MEDICARE

Overview of Major Issues and Policy Considerations

Medicare has contributed substantially to the well-being of America's oldest and most disabled citizens. Supporters cite its critical role in providing mainstream care for the aged and disabled in the United States with low administrative costs. The program also has a large number of detractors, although their complaints vary considerably. Some critics of Medicare point with alarm to the size and growth of the program within the budget and believe that it needs to be substantially reduced. Often these same critics point to the private sector and suggest that solutions can be found by fundamentally changing the nature of the program. But other critics, who generally favor a public approach, find fault instead in how little Medicare covers and what gaps remain that could be filled for this population.

The push and pull of these competing complaints about the Medicare program indicate that it will likely be subject to debate for some time to come. And even many of Medicare's supporters believe that the aging of the population and the continued high costs of health care in the U.S. will require considerable changes in the program in the future. Balancing these various claims will prove no small task for deciding the future of Medicare.

Assessment of Current Situation

Medicare serves those most in need of medical care--the elderly and disabled. It remains one of the most popular federal programs, changing little in its first 29 years. But this important program also carries a substantial price tag. Spending in 1995 will total about $176 billion for 36 million enrollees, 90 percent of whom are aged 65 and above. Altogether,

these expenditures account for over 18 percent of total spending on health services in the U.S., making the program of interest well beyond the concerns of beneficiaries alone.

The Medicare program was established by legislation in 1965 as Title XVIII of the Social Security Act and first went into effect on July 1, 1966. The program is divided into two basic parts: Part A is Hospital Insurance (also referred to as HI), and Part B is Supplementary Medical Insurance (SMI). Hospital Insurance covers a reasonably comprehensive package of hospital services, a rapidly expanding home health benefit, and a limited skilled nursing benefit. It is funded by contributions from the FICA payroll tax of 1.45 percent each from employers and employees. Over time, the rate of growth of those revenues will not be sufficient to match the rate of growth of the spending. SMI, on the other hand, is funded by general revenues and an enrollee premium equal to about 25 percent of the actuarial costs of the insurance. It covers physician services, outpatient care, laboratory services and other ambulatory care.

At its passage, the overriding goal of the Medicare program was to assure access to mainstream care for persons over the age of 65. The elderly were under-served by the health care system, largely because many older persons could not afford to obtain care. Insurance coverage as a part of retirement benefits was often the exception and not the rule. Moreover, private insurance companies had shown a reluctance to offer coverage to older persons even when they could afford it.

Strong opposition to a public program by groups such as the American Medical Association meant that most of the attention was devoted to allaying fears about government control. Consequently, the rules established to govern Medicare did little to disrupt or change

the way that health care was practiced or financed in the United States. And Medicare statutes specifically assured free choice of provider and no interference in the routine practice of medicine. Payment rates were designed to resemble those in the private sector, both in the mechanics and the level of payment. Physician and other provider groups that participated in the new program at least would not be put at a disadvantage.

By most accounts, Medicare achieved the goal of improved access to health care by our nation's elderly and disabled. By 1970, Medicare had enrolled nearly all of the elderly and after 1972, it added a substantial number of America's disabled. However, the "success" of the program contributed to the rapid growth in federal costs and ushered in the second phase of Medicare--a concern for cost containment. Attention turned to restraining the growth in spending on the program.

When attention did turn to costs, Medicare's growth in the late 1970s was above that for the rest of the system, in part because of the unique aspects of the program which will be discussed below and in part because cost containment had never been a priority. In the late 1980s, Medicare began to reduce the rate of growth of spending, causing it to fall relative to that for the rest of the population. For seven of the last ten years, Medicare's growth has been lower than that of the rest of the health care system. Thus, even in the area of cost containment, Medicare deserves more credit than its critics often allow.

Since 1980, Medicare has been, each year, a major focus of budget reduction efforts. While many of these changes have concentrated on reducing payments to providers, some reductions have also affected beneficiaries. Most recently, as part of the 1993 budget reduction efforts, Medicare was cut by $56 billion. Thus far, these cuts have put off the

projected exhaustion of the Part A Trust Fund for more than 10 years by major cost-cutting efforts and an increase in the wage base subject to taxation. In the early 1980s, the demise of the Part A Trust Fund was predicted for 1990. Policy changes have successfully pushed back that date. Nonetheless, current projections put the date of trust fund exhaustion at 2001, less than 10 years away.

Medicare still needs a number of changes to improve its performance and protect its future. Its absolute size and rate of growth cause Medicare to stand out from most other domestic programs. It is one of the fastest growing programs in the federal budget, and costs are projected to rise at an annual rate of about 10 percent in the future. Consequently, even though growth is expected to slow as compared to earlier years, the rate will still likely be about twice the rate of growth of Gross Domestic Product (GDP). Medicare will consume a larger share of our national income each year. Consequently, the debate over deficit reduction and the federal budget will undoubtedly focus considerable attention on Medicare.

There are several reasons to expect the rate of growth of Medicare to be higher than that in the private sector over time. Both technology and the aging of the population will affect the rate of growth of Medicare expenditures, placing special demands on this program. As more people live into their 80s and 90s, the costs of Medicare will rise disproportionately. Further, improvements in technology which make procedures safer and more effective are likely to be more heavily used by the frail for whom riskier procedures were not advisable in the past. For example, cataract, hip replacement and heart by-pass surgeries are areas where major advances have occurred and all are procedures disproportionately used by the elderly. CT scans, MRIs and other advanced imaging techniques also make care safer and more

accessible for the elderly and disabled. Finally, it is important to keep in mind where we are starting from in terms of Medicare versus the private sector. In the 1990s, as employers have become more serious about costs of health care, that sector is now slowing--but it is still above payment levels in Medicare.

And even though much of the current political discussion concerning Medicare focuses on finding ways to slow the rate of growth in the program, it is difficult to argue that we spend too little on Medicare given its failure to provide coverage for prescription drugs. High deductibles and lack of "stop-loss" protections[1] are also cited as inadequacies. For example, the hospital deductible of $716 is considerably higher than that normally found in the private sector. Medicare is considerably less comprehensive than many health insurance policies routinely held by American workers.

Medicare was never intended to be a long term care program, so its limitations in that area are not surprising. The artificial lines drawn between acute and long term care services, however, make little practical sense and have led to a tug-of-war in certain parts of the program. The skilled nursing facility and home health benefits have sometimes been allowed to grow very rapidly, often followed by periods of more stringent regulation and oversight. This lack of coordination likely leads to a less efficient health care system overall as well.

Expansion of these various benefits would, however, be very expensive. For example, during the health care reform debate last year, a limited expansion of Medicare to include prescription drugs would have cost over $14 billion per year once fully implemented. It is

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[1]Stop-loss protections refer to upper bound limits placed on the amount that individuals will be required to pay in total cost-sharing.

more likely, in the present environment of fiscal restraint, to expect proposals for further reducing coverage or requiring beneficiaries to pay a greater share of the costs of their care.

Older Americans already spend a disproportionate share of their incomes on health care expenses. For example, older Americans residing in the community spent about $2500 in 1994 in premiums and out-of-pocket costs. The burdens of these and even higher costs on the oldest old and those with substantial health problems were even greater, often consuming over a fourth of such families' incomes. Cutbacks in Medicare that merely shift burdens to enrollees would further raise the share of health spending that must come out of elderly persons' incomes.

Medicare is also the subject of frequent criticism and debate by physicians and hospital administrators for the restrictions it places on them, although these same health care providers nonetheless rely upon Medicare for a substantial share of their revenues. Concerns about erosions of the quality of care or the mainstream nature of Medicare make further reductions in provider payments a less viable option than when cost cutting began in the early 1980s.

Thus, there are few easy solutions to the problem of seeking a balance between protections for older Americans for their acute care costs and relief for the federal budget from what is viewed as an enormous spending burden.

Projections for the Future

The Medicare program will face unprecendented challenges in the future. Current projections by the actuaries suggest that the trust fund for Part A of Medicare will be depleted

by the year 2001. Although that date may slip in the next trustees' report, Medicare needs to be seriously addressed within the next two or three years. And even if ways are found to slow the rate of growth of spending on health care, the increase in the number of beneficiaries as the baby boom generation approaches retirement age will lead to further pressures after the year 2010.

Moreover, even without the trust fund issues that relate specifically to the financing of the Medicare program, there would inevitably also be pressures for paring back the program as part of the efforts to balance the federal budget. Between 1996 and 2002, the year that proponents of a balanced budget seek to reduce the annual deficit to zero, Medicare's spending is projected to total $1.85 trillion dollars. This constitutes approximately 30 percent of that part of the federal budget often referred to as vulnerable to reductions to achieve a balanced budget (that is, everything except Social Security, defense and interest on the federal debt). Many different estimates of how much less will need to be spent on Medicare to balance the budget abound, ranging from about $200 billion to $500 billion over the seven years.

Even if the most conservative of these numbers is the eventual target, and even though such changes will not actually lower the absolute dollars spent each year, they will of necessity have a major effect on some part of the program. Each year Medicare grows for a number of reasons: the number of people eligible for the program rises, the proportion of beneficiaries who are sick or frail--and thus more expensive to serve--also rises, and health care inflation and the introduction of new technology also contribute to costs. While most analysts of the program could agree that improved efficiencies and moderate limits on

payments to providers could likely save considerable amounts of money for the program, that will be enough to achieve the savings that some have in mind.

There are essentially five types of changes that would help with the solvency of Medicare, although the first two are less likely to be options in the short term. The first, a payroll tax increase to bolster Medicare's finances, seems to be off the table for consideration. Second would be a strategy to reduce the numbers of persons eligible for Medicare. Means-testing the program, and thus making high income people ineligible is sometimes debated. Less likely in the near term but something likely to be proposed later, is an increase in the age of eligibility for Medicare which would also lower the number of persons eligible at any one point in time.

A third option is to require that beneficiaries pay more of the costs of their care, usually through higher deductibles and copayments. For example, an increase in the Part B premium could be required--either across the board or targeted only on those with higher incomes. Deductibles or cost sharing requirements could be raised. The Part B deductible, which is now just $100, is one likely candidate for an increase. Home health services, which now have no copayment required, are often listed as an area for adding cost sharing. The problem is that some of these changes would substantially increase the already high out-of-pocket burdens on the elderly. And some, such as home health copayments, would fall especially hard on the most vulnerable older Americans. Implicitly, proposals to give vouchers to beneficiaries with very strict limits on adjustments for higher costs over time are often another way to pass on higher costs to beneficiaries who would have to supplement the vouchers with additional funds in order to find viable insurance.

Fourth, payments to providers of care could be reduced. This would mean, for example, cutting payments to hospitals, nursing homes, and/or home health agencies. Since hospital services make up the bulk of Part A spending, many of the cuts would have to take place there. Hospitals, however, are already objecting strongly to the levels of payment they receive under Medicare, arguing that they often do not even cover the costs of such care. To the extent that they are able, hospitals will attempt to shift any shortfall in payments onto other payers of care, such as private insurance patients. And if there are major shortfalls that cannot be shifted, hospitals and other health care providers may be forced to close their doors or stop treating Medicare patients. Both of these effects create problems for our health care system. Since the early 1980s, Medicare has relied heavily on this type of savings and some further savings are likely possible. At some point, once the gap between costs and what Medicare will pay widens enough, this option will cease to be a viable source of new savings, however.

Finally, if we are serious about major, long term reductions in spending of the magnitude discussed above, we would have to find ways to rein in the use of new technology and reduce the growth in service use in addition to any other changes. One strategy might be to restrict what services are covered or under what circumstances they will be reimbursed. This could either be done by the government or by managed care systems if we require all Medicare patients to go into such arrangements. While putting Medicare patients into HMOs has some appeal since it leaves the hard decisions to the private sector, it also has a number of disadvantages as well. Thus far, Medicare's experience with HMOs does not suggest real savings, largely because these organizations have attracted healthy patients and Medicare has

often paid HMOs too much for them.

Whatever the approach, as yet, we have few mechanisms that promise to achieve such a large and rapid reduction in the rate of growth of health care spending, especially if the changes are restricted to Medicare alone. In either case Medicare would be a vastly different system than it is today, and it would likely take some time to develop these new mechanisms.

COMPREHENSIVE HEALTH AND LONG-TERM CARE ISSUES PAPER FOR THE WHITE HOUSE CONFERENCE ON AGING

I. Overview of Issues

This year marks the 30th anniversary of the Medicare and Medicaid programs. Together they have helped bring health and economic security to older Americans. Yet, the nation faces a dilemma—brought on in part by the success of these programs. As the life expectancy of the elderly in the U.S. has increased to be among the best in the world and as modern technology has brought new ways of both extending and improving the quality of life, the cost of caring for older people has risen. Health and long-term care for the elderly is expensive for taxpayers and it is expensive for older people themselves. Strengthening the programs to make them work better for older Americans must be balanced against competing demands such as the need to devote resources to assuring children a healthy and productive start in life.

Public programs—primarily Medicare and Medicaid—cover 63 percent of all health care expenses of people age 65 and over. Yet, they fall short of protecting older Americans against the burden of high health care bills and assuring access to quality health care. The major gap is coverage for long term care. Prescription drugs are the major acute care service not covered by Medicare. For those with moderate incomes, the costs of private supplemental insurance and the out-of-pocket cost of deductibles, co-payments and uncovered services remain much higher for older people than for the younger population.

Increasing pressures to reduce spending on Medicare, Medicaid, and other smaller publicly-funded health programs are on the horizon. The size of these programs relative to the rest of the federal budget is already quite high. Because of the rapidly growing costs of

care associated with health care spending, these programs are viewed by many as unsustainable in their present forms. Moreover, the pressure not only arises from general concerns about the federal budget overall but also the financing crisis facing Medicare in the near term and the longer term challenges of an aging baby boom generation.

Other critical challenges also command attention. Because our health care system is fragmented, there are major problems with coordination of services and continuity of the care provided. Too often care is driven by who pays rather than by what best meets needs. Consequently, people may be inappropriately kept in the hospital when what they need is long term care. Or, because drugs are not covered by insurance, people forgo taking medications, their health status worsens, and they end up using more expensive services. Such situations lead not only to inefficiencies and higher costs, but also to lower quality care for those who have complex needs.

The complex system of financing and delivering health care also leads to confusion. Few families know where to turn or what options are available when long-term care is needed. Filing claims and sorting out what is owed after a serious illness are onerous. Medi-Gap supplemental insurance policies can be confusing and costly. As managed care plans increasingly market to older people, the merits and quality of care of alternative choices are often obscure. Expanding choices, fostering independence, and enabling older people to make informed decisions about issues critical to their well-being are major challenges.

Finally, until quite recently research in health care often ignored the needs of older Americans. It was simply not considered a very high priority. Trials of new drugs and tests

of new procedures often still do not include elderly subjects even though the elderly are high users of health care.

II. Assessment of Current Situation

Despite popular views that older Americans enjoy high incomes and standards of living, most elderly Americans have modest incomes. For example, over three-fourths of Medicare beneficiaries have incomes below $25,000 and only about 5 percent have incomes above $50,000. Out of these modest incomes, older persons must make substantial payments for health care insurance premiums and out-of-pocket spending. In 1994, it is estimated that such expenses totaled about $2500 per elderly person residing in the community, and those amounts vary substantially across families by age, presence of supplemental insurance, and income. Persons over age 80, for example, devote over 29 percent of their incomes, on average, to health care expenses.

For persons with substantial long term care needs, burdens of health care spending quickly become catastrophic. The annual cost of a nursing home exceeds $30,000 per year in most parts of the country and extensive home care services can mount up to $10,000 or $15,000 per year. These expenses are beyond the reach of most elderly Americans if they must fully pay for them out of pocket. Moreover, most seniors who need long term care also have high acute care spending needs as well.

