pilot program to improve oversight of nursing home chains with reported quality-of-care problems and provide training to workers who care for residents with dementia to prevent abuse. 42 U.S.C. § 1396r(f)(2)(A)(i).

The ACA's Elder Justice Act ("EJA"), 42 U.S.C. § 1305 et seq., among other things, coordinates federal, state, local, and private agencies' activities addressing elder abuse, neglect, and exploitation. ACA's EJA adopted many provisions contained in previous proposals of the Elder Justice Act of 2007, S.1070, and H.R. 1783, 110th Cong. (2007). According to Senator Hatch, the Senate sponsor, "[T]housands of cases of elder abuse, neglect and exploitation go unaddressed each day...This bill will give much needed attention and

resources to fight these crimes...." The bill had been continuously reintroduced since 2002. The stated purposes were to create a federal funding stream for state Adult Protective Services, assure that HHS identify an office to provide coordination and technical assistance for the APS system, provide demonstration grants, and define and report on guardianship and other fiduciary concerns.

All of those purposes were fulfilled in the ACA. Through the ACA's EJA, dedicated funding for Adult Protective Services (APS) was established, state demonstration grants testing a variety of methods to detect and prevent elder abuse were created, Elder Abuse, Neglect and Exploitation Forensic Centers to develop forensic expertise was established, and grants for Long-Term Care Ombudsman Programs and to enhance long-term-care staffing were created. 42 U.S.C. § 1397l(d)(1).

The ACA also includes provisions from the Patient Safety and Abuse Prevention Act, which were intended to prevent workers with criminal histories from working within long-term-care settings by creating a comprehensive nationwide system of background checks. Senator Kohl introduced these provisions in recent years seeking to "expand a highly successful three-year pilot program, … authorized under the 2003 Medicare Modernization Act, which prevented more than 7,000 applicants with a history of substantiated abuse or a violent criminal record from working with and preying upon frail elders and individuals with disabilities in long-term care settings." U.S. Sen.

Spec. Comm. on Aging, *Issues, The Patient Safety and Abuse Prevention Act*, *available at* http://aging.senate.gov/issues/elderfraud/patient_abuse_prevention.cfm (last visited January 23, 2012). The Senate first held a hearing on the criminal background check provisions that are now part of the ACA in 1998. In a 2002 hearing investigating the grave problem of nursing home abuse, Senator Kohl's criminal background check bill was again considered. Parts of the bill were included in the June 2003 Medicare Modernization Act as a pilot program in seven states. In July 2008, the Senate Committee on Aging released a report on the overwhelming success of the pilot program. *Id.*

ACA enables states to conduct national criminal background checks, including fingerprint checks, on individuals who apply for direct patient access jobs in long-term care facilities and with home care agencies that receive funding from Medicare or Medicaid, 42 U.S.C. § 1320a-7l(a), thus eliminating the ability of persons with criminal histories to move from state to state to work with vulnerable seniors and persons with disabilities. *See* Nat'l Health Policy Forum, *The Basics, The Elder Justice Act: Addressing Elder Abuse, Neglect, and Exploitation* 1-8 (2010), *available at* http://www.nhpf.org/library/the-basics/Basics_ElderJustice_11-30-10.pdf.

CONCLUSION

Amici respectfully submit that the Court should hold in accordance with the position of Respondents.

Respectfully submitted,

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