These high expenditures do not come about because of a lack of other sources of support. Rather, it is because the overall costs of care are very high and public and private insurance programs leave a number of gaps in coverage. For example, the elderly represent

only about 12 percent of the U.S. population, but account for 36 percent of all health care spending in the U.S. These costs are spread over a number of payers of health care on behalf of older Americans. Medicare accounts for 45 percent of spending on the elderly and Medicaid and other public programs cover another 18 percent.

Private sources of spending—covering a little more than a third—include supplemental insurance coverage and beneficiary out-of-pocket payments. About three-quarters of seniors have some form of private coverage. Generally, individuals pay for much of the costs of this supplemental insurance. The exception is older Americans fortunate enough to have good employer-subsidized employee or retiree coverage. But only 38 percent of Medicare beneficiaries have this type of supplemental insurance. Although that number has grown substantially since the 1970s, it may not expand much further as more and more employers have chosen to limit or cut back their retiree health benefits. Furthermore, supplemental coverage does not eliminate the risks of very high health care burdens when an individual has an expensive acute care episode.

Private insurance for long term care is much less prevalent. Only about 2 million such policies have been sold in the U.S. and many of those are owned by persons under the age of 65. Many persons over age 65 with any type of health problem would find it difficult to purchase private long-term care insurance. Thus, as yet private insurance offers little in the way of protection against long term care needs.

What about the public programs that offer health care services to older Americans? Medicare is the largest and most important program. It covers nearly 98 percent of all persons over 65 residing in the U.S. Eligibility for Medicare is related to eligibility for

Social Security benefits, either as workers, dependents or survivors. Once eligible, an individual is covered without charge by Part A, Hospital Insurance. This part of the program is funded by payroll tax contributions and covers hospital, home health and limited skilled nursing home services. Part B, Supplementary Medical Insurance, is voluntary and enrollees in Part B must pay a premium equivalent to a little more than 25 percent of the actuarial costs of the insurance. Most, but not all, Part A beneficiaries sign up for Part B. This part of the program covers physicians services, outpatient care, and laboratory and other ambulatory services. Medicare was intended to be an acute care program and thus it covers only limited long term care services.

Medicaid, on the other hand, covers a broader range of acute and long term care services, but to a more limited group of older Americans. It is a joint federal/state program and hence many of the details vary across the United States. Moreover, there are actually several types of older Medicaid beneficiaries who qualify in different ways and may receive different services. Low income seniors become eligible by qualifying for the Supplemental Security Income program. Most of these "categorical" eligibles are automatically enrolled in Medicaid and can receive all acute and long term care services offered. Even for persons with Medicare, this is likely to be an important benefit, filling in acute care services such as prescription drugs and alleviating the older person from having to pay cost sharing under Medicare or Part B premiums.

Another group which becomes eligible are those who have very high medical expenses and hence their incomes net of medical expenses are low enough to qualify them as "medically needy." These beneficiaries are often nursing home residents who rapidly spend

down because of the very high costs of nursing home care. They receive help, but only after they have already spent a great deal of their incomes and assets.

A last group of eligibles are those who are in what is referred to as the Qualified Medicare Beneficiary (QMB) program. These additional enrollees in Medicaid have incomes below 100 percent of poverty (or between 100 and 120 percent of poverty for a less generous, related program). In this case they are not eligible for all Medicaid benefits, but only for relief of the premiums and cost sharing expenses that Medicare requires. This benefit, added in 1989, thus could help to fill in gaps in coverage for those with very low incomes. Participation in the QMB program remains low, however.

Medicaid has become, by default, the major public program for long term care. Since it was designed as a welfare program, individuals must spend most of their own incomes and assets before becoming eligible for any help. In turn, this has led many persons to seek ways to avoid these requirements, creating inequities and compliance problems. But even more important is the poor balance between nursing home and home and community based services. One of the major gaps in health care coverage for the elderly is in the lack of home care services. Some states, like New York or Oregon, have been aggressive in offering home care services to their Medicaid beneficiaries, but these states are the exceptions and not the rule. Partly as a result of few public dollars available to support development, capacity in home care has tended to lag. In the last few years, however, there has been a rapid increase in the availability and use of such services, albeit from a very small base.

From the perspective of public costs of these various programs, aggregate spending

by Medicare and Medicaid is very high. In 1995, total spending by Medicare on persons age 65 and older will be about $155 billion and on Medicaid for people age 65 and over nearly $46 billion (counting both the federal and state shares). This will constitute 12 percent of the federal budget and 2.5 percent of GDP in the U.S. These two programs are each expected to grow about 10 percent per year for the foreseeable future.

Information on the quality of health care services for older Americans is more difficult to come by. But interestingly, in recent surveys, Medicare beneficiaries report higher levels of satisfaction with their health insurance as compared to all other types. Among Medicare beneficiaries, 52 percent say they are very satisfied, as compared to only 44 percent of those with employer-provided insurance. Moreover, when considering various issues, 89 percent of Medicare beneficiaries report they are very satisfied with the overall quality of their care. The percentages drop off, however, when the question refers either to out-of-pocket costs (72 percent very satisfied) and availability of care (46 percent). Some of the concerns about availability may be capturing some of the increased reluctance by providers to take new Medicare patients. As yet, however, this problem is still an isolated one.

III. Future Directions

What will the future hold? It seems very likely that there will be increasing pressures to reduce spending on health care services for the elderly through the public sector. Indeed, there are already calls for major reductions as part of the budget balancing discussion underway in the U.S. Congress. These items are too large a part of the federal budget to

ignore. This means that not only are expansions in areas such as long term care or prescription drugs unlikely in the near future, but also that some of the budget cutting efforts are likely to affect current levels and quality of services offered.

There are few easy ways to slow public spending. Payment levels to providers of health care services are already lower for both Medicare and Medicaid than those found in the private sector. Although most providers still take Medicare patients, major cutbacks in payment levels could reduce access to care over time, or affect the high quality of care that beneficiaries now generally receive. It could also threaten the financial stability of institutions that depend on Medicare revenues, such as rural hospitals and specialized teaching hospitals. Payment levels under Medicaid are already so low that it would be difficult to cut them any further. Under Medicare, beneficiaries may be asked to pay more for their care in the form of higher cost sharing or premiums.

The movement to managed care that is taking place so rapidly elsewhere in the health care system will have a major impact on America's senior citizens as well. Even if Medicare and Medicaid stick with the largely fee-for-service systems they have in place for older beneficiaries, the private marketplace changes will influence the availability of care for seniors. It is very likely that expansion of managed care will be undertaken as a means for holding down the rate of growth of spending in these programs.

If done well, managed care holds a lot of promise; effective coordination and support of those with high cost illnesses could be a benefit to both patients and taxpayers. Moreover, competition among private plans to package services creatively for senior citizens might lead to some improvements in the coordination of acute and long term care services. But

managed care plans have tremendous financial incentives to cover only healthier patients and to cut corners in the provision of quality care. Managed care plans have little experience meeting the special needs of elderly and disabled patients. Studies to date show that managed care costs rather than saves Medicare money—in part because the current method of paying managed care plans can not adjust appropriately for the health status of enrolled beneficiaries. Moreover, reporting requirements about the quality and quantity of care provided by managed care plans are very limited. Nor do beneficiaries have the information they need to make informed choices among managed care plans.

Fiscal pressures make it important to set priorities. Expansion of home and community based services needs to be weighed against reducing out of pocket costs for acute care such as prescription drug benefits. Improved supplemental coverage and outreach to low-income seniors to participate in the QMB program must be evaluated against more funds for prevention and basic and applied medical research on issues important to the health of older people.

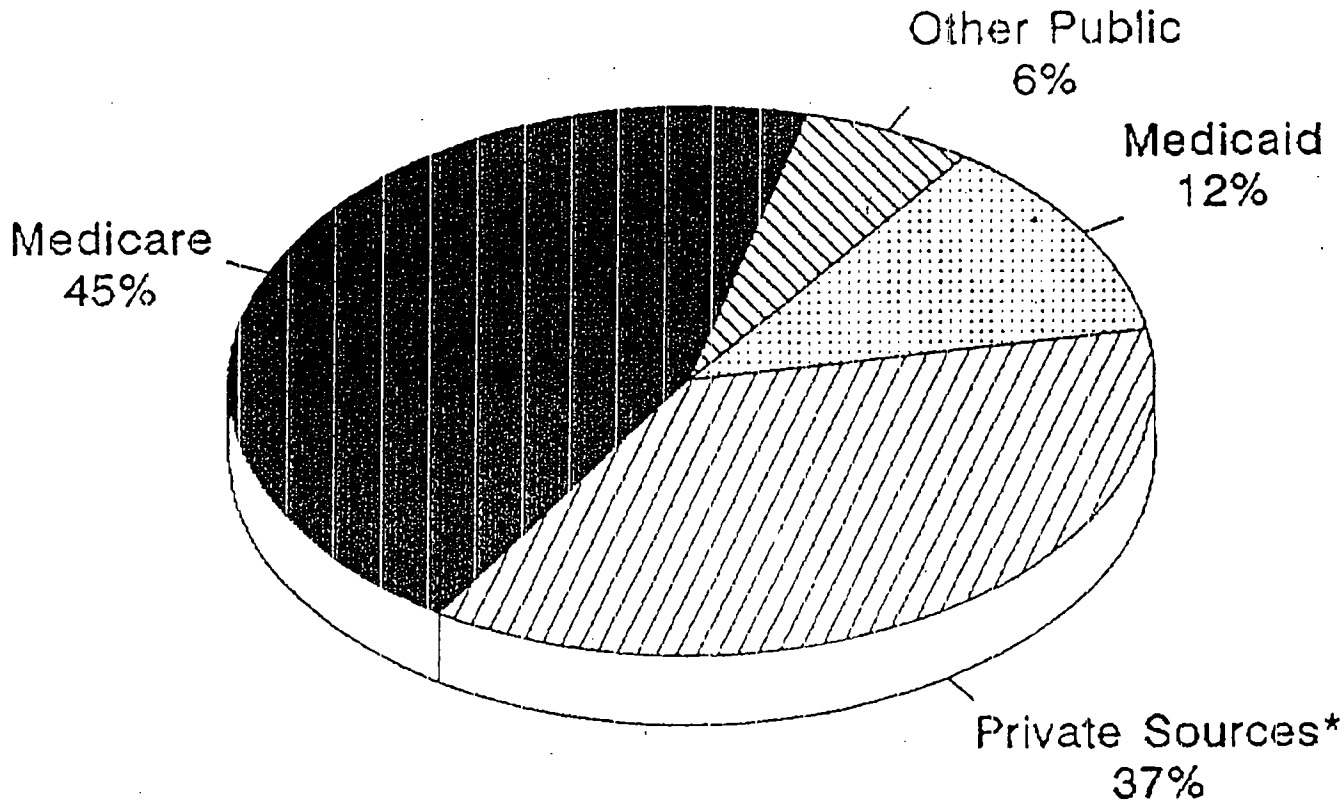
Resolving the dilemma of assuring affordable quality care for older people and addressing the federal budget deficit and looming Medicare insolvency requires making careful choices and trade-offs. Accurate information and an informed public debate are critical. The full array of options needs to be developed, analyzed, and carefully considered. They should include new revenues such as increased income or payroll taxes, premiums, and taxes on Social Security or Medicare benefits. Increased revenue options should be analyzed by their fairness and intergenerational equity. Restructuring benefits to provide better coverage for the chronically ill and older people with modest incomes should be weighed

against moderately higher Part B premiums or deductibles for all. Tighter provider payment rates for managed care plans, hospitals, and physicians should be considered in the context of acceptable differentials between public program and private insurer provider payment rates, and the need to preserve a high quality health care system for all Americans.

Most importantly, older people need information and choices so that they can take greater responsibility for decisions that affect their independence and well-being. This includes making decisions among physicians or managed care plans and selecting a home care aide or assisted living facility, as well as their role as citizens and voters expressing their views about programs which have a 30 year record of guaranteeing their health and economic security.

Health Spending for the Elderly, 1987

Who Pays the Bill?



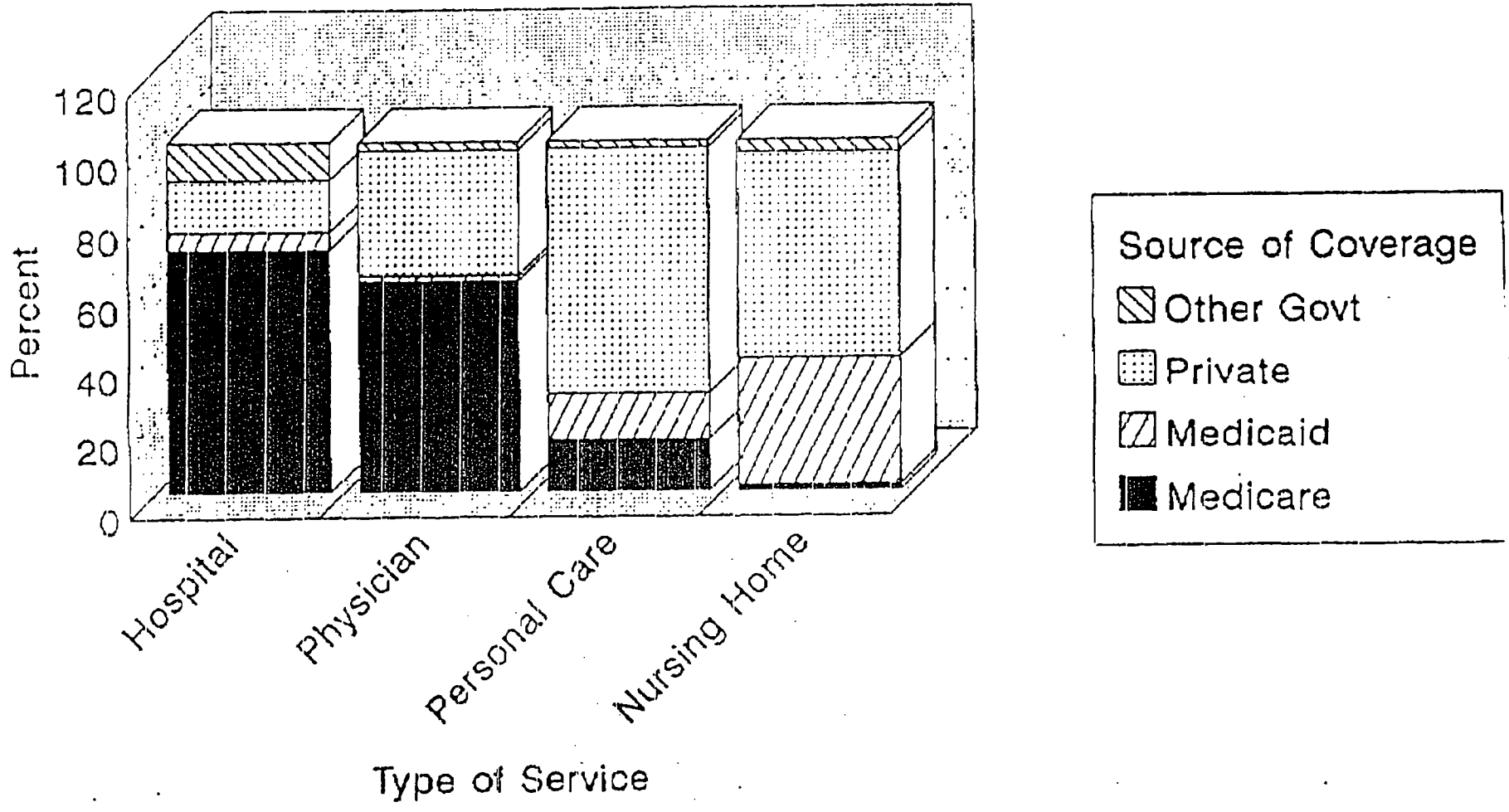
* Includes supplemental insurance, beneficiary direct payments, and philanthropy.

Source: "Health expenditures by age group, 1977 and 1987," Health Care Financing Review/Summer 1989

Chart 1

Health Spending for the Elderly

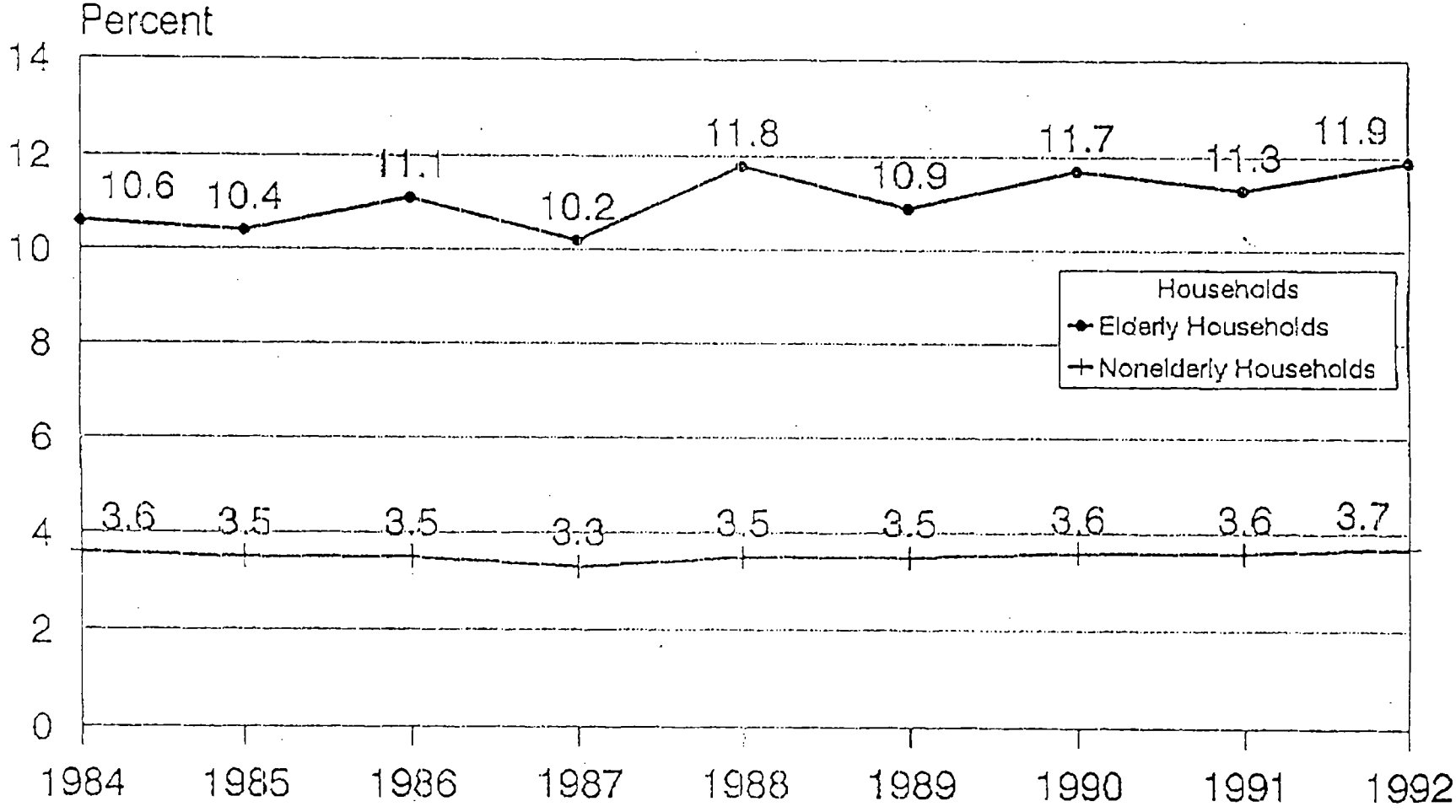
What Percent Does Medicare Pay?



Source: "Health expenditures by age group, 1977 and 1987," Health Care Financing Review/Summer 1989

Chart 2

Direct Household Spending for Health Care as Percentage of Household Income, 1984-1992



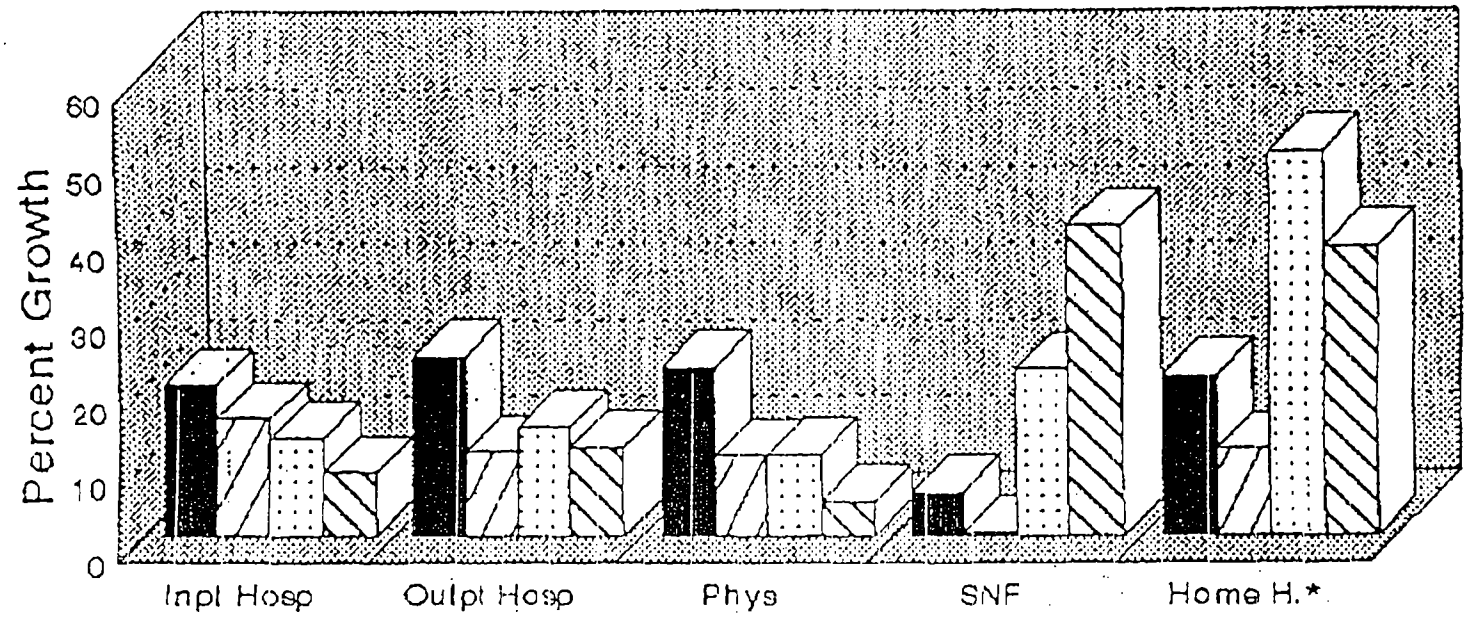
Source: Congressional Budget Office calculations based on data from the Consumer Expenditure Surveys of the Bureau of Labor Statistics, 1984-1992.

THE COMMONWEALTH FUND

Chart 3

Annual Growth in Medicare Outlays

Select Years



1980	19.9	23.7	22.2	5.7	21
1985	15.4	11	10.5	0.4	11.2
1990	12.9	14.3	10.6	21.9	50.1
1993	8.3	11.6	4.5	40.6	37.8

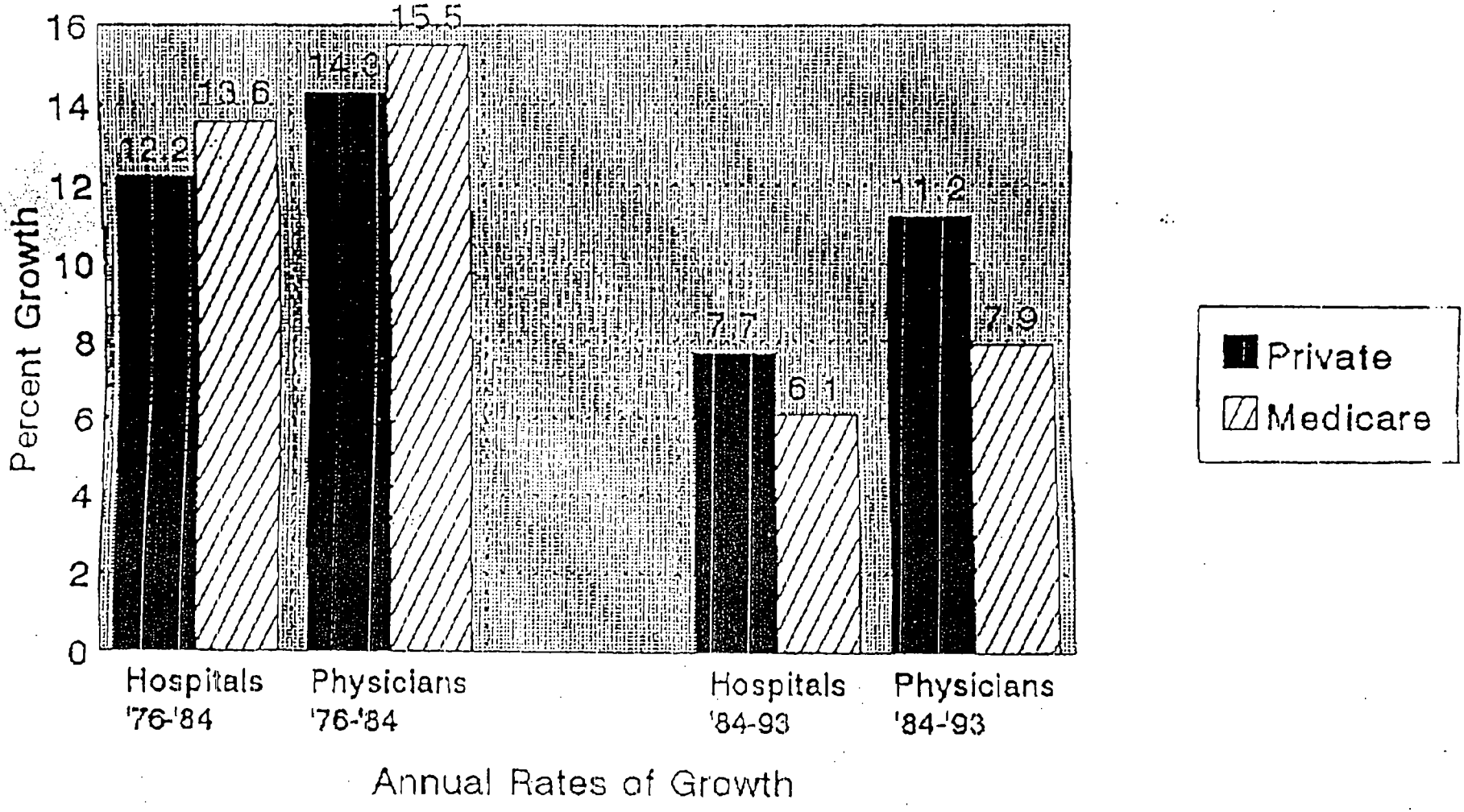
*Home Health includes Part A only

Source: HCFA/Division of Budget

Comparison of Growth in Hospital and Physician Expenditures

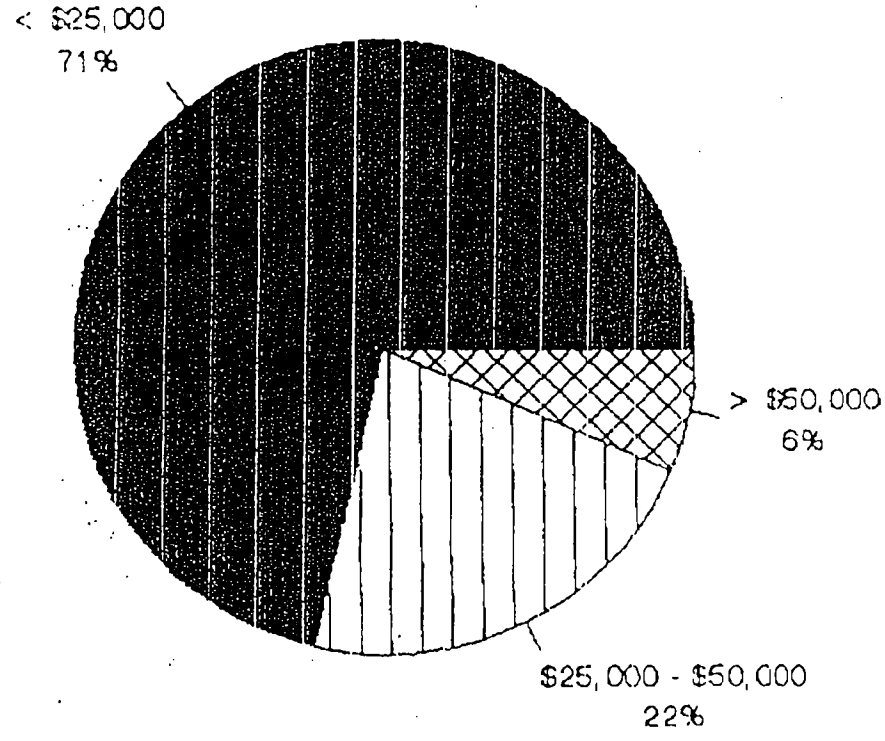
Per Enrollee

Private Health Insurance vs. Medicare

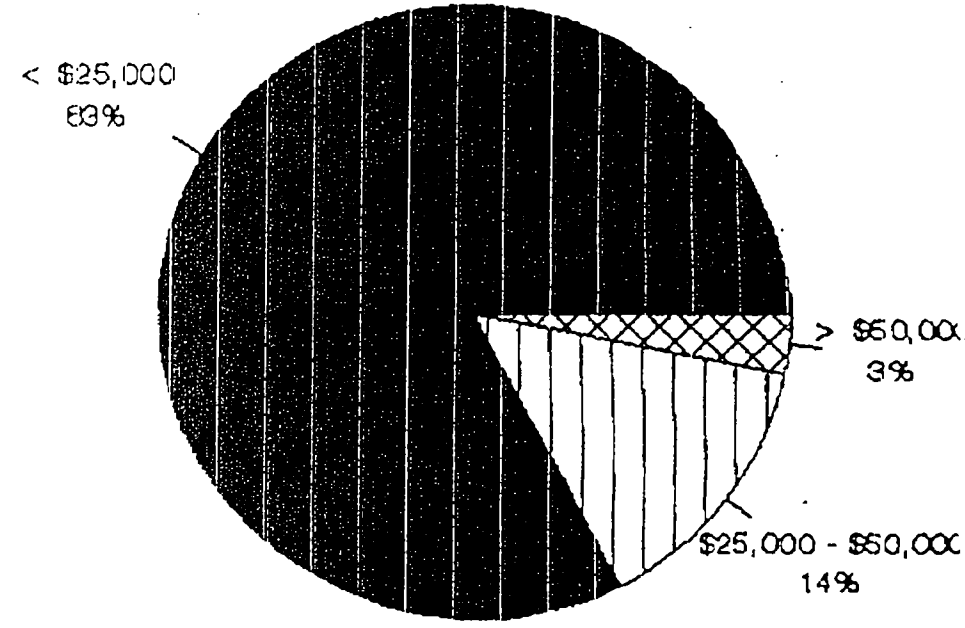


Source: HCFA/OACT

ncome Distribution of Medicare Beneficiaries by Gender, 1992



Males

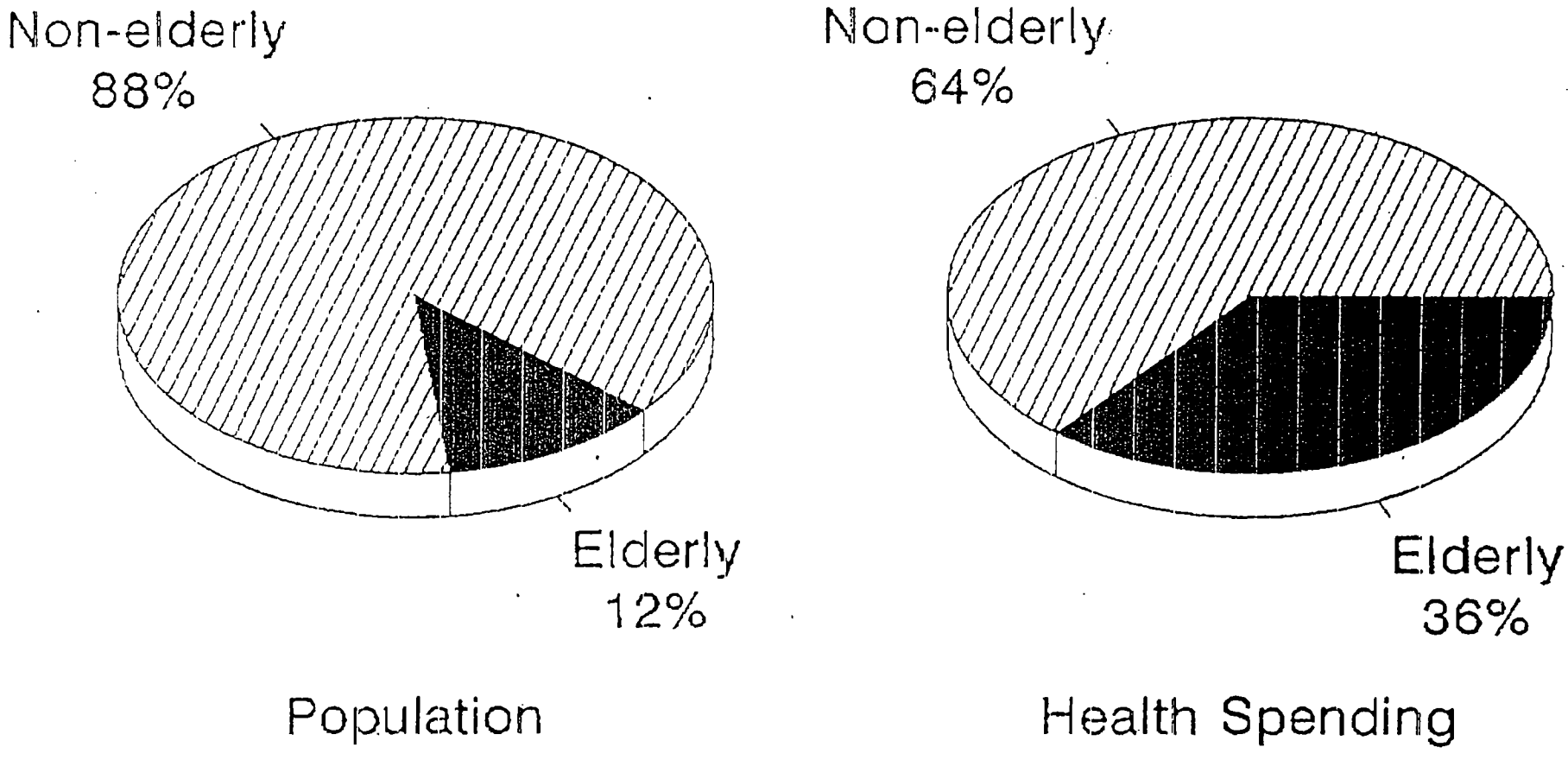


Females

ource: HCFA/OACT: Medicare Current Beneficiary Survey, 1992

Health Spending for the Elderly, 1987

Share of National Totals

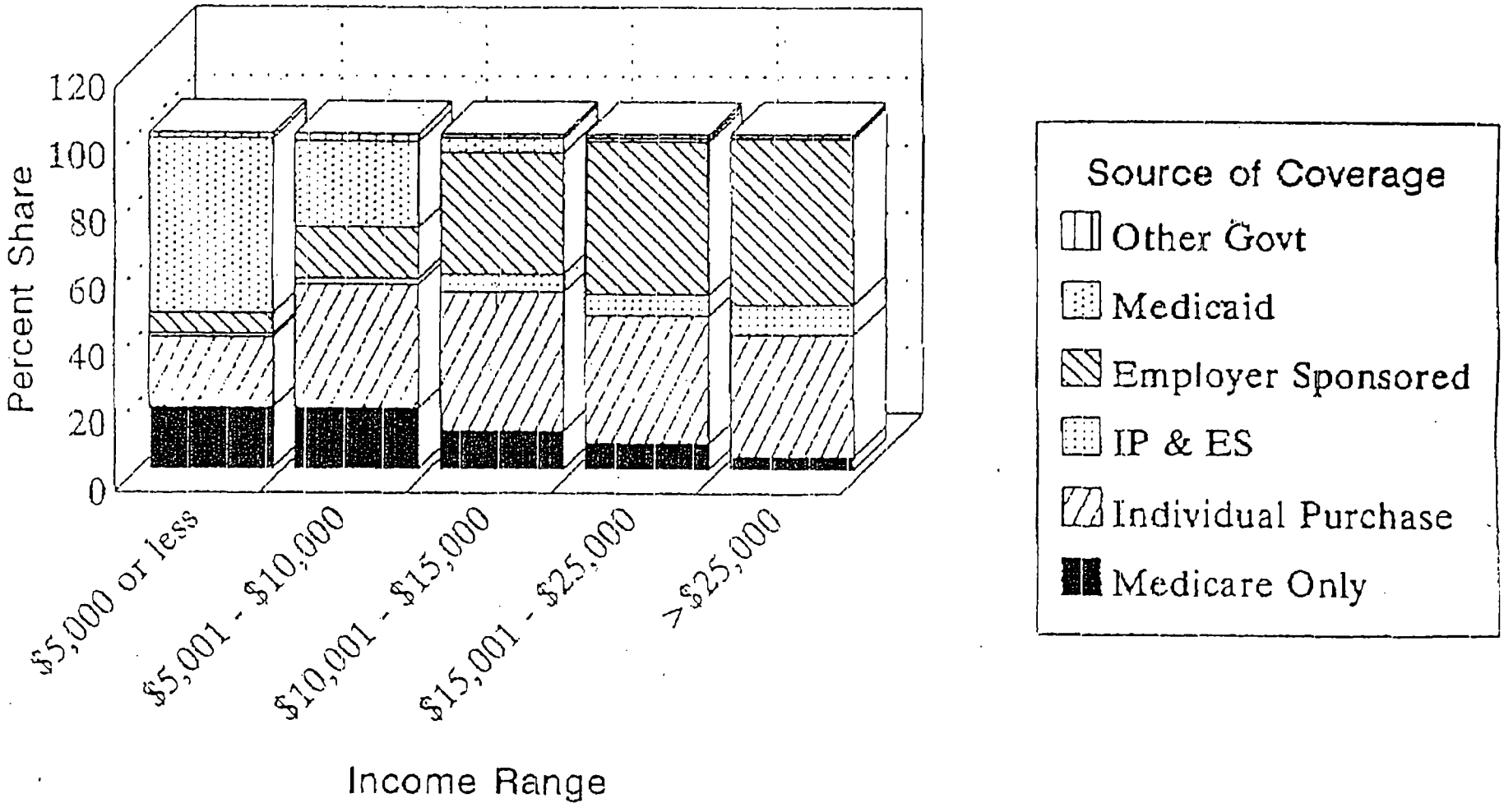


Source: "Health expenditures by age group, 1977 and 1987," Health Care Financing Review/Summer 1989

Chart 7

Insurance Holdings of Aged Medicare Beneficiaries

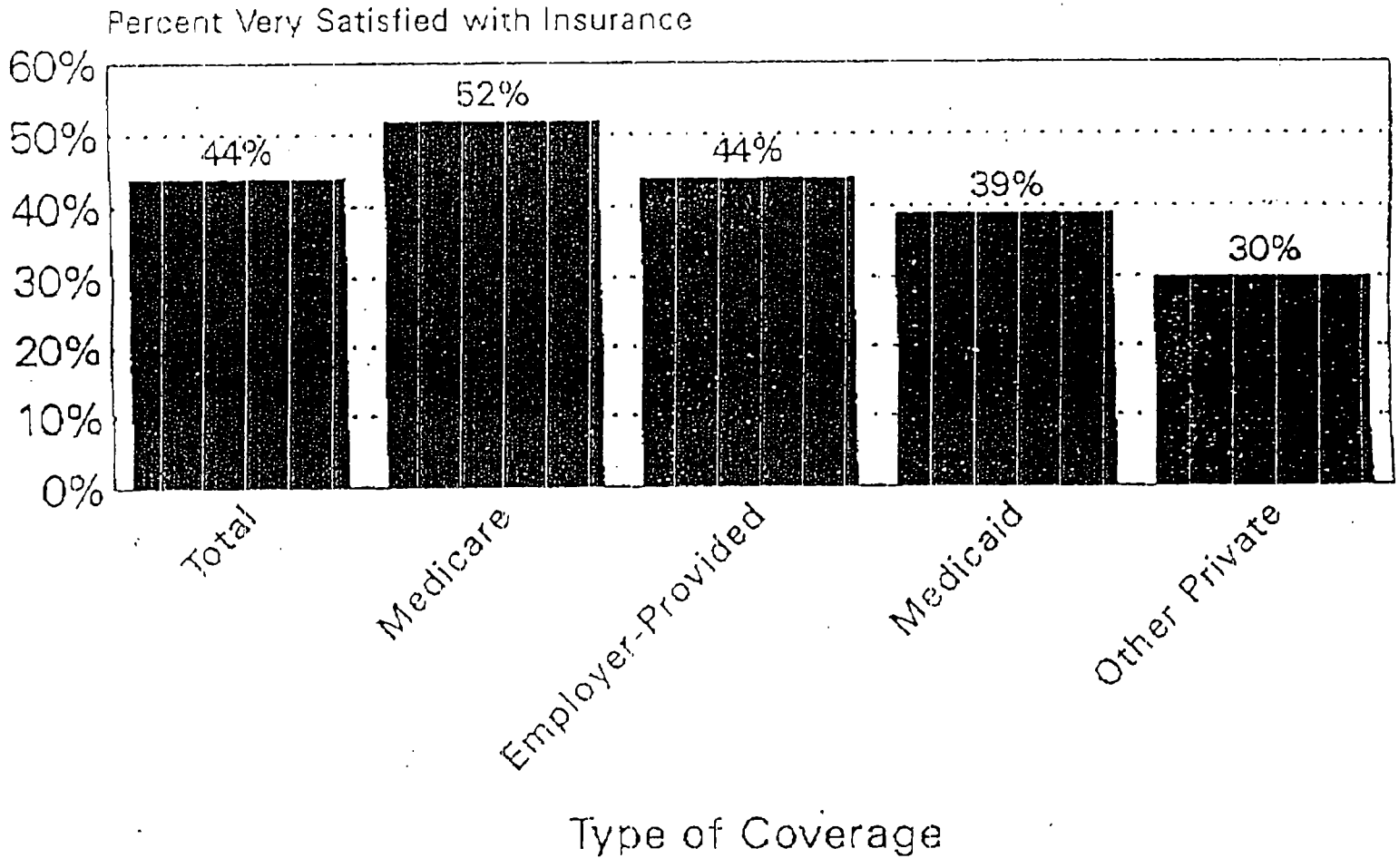
Percent Share By Income



Source: "Why More Cost-Sharing Won't Slow Medicare Spending"
Journal of American Health Policy, July/August 1993

Satisfaction with Health Insurance

Medicare Recipients Most Satisfied



Kaiser/Commonwealth Fund Health Insurance Survey, 1993
Louis Harris and Associates, Inc.

Chart 9

White House Conference on Aging
Issue Paper:
Other Retirement Income and Resources, Including Pensions

Overview

Retirement income is often conceived of as a three-legged stool: Social Security, pensions, and asset income. In the 1990's, many add a fourth leg, earnings, to this income picture. Since other issue papers deal with Social Security and employment (and thus, earnings), this paper will focus on pensions and asset income. At retirement (that is, among persons age 65), pensions account for about 11% of retirement income (about $5,230 at the median), and asset income accounts for about 19% of retirement income (about $1,720 at the median (Grad, 1994)). As seen in Table 1, Social Security and earnings make up most of the balance of the retirement income portfolio.

Table 1

Retirement Income Sources for Older Households

	Age 62-64	Age 65-69	Age 75-79	Age 85 & over
Social Security	20.6%	38.5%	55.8%	57.8%
Earnings	56.4	28.5	8.5	3.8
Pensions	8.2	10.9	10.4	6.3
Asset Income	11.1	18.7	22.3	28.1
Other	3.8	3.0	3.0	4.2

Other income includes Veterans' benefits and public assistance; Pensions include private and public sector pensions.

The table reads: Among households 65-69 years old, Social Security makes up 38.5% of total

income. (Source: Grad, 1994).

Pension coverage is not universal, although coverage has increased over time. Among retirees, less than half (45%) receive income from pensions. Among workers, 55% work with employers who provide a pension; however only 43% are vested in the plan and can expect to receive benefits (Silverman and Yakoboski, 1994).

The type of pension employers provide has also changed over time. The increase in the proportion of defined contribution (vs defined benefit) pension plans has shifted the risk of retirement income security from employers to employees (82% of private-sector plans are defined contribution). Add to this the underfunding of many defined benefit plans, most notably public sector retirement systems, and the future income security of many workers is highly uncertain.

Income from assets looks to be a substantial portion of the retirement income portfolio, and two-thirds (67%) of retirees report some income from assets, most of this coming from interest on bank accounts (savings, CD, interest on checking). The median amount of asset income is low ($1,720) and over one-fifth report less than $250 per year in asset income (Grad, 1994).

A relatively low proportion of workers take advantage of tax-advantaged retirement savings programs (401k, 403b). Reasons include confusion over the choices available to workers, lack of information and assistance from most employers' human resource/benefit offices, and a mis-understanding of the effects of pre-tax savings on take-home pay. While some employees are becoming more sophisticated in their understanding of financial markets and products, the vast majority of service and blue-collar workers remain overwhelmed and are stunned into inaction by the choices they face in the financial arena. As long as this confusion exists, workers will under-save, further weakening the financial future they face due to their higher risk defined contribution

pensions.

Once retired, many families do not know how to manage the private savings they do have. Nearly 20% of families spend-down their retirement savings faster than they should and another 25% have asset management patterns that hint at confusion and guess-work in handling finances (Hogarth, 1991).

Thus, pensions and asset income, which account for 19 to 34 percent of retirement income, provide wobbly legs, at best, for retirement income.

Assessment of Current Situation

Pensions

Coverage of Workers

Pension coverage varies by firm size and type of industry. Among workers at small firm (with fewer than 25 employees), about 20% are covered by a pension plan and 14% are vested in plans. However, among workers at large firms (1,000 or more workers), over three-fourths (78%) are covered by a pension and three-fifths (62%) are vested. Persons employed in the public sector are more likely to be covered than persons in the private sector (90% versus 55% respectively). Within the private sector, workers in manufacturing jobs are more likely to be covered than workers in non-manufacturing (e.g. service sector) jobs (66% versus 53% respectively) (Silverman & Yakoboski, 1994). Coverage also varies by age, with older, more experienced workers more likely to be covered than younger workers (58% versus 35 percent, respectively)(Woods, 1994).

There are two major types of pension plans: defined benefit and defined contribution. For defined benefit plans, employers establish a benefit formula for retirees and set aside the needed

funds each year to enable future payments to be made. For defined contribution plans, employers set aside a fixed sum each year; the funds grow based on investments and future payments are based on the earnings of the fund, not on any set payout formula. Over the past 20 years, the proportion of defined contribution plans in the private sector has grown from 67% to 82%; much of the growth has occurred in small plans with fewer than 10 employees. Most public sector plans (83%) are defined benefit.

Among workers aged 25 to 54 in 1993, 55% were covered in pension plays by their employers. Of these, 28% were in defined benefit plans; 17% were in plans that allow employees to make tax deferred contributions, usually with some match from employers (401k-type plans); and 10% were in some combination of a contributory and employer funded plan (Woods, 1994).

The risk in defined benefit plans lies with employers -- if they underfund the plan, they will not be able to make promised payments to retirees; if they over-fund the plan, they are subject to federal tax code violations and penalties. The funding levels depend heavily on actuarial assumptions about the workforce and on interest rate assumptions in financial markets. Some studies have shown serious underfunding of public sector pensions (U.S. General Accounting Office, 1993), which has serious implications for not only for future retirees but also future tax payers.

On the other hand, the risk of defined contribution (DC) plans lies with the workers. Employers contribute an amount or percentage into the DC fund. If funds are successfully invested and managed, the worker has a large fund to draw upon at retirement; if funds are poorly managed, the worker faces a smaller fund to finance retirement. Data from the 1989 Survey of Consumer Finances shows that among workers in defined contribution plans, the average value of the DC fund is $27,750; the average age of these workers is 42, leaving them with potentially

another 20 years to accumulate DC fund assets.

Tax codes and policies strongly influence the structure and funding of pensions. To the extent that tax policies provide employers incentives for one type of pension over another, or limit levels of funding, workers will face limits on retirement benefits. For example, there are maximum funding limits, which limit the tax-deductible amount employers can contribute to a plan; and if there is less money in a plan, the benefits which that plan can pay out will be smaller than they might be otherwise.

Coverage of Retirees

Increased coverage of workers should mean increased pension resources in retirement. Only 21% of households age 85 and over report any pension income, compared to 33% of households age 65; in those 20 years, pension coverage increased and has continued to increase into the present. Data from the 1989 Survey of Consumer Finances reveal that 58% of retirees receive a pension, with a median value of $6,240. For those retiring with a defined contribution plan, the average value of the fund at retirement was $98,500 and they receive an average of $4,800 per year in retirement benefits.

Private sector defined benefit plans may be insured by the Pension Benefit Guaranty Corporation (PBGC). This insurance provides some retirement income security for workers, but as with other federal insurance programs, PBGC faces large liabilities. Some raise the issue of the need for a taxpayer bailout in the future (Salisbury, 1994).

Payout option selection varies by gender. Over half (56%) of male retirees choose a payout option with a survivor benefit equal to the retirement benefit (i.e. pension payments to the survivor remain constant after the death of the worker/retiree), while two-thirds of female retirees choose a single life payout option with no survivor benefits (i.e. benefits end upon the

death of the worker/retiree).

Beyond this, little is known about the factors affecting the pension payout options people choose. And it turns out that this decision of how to receive a pension payout has serious implications for the financial well-being of the pensioners and their survivors in retirement. For several payout options (e.g. annuities), the choice is irrevocable once made. Thus, consumers need the best information possible to make this life-affecting decision. Furthermore, the payout option decision is complicated not only by the number of pensions for which one and one's spouse are eligible but also by the sheer number of choices in any one individual plan (in one case, 18 different payout options); there are dozens of possible combinations of payout options for multiple source of retirement income which consumers must sort through.

Asset Income

Saving for Retirement

It is somewhat difficult to distinguish savings for retirement from other household savings with a few exceptions: individual retirement account (IRA) holdings and participation in a tax deferred earnings plans (401k/403b plans). Among workers in the 1989 Survey of Consumer Finances, 13% have an IRA with a median value of $20,000; the annuity value of this is about $963 per year. In addition, two percent are in Keogh-type plans.

About 21% of workers have some sort of tax exempt saving (401k or 403b plan) for retirement separate from an IRA. The median value in these other tax deferred funds is $11,000; the implicit annuity value is about $850 per year.

Reasons for low participation rates in IRAs and tax deferred savings include confusion over the choices available to workers, lack of information and assistance from most employers' human resource/benefit offices, and a mis-understanding of the effects of pre-tax savings on take-

home pay. While some segments of employees are becoming more sophisticated in their understanding of financial markets and products, the vast majority of service and blue-collar workers remain overwhelmed and are stunned into inaction by the choices they face in the financial arena. As long as this confusion exists, workers will under-save, further weakening the financial future they face due to their higher risk defined contribution pensions.

Adding to concerns about low savings rates for retirement is the use of pre-retirement lump sum payments upon separation form employment. Among persons age 27 to 54 receiving a lump sum payment, 28 to 31% spend the money on consumer products, medial or general expenses rather than rolling it over into another retirement investment (e.g. a rollover IRA) (Woods, 1994).

Asset Income in Retirement

Assets are clearly an important retirement resource and source of income. It appears that assets play an increasingly important role in income as one ages (note that assets account for 19% of income at age 65 and 28% of income at age 85). While asset holdings appear widespread (67% of older households report some income from assets), there are differences by race (72% of white households, 26% of African-American households, and 34% of Hispanic households report asset income) and by income (90% of high income households and 30% of low income households report asset income) (Grad, 1994).

The financial asset holding pattern of older households is heavily weighted towards low risk investments. At retirement, the average household holds 56% of its financial assets in saving and checking accounts, 13% in stocks and bonds, and 30% in life insurance. Eight years into retirement, the portfolio has shifted to be even more conservative with 73% of holding in savings and checking accounts, 10% in stocks and bonds, and 17% in life insurance (Hogarth, 1987).

Thus, even though large proportions of households have financial assets to generate asset income, the assets themselves do not generate much return.

Among retirees in the 1989 Survey of Consumer Finances, 14% have an IRA with a median value of $24,000; the annuity value of this is about $2,250 per year. Less than two percent of retirees have any type of tax deferred savings with a median value of $10,000, and an expected annuity value of $2,130 per year.

Once retired, many families do not know how to manage the private savings they do have. Nearly 20% of families spend-down their retirement savings faster than they should based on average life expectancies (Hogarth, 1988). Another 25% have asset management patterns that hint at confusion and guess-work in handling finances (Hogarth, 1991).

Projections for Future

In the near term, it is necessary to maintain the income security of current retirees. In the longer term, it is necessary to consider incentives for providing income security of future retirees.

Income Security of Current Retirees

Insuring the continued payout of pension benefits is a priority for current retirees. Insurance for pension funds, whether via PBGC or some private sector venture, is one mechanism for assuring the payout of benefits. Pension funds need on-going support and encouragement for appropriate funding levels and investment policies for pension funds.

Regarding assets, retirees may benefit from education to help them better manage and use their financial assets. Given the large proportion of financial assets retirees hold in bank accounts and the continued changes in financial markets (e.g. further deregulation of banks, changes in the Glass-Steagal Act), retirees may be particularly susceptible to misunderstanding the consequences of asset management choices.

Income Security of Future Retirees

Future retirees have the benefit of time to make choices and decisions that can help improve their retirement income security. Participation in tax-deferred savings (IRAs, 401k/403b plans) is low; workers need information and encouragement to increase participation in these programs. Levels of retirement savings in these tax deferred accounts also seems low; workers may benefit from a clearer understanding of future income needs and the relationships between pre-tax savings and take-home pay.

While workers may not be able to influence the type of pension their employers offer, they are able to set up a personal savings plan in response to the type and level of pension benefits they expect. Workers need to understand the risks they face in defined benefit and defined contribution plans, and they need useful information on their pension plans in a timely manner. Clear, concise annual reports on funding levels and future benefits may help workers adjust personal savings.

Choosing a pension payout option is a complicated decision. While TEFRA helped to improve household decisions regarding survivor benefits for pensions, payout choices remain a complicated decision. A poor choice severely effects retirement income security for the rest of the life span. Education and assistance in making this critical decision is a priority.

Policy Considerations

Many citizens and workers are surprised that only 55% of workers are covered by pensions. In part, this is a function of current employment patterns and pension vesting requirements. "Portable" pension plans across industries and/or occupations is an option to explore.

In a similar vein, tax payers may be facing a significant burden in the future due to underfunding of public sector pension plans. Clearly there are tax-burden constraints at both the

state and federal level. However, providing retirement income benefits for a range of public sector employees, from school teachers to municipal workers, is essential to maintain a workforce for these positions.

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EMPLOYMENT OPPORTUNITIES FOR THE AGING: ISSUES AND POLICY CONSIDERATIONS

1. OVERVIEW

This paper briefly summarizes the issues underlying the debate about increasing employment opportunities for older Americans. In the interests of brevity, it is limited to the development of a framework which may facilitate discussion among the Conference delegates. The paper is organized in three sections: the history and the current status of employment among seniors, projections of these employment prospects for the 21st century, and possible reforms of policies affecting these employment prospects.

2. ASSESSMENT OF CURRENT SITUATION

The provision of pension benefits to workers is a relatively new element within the U.S. economy. The American Express Company was the first company to provide such benefits in 1875--to disabled workers with twenty years of service. The railroad industry pioneered the provision of pension benefits to its general workers in the late 19th and early 20th centuries. By the beginning of World War I, about half of railway workers were enrolled in a pension plan. There was no public retirement system, of course, until the passage of the Social Security Act in August of 1935. Changes in tax law and rules governing collective bargaining during and after World War II accelerated the growth in pension plans during the 1950s.

In part due to the spread of these plans and also due to a general increase in economic prosperity, the labor force participation rates (that is, non-retirement rates) of older male workers fell precipitously after World War II. In 1947, 90 percent of men between 55 and 64 and nearly 30 percent of men over 65 worked; by 1988, the comparable figures were only 54 percent and 11 percent. This decline in the attachment of males to the workforce seems to have ceased sometime in the 1990s. A similar decline did not occur among older women, probably because any increased tendency to retire was offset by a general movement of women of all ages into the workplace.

Since the last White House Conference on Aging, the situation of older workers has changed, not because of any specific policy changes but due to changes in the United States economy itself. Keenly affected by foreign competition and the domestic recession of 1990-92, many U.S. corporations, large and small, have "restructured" themselves. Organizations have begun regular cycles of "downsizings" which often feature incentives for the early retirement of older workers.

In 1995, the American retirement system is performing well and has enough resources for its current needs. Incomes of the elderly are at an all-time high and their poverty rates are now no higher than for the rates of the younger population. Elderly incomes come from a wide range of sources. Three are associated with the retirement system itself: social security (40 percent

of income), private pensions (21 percent), and personal savings (about 20%).

An additional 15 percent of elderly incomes comes from wages and salaries derived from employment. Employment during "old age" has many positive impacts, besides the generation of income. One is an increased self-esteem; another may be continued health and vitality--many older workers say they enjoy working because "it keeps me young."

3. PROJECTIONS FOR THE FUTURE

Despite its current soundness, there is some concern about the security of the U.S. pension system in the 21st century when members of the baby boom reach retirement age. Most seriously, the social security system is projected to begin paying out more than it receives in revenues in 2019 and to have exhausted the resources of its retirement trust fund by 2029. Because of the stringent funding rules set out by the Employee Retirement Income Security Act (ERISA), the private pension system is relatively healthy.

Despite the potential difficulties for the social security system, American workers are optimistic about their retirements. According to the authoritative Employee Benefits Research Institute, only 30 percent of American workers (over age 26) say they are "not too" or "not at all" confident about their ability to meet basic expenses in retirement. The Congressional Budget

Office has recently projected that "baby boomers [in retirement] will have higher real incomes than older people today.."

4. OPPORTUNITIES FOR REFORM

Because of the dire projections of possible insufficiency in the public retirement system, many scholars have suggested reforms. Their suggestions can be broadly categorized as reforms of the social security system and reforms of private sector policies toward older workers. Private sector reforms could increase the employment opportunities of older persons making them less dependent on social security benefits.

The two most commonly suggested reforms in the social security system which affect work effort are the elimination of the earnings tax or changes in the benefit formula. Those opposing elimination of the earnings tax note its repeal would be expensive (increasing social security costs over $13 billion) and would disproportionately benefit the wealthier segments of the older population. Changes in the benefit formula might split the formula into two components, one providing equal returns to contributions for all retirees regardless of their incomes, the other providing adequate benefits for the most needy. Increasing the rate of return on contributions during the working career would increase the incentive to work. Alternatively, the number of "drop-out" years could be reduced from its current level of five, increasing the return to persons who work steadily throughout their careers, but potentially hurting parents who

interrupt their work to raise children or workers whose careers are interrupted by sickness.

Reforms of private sector employment policies would make older individuals less dependent on social security. Many possible reforms have been suggested. The Commonwealth Fund, a major New York philanthropy, in its Final Report on The Americans Over 55 At Work Program, lists a number of the more commonly suggested possibilities: increased availability of training, flexible retirement programs, expanded self-employment opportunities, making pensions "age-neutral" and portable, and more vigorous enforcement of anti-age discrimination regulations.

One possible obstacle to such private sector reforms are the attitudes of American managers who are generally held to be antithetical to the increased employment of older workers. This reluctance is not discriminatory if it is based upon the productivity and cost of these workers relative to younger workers. The disadvantages of older workers usually cited by managers are lower productivity because they are slower and less technologically proficient, reduced promotion opportunities for younger and middle-aged workers, less flexibility in their work assignments and higher health costs.

Besides the possible reduced productivity that might result from increased employment of older workers, there is a less obvious cost to society: their reduced availability to family and volunteer activities. Many older persons volunteer in their communities or perform key roles in their families. If working,

they are less able to care for their grandchildren as their sons and daughters work, to visit sick persons at the local hospital, to perform church related tasks, or to care for disabled friends in their neighborhoods.

DRAFT

WHITE HOUSE CONFERENCE ON AGING - ISSUE PAPERS

Maximizing Housing and Support Services Option
Sub-Issue: Linking Support Services to Housing

February 28, 1995

I. Overview of Major Issues and Policy Considerations

Fully 78 percent of all seniors living in the United States in 1989 owned their own home. Almost 80% of these seniors had fully paid off their mortgage, and over 58% had lived in their house for at least 20 years. Given these statistics it is no surprise that the majority of these people want to age in place and not move even if they lose some functional independence. Many of the remaining seniors who rent, rent an apartment they are fond of, in a location that connects them to friends, family and neighborhood institutions and services they like. Most of them also want to age in place. Even if the house or apartment of these seniors is well designed and barrier free, there can come a time when advancing frailty and functional disabilities will require that they also receive a number of support services with daily living in order to remain in housing they control, and avoid moving to institutional care. Therefore, the link between housing services and support services becomes crucial.

Conventional housing can contain many barriers to independent living and can be in locations that are dangerous or isolating. Another major link between housing and support services is deciding when a pre-retirement home is no longer supportive and choosing some form of assisted independent living that allows the resident to retain maximum independence, privacy and quality of life, and postpone or avoid a move to an institutional living arrangement.

From a policy perspective, the major question are: Does our society provide comprehensive and coordinated visiting support services to stay in conventional housing if desired? Does our society provide adequate case management with the complex choices between staying in conventional housing with visiting support services or moving to a more supportive assisted living arrangement that fits one's needs and life style? Does society provide adequate assisted independent living choices? As the following text suggests, as personal income eeclines, so does choice in support services and housing. Furthermore, the more complex a person's support needs the fewer support choices available and the poorer the management and coordination of those services. These problems result because our support programs are categorically conceived, resulting in narrowly focused support service vendors providing very specific and limited services. Most communities lack a comprehensive overview of the range of services, the quality of service coverage, the range of individual support packages needed, or the coordination of service delivery.

II. Assessment of Current Situations

Typically, the poorer a person is the fewer support options he/she has. The poorer you are, the more likely you live in a house that is too costly to adapt successfully within the resources available to you. The older and cheaper the home the more stairs are likely, the more windows that are difficulty to open, the more drafty the house and costly to heat, the worse the lighting, the less adaptable the plumbing, the more overgrown the landscape and the more dangerous the neighborhood. The rising costs of maintenance, utilities and taxes can cause people on fixed incomes to sacrifice other support necessities just to retain their home. The less supportive the housing, the sooner and more frequent the need for support services to help with activities of daily living. The more costly the housing, the fewer resources remaining to pay for those support services.

There are three basic sources of support services: 1) informal support from friends and family, 2) privately hired support and 3) community based and government subsidized support provided by a combination of volunteers and professionals. Once again, the poorer one is the fewer support options. Typically, seniors will have incomes similar to their potential informal support network. The lower the income of the informal support network, the fewer resources they have to provide services like housing, transportation or meals. The more one intends to live alone and rely on informal support, the more planning is needed. The burden on informal care givers can become severe over the long term and the quality and reliability of support can go down if the care givers' resources, both time and money, are low and being depleted.

The cost of private pay services are high and getting higher because of the time and expense of travel at odd hours between dispersed clients. Therefore, the poorer you are, the less feasible are private pay services.

This leaves community based services. As stated in the opening section on current policy, we have evolved social service programs categorically so they are not coordinated under one comprehensive support service. Each service vendor concentrates on a single categorical service or a few closely related services. When persons begin to require multiple community based support with say physical therapy, occupational therapy, personal care, housekeeping, meals, transportation, episodic nursing, and so on, they can find they are only available from multiple vendors. The range, quality and reliability of each vendor can vary dramatically depending on the availability, service load and dedication of the care givers. Some community based support can be non-existent in poor inner city neighborhoods, the newest suburbs and most rural areas. If the resident relies on government subsidized services there can be a waiting time in some areas before some services are available, and most subsidized services are not available at nights or on weekends. Once multiple services are needed, they need to be coordinated or quality of life will be sacrificed, but many community based services whether private pay or subsidized are not case managed. Even when case management is available, it frequently lacks the power or authority to tell the different vendors when and how to deliver support so it is coordinated among vendors and with informal care givers.

For seniors who have housing choices in old age, linking support with housing also means deciding what combination of housing support and service support best fits their life

style and tastes. One way to adapt to advancing age is to move to more adaptive housing where support services are part of the housing accommodations.

Assisted living schemes include "congregate living" facilities where residents retain a private apartment but receive various services short of nursing care. The common service is congregate meals eaten in a group dining room, hence the origin of the name. Another model is "total life" or "continuing care" facilities which retain independent and private apartments but provide a nursing wing on-site along with congregate living characteristics. Still another is the vast array of "board and care" facilities that can range from an adapted private home to a purpose built facility. These tend to be unlicensed and small owner operated boarding homes that provide at least a private bedroom and family style dining, but can vary with regard to all other support, if any, that they provide. There are many variations of these models and other, less popular forms of assisted-independent group living with on-site support. All these housing plus services solutions can help the resident postpone a move to long-term institutional care, but all provide some living adjustments for persons who have spent their lives in private conventional housing. Deciding when to move is another form of linking housing to support services. If a move is planned long enough before it becomes an absolute necessity, the resident will have more life style alternatives to choose from, and the time to acclimate to and enjoy the more supportive surroundings.

Once again, the poorer a person is the fewer the choices. Most assisted living facilities are private and expensive. Less than 30% of the publicly subsidized housing for seniors has been designed or converted to include on-site support services case managed by

on-site staff. Among the best of this housing, the Section 202 Program, there is an eleven year waiting time in the larger urban areas nation wide.

Even where a person can afford to move to assisted living, making the right choice can be tremendously difficult. Take as an example just the main service of congregate living the meals. Some facilities provide just 5 meals per week, others three meals a day seven days per week. Some require that all meals be purchased and eaten in the congregate dining room. Others only require a minimum number of congregate meals per month, more to meet cost economies than some minimum level of frailty in tenant eligibility. Some have a cafeteria style of dining other use waiter service. Some have an on-site kitchen staff, others use catered meals cooked off-site. All of these factors affect the support capacity, social "atmosphere," and life style surrounding congregate living. All other support service characteristics can vary as well. All service can be affected by the size of the resident population and the size of the on-site staff. All these variations in housing and service design and delivery can affect the degree of individual resident privacy and control.

III. Projections for the Future

There are four progressive messages about linking housing and services as this country ages and the proportion of frail seniors increases. First, is that the home one chooses in old age can be a source of comfort, security and identity if it is barrier free, easy to maintain, affordable, in a convenient and safe location, and the resident has access to support services as needed. Without these basic amenities, private housing can become an

expensive, uncomfortable, worrisome barrier to successful independent living.

The second message is that the choice between adapting a pre-retirement house in old age, or choosing a more supportive accommodation in an assisted living facility, is a complex process with both life style and support service links to consider. How vital is home ownership to personal identity and status? How skilled and willing is the resident to remain his/her own landlord while aging in place? What types of adaptation can the resident afford and are viable/warranted at the current residence? What types of informal and formal support services are available in the location of the present home? How secure and barrier free is the home, neighborhood and community? What alternative housing moves are available and affordable and how far away are they from informal support networks and treasured social institutions? How much of a compromise in desired living arrangements are the available assisted living alternatives?

The third message is that most support service professionals are trained in nursing or social work and know precious little about how to advise seniors on making housing choices in old age. They know very little about how to adapt the environment, the costs of doing so, how to finance it or even who to contact to advise their clients. They also know very little about the alternative housing options should the person need to move or want to move. Most know far more about the nursing homes in their service area than the various assisted independent living arrangements available.

This all leads to the fourth message which calls for two new policy priorities. First, we need to begin to train "comprehensive case managers" able to assess holistically the medical, daily living, social networks and housing needs of their clients and help them

arrange a supportive living environment that will maximize their independence and dignity. This is a combination of medical case management, support service case management and care and repair of housing case management, all of which have been defined separately. Unfortunately, we have so compartmentalized these professional skill areas and community support networks in the United States, that most localities do not have case managers with this full range of skills. Second, we must link our federal, state and local funding for, housing, medical and social services so comprehensive case managers have the capability and authority to access and deliver all these resources in an orderly and useful manor for a single client. Currently, funding for the component parts are still so fragmented and categorical that comprehensive service management is impossible.

IV. Aging In Place and the Links Between Housing and Support Services

Perhaps the most disturbing aspect of aging in place in the community is that the combination of housing and support services will either be too little support making life too difficult for the resident, or too much support, causing skills of independent living to atrophy. The ultimate goal of linking housing and support services is "holistic aging in place." Holistic aging in place cannot occur if there is a wide array of different support components each conceived at a state or national level and each administered by separate bureaucracies. Holistic aging in place means locally conceived support systems that are comprehensive within a range appropriate to cultural, socieoeconomic, and environmental needs. Holistic aging in place provides even low-income and very frail people with

meaningful life-style and support choices. It also means programs with equal partnership between user and provider. This partnership should be flexible and dynamic so that it teaches both user and provider how to adapt and improve the quality and efficiency of support. If it is truly flexible and dynamic, support needs will be allowed to evolve so that support is only provided at the margin of the individual users efforts to remain independent by his or her own means. Ultimately, this means support programs that promote "individual freedom," even if this could mean increased risk of delayed support in emergencies. In short, holistic aging in place places greater value on individual privacy, dignity, choice and control of daily living than it does on categorical programs and the extremes of emergency care.

Finally, holistic aging in place will work best if it becomes a social commitment of our society and a right of all citizens throughout the life cycle, so holistic programs must include societal education about the aging process and societal involvement in facilitating or providing support. The best and most supportive housing for elderly people is the best possible housing for people in general. We can all benefit throughout our lives from housing that was initially designed to be adaptable over the life cycle, as opposed to housing that must be adapted to fit increasing frailty. Special housing for different stages in the life cycle only serves to segregate people by age and disability, and this can never be called a holistic solution to aging in place.

WHITE HOUSE CONFERENCE ON AGING

Issue Paper

Consumer Choice/Decision Making/Promoting Independence

BACKGROUND

Providing opportunities for choice is necessary to meet the varied and changing needs of older persons. Think of the possibilities for choice:

The retirement decision forces choices in lifestyle, expenditures, and time allocation. When an aged person becomes disabled, there are choices to be made about how to meet their daily needs, including whether or not there will be outside help, who will help, what tasks to help with, how often, where care will be given, how safety will be balanced with independence, and how to ensure choices available to quality and satisfaction. When a person moves to senior housing, assisted living, group home, or other site, they must choose what location, at what rental, and so forth. Finally, there are choices about health care, particularly end of life decisions.

Most program designers would agree that programs should be responsive to the needs and wants of the person they intend to serve. They may not agree to the same extent, however, that such responsiveness should be in the form of consumer choice. After all, in many social programs it is questioned whether the consumers have the information or knowledge to make the "right" choice; further, there's concern that the individual may make the "wrong" choice, including harmful choices, thus defeating the purpose of the program in the first place; and finally, many programs operate on the assumption that consumers will want more than professionals think they should get.

The failure to be responsive to the needs and wants of users or consumers and particularly restrictions on freedom of choice is not without consequences. Many social welfare programs reach only a small percentage of their intended recipients. There are always more poor families than those receiving welfare and the utilization rate of SSI is somewhere between 40 and 70 percent of eligible people. This may be accounted for in part by overlooking the preferences of the target population. Similarly, despite the fact that homelessness is a major problem in this country, there are public and subsidized housing units for the elderly that are vacant because people choose not to live in that environment, do not want to live in a studio apartment, or are concerned with the lack of services or amenities. Utilization of mental health services by older persons is less than expected which may be due in part to the stigma mental health services represent to older persons or the failure to give older persons choices of settings or service modalities.

Nearly 80 percent of long term care is provided by informal caregivers with a lesser amount provided by formal agencies. This may reflect the older person's and the family's preference, but it might also suggest that agencies are providing formal services without adequate attention to consumer preferences -- e.g., convenient for consumers, or without effective marketing.

Another consequence of lack of choice is that people may accept without complaint what they receive free and/or from the government because they are afraid that if they complain they may lose the service altogether or be punished in other ways - a particular concern of nursing home residents.

Finally, in the nursing home setting "lack of control [and choice] has negative

effects on the emotional, physical, and behavioral well-being of nursing home residents." (Hofland, 1988). Those outside of institutions can also face such effects.

WHAT RESEARCH SHOWS

Research in the marketing world has concluded that older persons are able to exercise choice: "Older persons appear in general to be competent consumers and more often than not are active complainers when they feel something is wrong. Their problems appear to be similar to those of persons in any other age group." (Schutz et al., 1971)

Moreover, older people cannot be lumped together: "Older people no more fit a stereotype than members of other arbitrary groupings of people. Indeed, as persons age they become much more heterogeneous in terms of both physiological and psychological traits. The only blanket assertion that applies to older people is that they lived longer." (Bloom & Smith, 1986)

Research from the long term care sector documents the capacity of older adults to make informed decisions. For example, one study found that

> "[Although] the cognitively impaired seem to have special problems in understanding correct information . . . the condition of the depressed elderly did not seem to substantially alter their capacity to give a valid consent because their reasoning was not significantly poorer than the control group's nor was their overall comprehension impaired relative to the control participants." (Stanley, 1988)

Long-term care policy, however, often seems to be based on the assumption that older people cannot make informed decisions. Referring to a program (described in the next section) emphasizing consumer choice, Lawton (1994) said,

> "There was this general good sense and rationality shown by the older tenants . . . This is another assurance, within limits, that people are not just giving to grab services because they are there . . . This outcome is big news."

At the same time, it should be noted that an older person's decision to age in place it is usually made in a family context.

> "Whether or not an elder desires or is able to age in place is often a function of the availability and willingness of family members to provide needed support; . . . " (Silverstone and Horowitz, 1992, p. 28)

Clearly older persons can and do make choices even though they may be shaped by family situations or made more difficult by cognitive impairment.

AN EXAMPLE

A program on supportive services for senior housing funded by the Robert Wood Johnson Foundation can serve as an example of a successful program based on consumer choice. The program developed a consumer-driven model of supportive services that now involves 20 states, over 500 senior housing developments, and over 75,000 persons.

The program was operated through state and local housing finance agencies (HFAs).

The SSPSH operates on the assumption that, in order to ensure that services are both appropriate and used, residents must play a primary role in service planning and service delivery. This includes charging fees for many services. Advantages of consumer choice include:

Promoting resident autonomy. Residents, owners, managers, and families share the goal of fostering residents" independence and helping them to remain in their apartments. When consumers make the choices, instead of having services prescribed for them, they feel more in control and are less likely to fear that they will be stigmatized for being weak or "taking charity," or that they will be evicted. Several HFAs report that previously isolated residents have become happier and more active as a result of the SSPSH. For example, a resident purchasing one hour of housekeeping assistance weekly resumed a leadership role in the resident association "because I feel so much better being able to keep up my home the way I used to." In an even more dramatic example, a resident who had not left her development in eight years began doing so regularly after joining fellow residents on a trip organized with help from the service coordinator. Managers and residents in numerous developments report stronger resident associations and other indications of healthier resident communities as a result of the SSPSH.

Willingness to pay. Residents are more willing to help pay for services they want. For example, in some states residents pay for SSPSH services because of superior quality or greater flexbility, even though they are eligible for similar, less expensive non-SSPSH services.

Quality assurance. The "power of the pocketbook" helps to ensure that services not desired or of poor quality will have a short tenure. In the SSPSH, services are continued when financial break-even points are reached, when other outcomes are satisfactory, and when residents are satisfied. HFAs, managers, and service coordinators monitor service use, conduct surveys and focus groups, and talk regularly to residents, subcontractors, service staff, and other providers. When service use declines, as in a private business, questions are asked: Do consumers dislike the provider? Do less expensive alternatives exist? Are costs too high even in the absence of less expensive alternatives? Is demand cyclical? When answers are obtained, necessary adjustments are made -- e.g., a housekeeping contract may be put out to bid again for lower prices or different options, or personnel may be changed.

Improved staff-resident relationships. A consumer-oriented program helps to remind staff to treat residents as partners. Many managers report that they are surprised at how much residents can contribute to starting and maintaining supportive services programs. In addition, managers find that addressing residents' service needs more effectively increases their enjoyment of the time they spend with residents.

Impact on service providers. With services based on consumer choice, service provider agencies are more likely to "cluster"[1] services. Some agencies saved enough

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[1]With clustering, fewer providers, or the same number but in fewer hours, accomplish the same tasks. For example, instead of several residents receiving homemaker services from several homemakers who also serve clients in other locations, the agency assigns one homemaker to the residents. Laundry, shopping, and other errands are done for two or more residents at a time, reducing the homemaker hours required without decreasing each resident's time with the homemaker. Homemakers benefit from a more regular job and less traveling, which may decrease turnover.

money by clustering homemaker services to serve additional eligible residents who had been on a waiting list for services. Providers also start to think more creatively about services in which the development might be interested: For example, an agency that won a contract for service coordination followed up with an attractive proposal for minibus services. The resulting arrangement represented a better use of the minibus and affordable transportation for residents.

IMPROVING CHOICE

What can be done to improve consumer choice in housing and long term care programs? It is difficult to measure what consumers want when they don't have some way to "vote" either by paying or refusing to pay or registering their concerns in some other way. One answer is to provide services through the market. If the market is working efficiently, people have the option of buying or not buying, changing providers or taking other steps that one can take in a market situation. Market forces are hindered, however, by people's inability to pay, by extreme needs (e.g., incontinence), and by supply problems. A second option is to provide people with income rather than with services in kind. Income supplements can be individualized and in that way service workers would not have to try to force non-medical supervisory needs into a medical model and could successfully integrate resources related to income, health, social services and housing. The income supplements allow for direct cash payments to recipients enabling more autonomy and independence than third party or other reimbursement systems which "provide for" the clients. An income strategy would also allow informal

supporters such as relatives to be compensated for their efforts. Use of housing vouchers may also expand choice of housing but would be more limited than cash supplements.

A large segment of the services in long term care, however, will not be provided by the private market or through income supplements, but rather through purchase of service or direct provision by government at different levels. What can be done to make these programs more responsive to client wants and provide opportunities for choices? This, unfortunately, has been a neglected area of research. Interest in consumer choice must be instilled as a value in public programs and then methods of insuring it need to be developed. In addition, use of sophisticated market analysis can focus on those program characteristics that can be designed to be responsive to people's wants and choices.

Leutz has listed the following questions that policymakers can ask to ensure that programs provide for consumer choice: (Leutz et al., 1993)

- Do consumers have choices among areas and levels of coverage?
- Do patients have a choice of care setting?
- Do consumers have choices among delivery systems and provider agencies?
- Do patients have choices among individual providers?
- Are available services sufficient to satisfy clientele preferences?

CONCLUSION

The ability to exercise choice in housing and services has the benefit of better matching consumer wants with the type of housing and services supplied. Better

matching means increased satisfaction and, perhaps, greater willingness to pay or help pay for the housing or services thus extending public dollars. Choice means greater control, which can improve an older person's self image and lead to greater self determination. Clearly the White House Conference on Aging should have as a value the maximization of choice for older persons. This value must be incorporated in policy in two major ways: Providing a variety of housing and service options so there are real choices to be made and by giving the older person the personal skills and structural opportunities to exercise choice.

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Delegates Legal Issue Paper

Age Discrimination ...

Ineffective enforcement of the Age Discrimination in Employment Act and other civil rights laws has marked the Equal Employment Opportunity Commission (EEOC) for many years. The President's recent appointment of a full Commission and a permanent Chairman enables the EEOC to achieve enforcement of the law on several fronts. Legal issues to be addressed include:

- **prompt processing of administrative charges**, ending the EEOC practice of disposing of charges by finding "no violation" in 96 percent of its cases; eliminating the current backlog of 25,000 age discrimination charges; and reducing the average time for processing new charges from the current 18 months to 90 days;
- **issuing regulations on proving age discrimination** which describe discriminatory acts by employers, including the layoff of workers according to age-linked factors such as seniority, salaries, or pension eligibility; and
- **waiver protections** which define protections in the Older Workers Benefit Protection Act for older workers who unknowingly waive their rights.

Americans with Disabilities Act (ADA) ...

The ADA prohibits discrimination against people with disabilities by employers, by businesses open to the public, and by state and local governments. Older Americans Act (OAA) programs and the service providers with whom they contract and do business are covered by the ADA. Key legal issues include:

- **focusing on how to accommodate people with mental impairments**, so that they can

benefit from the ADA's nondiscrimination provisions;

- **educating older persons with disabilities** so that they understand that they are protected under the ADA; and
- **educating OAA programs and service providers** so that they understand how the ADA applies to their programs and the services they provide.

Adult Guardianship and Protective Services ...

Protective services and adult guardianship laws are designed to protect vulnerable older individuals who may be abused or who may lack the capacity to care for themselves. Key legal issues include:

- **assuring the right to an attorney who acts as an advocate** for all respondents in guardianship proceedings;
- **implementation of new state guardianship laws** that provide additional due process protections for respondents;
- **assuring autonomy and respect for the wishes of the older adult** whether expressed verbally or through an advanced directive;
- **using the least restrictive alternative when providing services** through an adult protective services program, and when determining the need for appointment of a guardian; and
- **addressing financial abuse** through developing programs and remedies that address exploitation.

Elderly Housing ...

The federal Fair Housing Amendments Act (the Act) continues to be used to define the

scope of accommodations in housing programs and services that elderly persons may need to maintain independent living in the shelter of their choice. Key legal issues include:

- **reasonable accommodation** , for both private and subsidized housing providers, defining and developing the reasonable services and assistance that must be made available to an elderly person with disabilities to ensure their ability to continue living in their current residence;
- **significant risk to the health and safety of others,** ensuring that the Act's strict standard for excluding a person from housing is upheld by distinguishing between an actual and immediate risk to others and incidents related to aging and disability that can be addressed through reasonable accommodation;
- **senior housing exemption,** defining in future HUD regulations "significant facilities and services" that housing for older persons must provide in order to meet the exemption under the Act; and
- **designated housing**, evaluating the impact of HUD's new regulations permitting public housing authorities to designate specific buildings or portions of buildings for "elderly families", "disabled families" or "elderly and disabled families" to ensure full compliance with the Act.

The Employee Retirement Income Security Act (ERISA) ...

ERISA's effectiveness in protecting the retirement benefits of workers has weakened over the past 20 years as the economy and the job market have changed. Despite numerous amendments to ERISA , higher - paid workers are ten times more likely than lower paid workers to be covered by a pension plan sponsored by a private employer. The shift away from

traditional pension plans and towards voluntary savings plans raises additional income security considerations. Key legal issues include:

- **requiring all employers to provide pension coverage for all workers**, including part-time and contingent workers and those employed by small businesses;
- **using voluntary savings plans** to supplement, not supplant, traditional employer sponsored pensions;
- **increasing pension adequacy** (1) through the elimination of benefit formulas that offset pension benefits by Social Security benefits, and that skew benefits in favor of certain workers; (2) through the addition of cost-of-living provisions for all pensions; and (3) through the development of a portable pension system;
- **protecting spouses and former spouses** by increasing the survivor benefit paid to a surviving spouse and by requiring that pensions automatically be divided upon divorce unless the parties agree otherwise; and
- **requiring public pension plans to meet minimum standards** for funding, accountability, disclosure, and spousal benefits.

Home Health Care Issues (Medicare and Medicaid) ...

The demand for and the utilization of home health care services is increasing rapidly under both programs. This has caused states to re-evaluate Medicaid expenditures for home health, including cuts in the scope of services (including the frequency of use) that are available, and the exploration of more restrictive eligibility criteria. For the Medicare program, growth in utilization has lead to an increased emphasis on monitoring and limiting over-utilization, including fraud and abuse, the exploration of needs assessment instruments, and the possibility

of co-payments as vehicles for addressing utilization and costs. Legal issues include:

- **assuring that due process in needs assessment (and re-assessment) approaches** include a mechanism for patient involvement in developing the plan of home health services and must include notice of a specific mechanism for the review of a denial, reduction, or termination of services based on a needs assessment; that the frequency of use of specific home health services in not subject to arbitrary and inflexible limits; and that where services are denied, reduced, or terminated on the basis of utilization protocols or limits, beneficiaries are informed in writing of such limits and of the mechanism for review; and
- **assuring an adequate scope of services** while balancing the need to observe budgetary constraints against providing program benefits that maintain and/or improve the medical status of a program beneficiary; that cuts in Medicaid and or Medicare home health spending do not have an unfair or disproportionate impact on certain groups of beneficiaries, e.g., persons suffering from particular illnesses or persons living in rural areas.

Long-term care, including nursing facilities ...

Older people and people with disabilities require a variety of long-term care services to meet their health care and daily living needs. An increasing trend is the movement away from traditional nursing homes. More services will be provided in the homes of individuals, in community-based settings, and in institutions with new and different names. At the same time, however, nursing facilities will continue to remain important settings for long-term care services. Key legal issues include:

- **assuring choice and control** over the types of services that individuals receive and the settings in which they receive them, regardless of payment source or disability;
- **assuring coverage of preventive care** as a beneficial and cost-effective part of all long-term care services;
- **assuring high quality of care and quality of life**, reforms mandated by the federal nursing home reform law for institutional settings, in all long-term care services;
- **assuring nondiscrimination in receipt of long-term care services**, regardless of source of payment or disability; and
- **assuring appropriate payment** that reflects and fully supports the principles described above (choice and control; preventive care; high quality of care and quality of life; and nondiscrimination).

Medicaid ...

The Medicaid program provides an array of health and social services for poor people of all ages. While major changes in the structures and methodologies for delivering service to this population are anticipated, it is important that new approaches to delivery of services do not undermine current enforceable rights, including access to state and federal courts. Key legal issues raised:

- **assuring due process**, beneficiaries should receive notice and an opportunity for review of decisions not to provide them care;
- **enforcing the nursing home reform law**, a model for the provision of high quality care for institutionalized older and disabled people, must move beyond reliance on

decertification to the use of other sanctions;

- **assuring non-discrimination in long-term care,** federal policy should promote full access to nursing facilities for Medicaid beneficiaries, to avoid racial and economic discrimination;
- **dual-eligibility/buy-in programs** should promote eligibility determinations at the point of entry of the program bought into; individuals should not lose the benefits of one program by virtue of their eligibility for the other; and
- **federal Medicaid eligibility policy** should support and promote responsibility of parents to children and spouses to former spouses by excluding child support and alimony payments from income in eligibility determinations.

Medicare Issues ...

A consistent theme in the management of the Medicare program is the provision of coverage for medically necessary services while pursuing the goal of cost-containment. The U.S. Congress and the Health Care Financing Administration (HCFA), the agency within the Department of Health and Human Services that is responsible for the Medicare program, are pursuing this theme and goal through: developing more sophisticated mechanisms for monitoring the utilization of services, exploring alternatives to fee-for-service as the primary vehicle for the delivery of Medicare covered services, and exploring the appropriateness of requiring beneficiaries to assume more of the cost of the program. Important legal issues include:

- **assuring an adequate scope of services**, including new and innovative technologies and procedures, must balance the task of providing services and assuring cost-containment; the Medicare program envisions a broad scope of services that are medically necessary

and safe and effective; currently, cost-effectiveness is not part of reviewing and approving new technologies and procedures in the Medicare program; whether and to what extent cost-effectiveness becomes a factor in adding new technologies and procedures raises important statutory and regulatory issues;

- **access to services** must address the availability of a variety of service delivery models, e.g., fee-for-service or managed care (including preferred providers and health maintenance organizations); rural areas may have fewer medical providers and may lack managed care options; in other areas, age, race, ethnicity, and health status may have an impact on where providers locate services and may frustrate access to services and thus raise constitutional equal protection questions;
- **monitoring and enforcing quality of service standards** must not infringe upon the beneficiary's right to privacy while assuring quality and appropriate utilization and access to services;
- **assuring an adequate and timely appeals mechanism for the review of beneficiary claims** that is appropriate for a variety of service delivery approaches, particularly the exploration of managed care options, including notice of denials, reductions, and terminations of services and appropriate review mechanisms which include administrative and court review and expedited review at the administrative level for exigent circumstances; and
- **assuring an adequate and fair mechanism for setting reimbursement rates** that is open to input from providers, suppliers, and beneficiaries and must take into account the need to assure access to services.

Older Americans Act Programs (OAA) ....

Amendments to the OAA continue to focus on targeting limited resources to persons in greatest social and economic need. Targeting necessarily raises issues of developing objective measures and mechanisms for assuring that resources are used in accordance with statutory mandates. Key legal issues include:

- **intrastate funding formula development** that assures equal protection of law in meeting the funding and service needs of rural and urban communities as well as the special problems of large urban cities, and provides clear standards for obtaining the approval of the Asst. Secretary on Aging of intrastate funding formulas;
- **confidentiality in the reporting process** that is flexible enough to allow for obtaining information about the amount and types of legal assistance provided without violating the attorney-client privilege;
- **developing approaches to adequate funding for Title III-B supportive services** that include adequate review mechanisms for providers of services when questions arise about funding levels and service requirements;
- **providing for voluntary contributions from individuals toward the cost of services** is recognized only in the nutrition project, Title III-C, while OAA regulations on contributions are written broadly to include voluntary contributions from all services;
- **elder rights coordination,** required by Title VII of the OAA, includes the statewide coordination of Ombudsman, legal assistance, elder abuse protection, and pension and benefits counseling services without providing funding for all services, for example legal assistance; and

- **serving older Native Americans** must be included in state and area agency plans with enough specificity to assure coordination with tribal efforts.

SSI and Title II Disability Programs ...

There are a number of issues that will be addressed regarding the SSI and Title II disability programs. These include:

- **re-engineering the disability process** and assuring that recommended changes to the disability evaluation process do not have an adverse impact on persons 50 years old and older;
- **changing the definition of disability,** based on recommendations requested by Congress and conducted by the National Academy of Social Insurance, are expected; new definitions are to be created in light of changes in disability policy over the last few decades; it is also expected that Congress may act on its own in this regard given the escalating number of applications and growing backlogs; and
- **preserving an adequate appeals process** must not be overshadowed by efforts to streamline the current appeals process.

Supplemental Security Income (SSI)/Social Security (Title II) ...

The quality of service provided by the Social Security Administration (SSA) has seriously deteriorated over the last decade due to the loss of staff and the lack of resources. When combined with an increase in the number of applications, particularly in the disability programs, this has resulted in less service for individuals, longer waiting times and increased errors.

The SSI program has been the subject of recent attacks that seek to terminate or limit

payment of cash benefits to specific populations: disabled children, legal immigrants, and persons suffering from drug addiction and alcoholism. In addition, there may be efforts to eliminate the entitlement status of the SSI program and subject it to a spending cap. Key legal issues regarding the SSI program include:

- **retaining the entitlement status of the program**;
- **preserving SSI as a cash benefit program**, as opposed to a voucher program or providing services only through block grants to the States; and
- **maintaining current eligibility requirements**, as opposed to limiting eligibility requirements, e.g., establishing a transfer of assets penalty, raising resource levels, which would greatly limit the ability of the program to serve its intended populations.

CRIME, PERSONAL SAFETY, AND ELDER ABUSE

I. Overview of Major Issues and Policy Considerations

Although the fear and rates of victimization among persons 65 years and older are lower than among younger populations[1], the consequences may be more serious. Older people are physically weaker and more vulnerable, their bones more brittle, and their convalescence slower. Even a relatively minor injury can cause serious, permanent damage. Elderly persons who have been attacked on the street may become virtual prisoners in their own homes, afraid to venture outside, especially if they live in high crime areas. Many have limited incomes so that the loss of only a small amount of money may have a significant impact. If isolated, lonely, or troubled by illness, they become likely targets for fraudulent schemes. Particularly disturbing is the disclosure that some older persons are victimized by family members, trusted friends, or caregivers. In fact, older persons appear equally vulnerable to crimes perpetrated by strangers and by individuals known to them.

Personal safety has become an overriding concern to many older Americans, affecting the choices that they make about where they live, with whom they socialize, and how they spend their leisure time. To the degree that concern about personal safety limits choices, reduces independence, and diminishes autonomy, the quality of life is threatened. Reducing the level of violence in the

home and on the streets is a matter for all groups in society. This means equitable access to employment, education, housing, and health care for younger people; regulation of products that magnify the consequences of violence (i.e., alcohol and other drugs and firearms); and participation of young and old in broad-based community boards to further a national agenda aimed at preventing violence through education, promotion of legislation, identification of service gaps, and development of resources[2].

II. Assessment of Current Situation

A. Brief Background History

Crime. Even if older adults have not personally experienced an act of violence, they are much more aware of crime and criminal activities than earlier generations through daily accounts of violence in the newspapers and their depiction on television and glorification in the movies. The latest survey data and analyses of earlier studies indicates younger people, especially teenagers and young adults, are much more likely to be victimized than older people and that younger rather than older persons are more likely to fear crime. Nonetheless, among the older population there are elders who live in fear of being robbed or assaulted.

A study[3] undertaken by the Bureau of Justice Statistics examined patterns of both lethal and nonlethal forms of violent victimization against younger and older Americans and compared the findings between the early (1979-1986) and late eighties (1987-1990). The average annual victimization rates for the later period

was 33.4 per 1,000 persons under the age of 65 for crimes of violence (5.9 for robbery and 26.7 for assault) compared to 4.0 per 1000 persons 65 years and over (1.5 for robbery and 2.3 for assault). Unlike younger persons who were more apt to be victims of assaults than robberies, older persons were about equally at-risk of both assaults and robberies. Surprisingly, the violence perpetrated on older persons by relatives more than doubled during the two time periods while the proportion of crimes by acquaintances and strangers remained about the same. One can speculate that some of the increase may have resulted from the attention given to elder abuse, neglect, and exploitation.

Elder Abuse. Congressional hearings and the media played a critical role in awakening the nation to the horrifying conditions endured by some older persons at the hands of family members. In response to these accounts, the states passed elder abuse laws or amended their existing adult protection statutes to establish a system for investigation and service delivery. Forty-three of the 50 states require certain professional groups (e.g., physicians, nurses, social workers) to report suspected cases of abuse or be subject to a fine or prosecution.

The manifestations of elder abuse are numerous but generally grouped under four headings: physical abuse (e.g., slapping, bruising, sexually molesting); psychological abuse (e.g., humiliating, threatening, isolating); financial abuse (using money or property improperly or illegally); and neglect (e.g., refusing or failing to provide the necessities of life, such as food, clothing, heat, medical care). Whether behavior is labelled as abusive or neglectful may depend on how

frequently mistreatment occurs, its duration, intensity, severity, and consequences.

A multitude of causes have been proposed from "violence as a way of life in America" to "ageism in society." Based on the limited research on abuse and neglect, the most likely explanations are the physical and mental infirmities of the victim, the unhealthy dependency of the perpetrator on the victim and vice versa, the psychological state of the perpetrator, and the social isolation of the family. Just how significant stress or a family history of violence is as a causal factor has yet to be determined.

To date, there are no national data on the number of older victims of domestic elder abuse, neglect, or financial exploitation although the states do maintain statistics on the reports they receive and the cases that are followed. Between 1986 and 1992[4], the number of reports called into the state protective service systems almost doubled but it is not known whether the number of cases or the number of reports was actually increasing. Several studies conducted here and abroad indicate that about 5 percent of the population 65 years and older are victims of abuse, neglect, and exploitation; for the US, this proportion represents more than one and one-half million people, a number that is far higher than the state protective service reports. In fact, it has been estimated that for every case reported there may be as many as 14 that go unreported[5].

The information about abuse of older persons in nursing homes and other institutions is even more limited. One research team[6] interviewed more than 500 nurses and nurses aides in 32 long-term care facilities and found that 36 percent

had seen at least one incident of physical abuse by other staff members in the preceding year and 81 percent had observed at least one incident of psychological abuse.

B. Review of Resources

Crime. The police are increasingly aware of the growing older population and the need to address their vulnerability and fear. Almost every police agency conducts crime prevention programs that focus on fraud, con games, financial exploitation, personal safety in and outside the home, and home security. Police patrols function as crisis intervention teams ensuring the immediate safety of elderly persons and then referring them to the appropriate community agency. Some police departments have special units that help elderly victims complete identification forms and repair broken locks and windows. Among other activities sponsored by police agencies are 24 hour hot lines, volunteer programs to assist an elderly person through the criminal justice system, databases to which older persons have provided information voluntarily so that in the event of an emergency the police will be able to enter the home or contact a neighbor or next-of-kin; and adopt-a-senior programs that match police officers with isolated older persons[7]. Of course, not all police departments offer these services.

One of the newest resources for reducing the victimization of older persons is the TRIAD program, which draws upon an agreement among the International Association of Chiefs of Police, the National Sheriffs' Association, and the American Association of Retired Persons to encourage a cooperative,

coordinated, multidisiciplinary approach to crime-related problems of older persons. The local triads, formed by a sheriff, police chief, representatives of AARP or other older volunteers, are guided by an advisory group of older persons and service providers who help the law enforcement departments in determining the crime and public safety needs of older people and suggest services to meet those needs.

Victim assistance programs sponsored by the criminal justice system are also becoming more aware of the special needs of older persons and may offer special waiting areas, arrange for special transportation, make home visits, provide escorts, and even station nurses at the court house. Again, not all victim assistance programs have made such special arrangements.

Elder Abuse. In more than three-quarters of the states, the services for abused, neglected, or exploited older persons are provided through the state social service department; in the remaining, the state units on aging have the principal responsibility. Calls are received on special phone lines and screened for potential seriousness. If mistreatment is suspected, an investigation is conducted. If the case is deemed an emergency, the investigation must be completed within a few hours of the receipt of the call. On the basis of a comprehensive assessment, a care plan is developed. In most states, once the immediate situation has been addressed, the case is turned over to other community agencies for ongoing case management and service delivery. The majority of funds supporting these activities in the states comes form the federal government under Title XX of the

Social Security Act, now the Social Service Block Grant program. However, the states with the more highly developed programs use additional state appropriations or county tax dollars.

Since 1978, the federal government under the Older Americans Act has allocated a small amount of money for research and demonstration projects on elder abuse and since 1989, a few million dollars to the states for preventive services, used primarily for public awareness campaigns and professional training. It has also supported a national resource center (now the National Center on Elder Abuse) to serve as a central clearinghouse, disseminate information, provide technical assistance, and conduct research.

III. Projections for the Future

A. Assessment of Resources to Meet Projected Needs

Crime. Older persons can reduce their level of risk by taking advantage of local programs that teach methods of personal safety. Through the 1994 crime bill, many police departments will have additional resources to expand programs such as those cited above that specifically serve the older population. Efforts should continue by the aging network to educate law enforcement and criminal justice personnel about aging and the special needs of older persons. Ultimately, however, crime reduction is a societal issue. Older persons can play an important part in these efforts by supporting legislation that will create educational and economic opportunities for young people, by serving as mentors in schools and community centers, by advocating for conflict resolution and mediation as means

of settling disputes, by sharing parenting and caregiver skills, and by participating in community boards dealing with crime prevention.

Elder Abuse. Significant progress has been made during the past decade in understanding the nature and scope of elder mistreatment, developing methods of intervention, and disseminating information and materials. Yet, the increasing number of reported cases and the specter of even greater numbers in the future necessitate that a more aggressive approach be taken. New research of the problem and more sophisticated state information systems are sorely needed to provide a more solid knowledge base for policy, planning, and practice purposes. Reduction in the social services block grant both in actual and real dollars over the years has hindered some state adult protective service programs.

More attention must be given to primary prevention beginning with informing citizens and training professionals about elder abuse, how to recognize the risk factors and where to turn for help. A closer partnership between the mental health system, substance abuse programs, and elder abuse services is vital given the high proportion of emotional problems and alcoholism in abusive families. Support groups and training for elders that emphasize elder rights and advocacy, outreach efforts to reach minority communities, financial management programs, and instructional sessions in behavior management for caregivers of Alzheimer's patients are other ways of reducing the potential for abuse and neglect.

B. Opportunities for Future Public and Private Programs

The scope and complexity of violence as a social and public health problem

requires a broad-based community response that links the aging, health, justice, mental health, social service, law enforcement, and educational systems. The triad program is one example. So, too, are the elder abuse task forces and multidisciplinary teams that have been organized by communities and states to handle elder abuse and neglect issues. Through such coordinating units, individuals and public and private agencies have an opportunity to promote non-violent families and a safe society.

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MAXIMIZING OPTIONS FOR A QUALITY LIFE
Community and Social Services Activities

Resources for Elders ↗

MAJOR ISSUES AND POLICY CONSIDERATIONS

Opportunities for recreation, entertainment, and social and cultural activities are important elements in the health and overall well-being of people and in the quality of life in a community. For older persons, such activities are particularly important both because they have the time to invest in such activities and because these activities provide them a link to community life that may no longer be readily available through other means.

Since older persons in our society may range in age from 60 or 65 to over 100 years old, they are a very heterogeneous group whose needs, preferences, desires, and capacities span the entire scope of human possibilities. Therefore, the range of social and recreational activities necessary to adequately address the needs and preferences of this segment of our population are also quite diverse.

Today, there are a large array of activities and opportunities available to old and young alike, particularly those who are relatively healthy and mobile. Many of these activities rely on a mix of public and private funding sources. Examples are public parks, the theatre, museums, public libraries, public radio and television, to name a few. Some activities are supported by the charges to participants, while still others are organized and conducted on a volunteer basis and require minimal financial

support. Social and recreational opportunities may be open to the general public, be based membership in certain religious, ethnic or socioeconomic groups, or be available to persons based on age or need. Over the last two decades, a number of programs have been developed to address the needs and interests of the more frail older and disabled segments of our population. Most of these program rely heavily on public monies.

While it is generally agreed that social, recreational and cultural activities are important, there is far less agreement regarding where the responsibility for initiating and funding some of these activities should reside. There are those who believe that federal support should be minimized or eliminated for recreational and entertainment programs, the arts and humanities, and programs designed to promote social interaction. The federal deficit and the general mood of the country are fostering increasing debate over the role of the federal government and federal monies in some of these programs and, more importantly, in other programs that are even more basic to quality of life. Policy decisions made in the coming months could affect not only the integrity, but the survival, of some of the recreational, entertainment, social and cultural alternatives now available.

CURRENT RESOURCES AND FUTURE NEEDS

Opportunities for Older Persons Today

Families, friends, private and public organizations and associations, businesses, religious institutions and numerous other public and private entities form a range of options for addressing

recreational and social activities for older persons. But a key factor to remember when considering the social and recreational needs of older persons is diversity. For those who are healthy and mobile, opportunities for involvement in social and community activities are much the same as for younger adults. Golf, tennis, swimming, dances, card games, bingo, social clubs, dining out, the theatre and numerous other activities suited to different levels of physical capacity and interest are available in many communities. Travel opportunities, recreational activities, social gatherings, and self-enrichment programs targeted to older adults are offered by churches, private agencies and by aging organizations. Community programs in the arena of the arts and humanities provide affordable life enrichment opportunities and enjoyment to many older persons. In large part, these opportunities remain affordable and in existance because of the support of tax dollars.

Many social programs not only attract participation by an elderly clientele, but also depend heavily the active participation of retirees and others who have the flexibility to give of their time and talents to assist in the basic operation of programs. It is older women and men who are often the organizers and work force behind the general operation, fund-raising and special events in churches, social clubs, community groups and civic organizations.

But there are also growing numbers of our population-- those experiencing the decrements of advanced age, those with debilitating chronic illnesses, those with physical or mental disabilities, and those with very limited incomes-- who no longer have the capacity or financial means to be active organizers or

participants in many of the recreational and social activities geared to the broader population. Activities designed for the general population are often not suited to those with difficulty walking, poor vision or hearing, mental impairments or a host of other physical or mental limitations. For these persons, young or old, the availability of and access to appropriate social activities is far more limited.

Family members often play a central role in the social life of frail family members. However, it is not uncommon for families members to live great distances from their loved ones, making visits a rarity. Even when living in close proximity, family members may be so overwhelmed with responsibilities relating to their jobs, children, spouses, or the assistance frail family members need with daily tasks that they find little time or energy to devote to even basic social interaction with the family member, Attempting to promote more time-consuming levels of social involvement or community activities and outings become a remote possibility. In many cases, health problems, incapacitating conditions and death rob older persons of the family members, friends and acquaintances who once were prominent in their social networks, leaving them with few social resources.

Over the last few decades, some programs have been developed to address the recreational and social needs of older persons who may otherwise lack alternatives for socialization and are at risk of becoming isolated and alienated from the larger society. Senior centers are one of these alternatives and are found in communities large and small throughout the country. Senior centers have

evolved over the last two decades to provide social and recreational opportunities, as well as basic services, to all sectors of the older population.

The early prototype for senior centers started in the 1940's, but the majority of senior centers today came into existence after the mid-1970's. In 1975, Title V of the Older American's Act (OAA)was funded to provide funds for the "acquisition, alteration, or renovation" of centers. Title III of the OAA provided operational monies for the development and delivery of a variety of services (Gelfand, 1984). Today, there are over 15,000 senior centers throughout the country, serving an estimated seven million adults from a variety of backgrounds (NCOA, 1995).

Meal programs, also provided largely by Older American's Act monies, are the backbone of many senior center programs, providing a natural combination of services to meet basic nutritional and socialization needs of older persons. Numerous centers have evolved to become community focal points for a wide variety of services to and by elders, including homemaker assistance, handyman programs, tax preparation, employment counseling and information and referral. Many centers also serve the broader community by providing information on aging issues, support for caregivers, and training for professionals, students and the general public (NCOA, 1995).

Most senior centers have a variety of funding sources, including federal and local dollars, as well as support from donations by participants. However, federal dollars for operational and administrative costs, meal programs and other

activities are vital to the continuation of many centers. For those centers receiving Older American's Act funds, participants are not required to contribute to the cost of the service.

Adult day care centers have been developed in some communities to serve those individuals who require more structure and assistance than can be offered in the usual senior center. These centers serve more disabled persons, both young and old, providing respite to caregivers and basic care, socialization, recreation, and social activities for participants.

Medicaid, OAA, Social Services Block Grants, state general revenues, and local tax dollars are available in limited amounts to support adult day care centers. In most cases, services are provided on a fee-for-service basis, which limits access for those without sufficient financial resources.

For those persons who are too incapacitated or do not choose to participate in activities outside of their homes, public television and public radio serve as links to the local community. From major cities to the small towns of rural America, public radio serves to bring community news, information, and opportunities for enjoyment to all community residents. In many communities, public radio provides space and technical support to local reader services. This service provides those who are blind or have low vision, the opportunity to keep abreast of recent literature and the news in their local papers, including local events, obituaries, weddings, and births. While public radio and television receive support from individual and corporate donations, federal support is vital to the program diversity of all stations and to the very

survival of a large number.

Future Needs and Resources

The aged sector of our population is projected to grow very rapidly over the next 20 years, with the very elderly, those 85 and older, being the fastest growing segment. The next generation of elderly persons are likely to be far more diverse ethnically, socially and economically than the current cohort, but their options for recreational, social, and cultural activities could be fewer.

Until relatively recently, the aged have been viewed as a singular group who are frail, poor, dependent and deserving of a high status on the social policy agenda. However, we have seen significant changes in some of the realities of aging, as well as in perceptions of older persons in recent years.

Today, over 30% of the federal budget is spent on the aged (U.S. Congress, 1994). The changes that have occurred as a result of these expenditures are remarkable, but may not be sustained. Since the 1960's, poverty rates have declined significantly, access to health care among the aged has risen dramatically, private pension coverage has expanded, and three-quarters of the older population own their own homes (Hudson, 1993).

Not only have the high expenditures and the obvious advances made some persons less inclined to look favorably on increased expenditures on the aged, but several trends are converging which have increased concern about the current level of expenditures. Poverty among young families and children is now higher than among

the aged, basic infrastructures supporting education, transportation and housing in many of our communities are deteriorating due to inadequate funding, and the rapid expansion in the number and percentage of the aged expected in the U.S. population over the next decade has many predicting dire consequences for the younger segment of the society who may have to bear the brunt of their support. Concerns about expenditures on the aged, set in contrast to the relative affluence of some older persons, have precipitated highly derogatory descriptions of the aged in the media. Insinuations that the older population is hedonistic, selfish and politically powerful are becoming commonplace in media depictions.

Regrettably, such depictions and generalizations about the condition of the aged population mask many of the realities of aging in this country. While some older persons are affluent, healthy and active, significant segments of the older population still live below or near the poverty level. Persons in the oldest segments of our population are at high risk, if not already experiencing, significant chronic disabilities, high medical expenditures, and the risk of catastrophic long-term care expenditures.

The next cohort of older persons may not be in a significantly better position than many of today's to participate in mainstream recreational and social activities or to provide full financial support for services targeted to older and/or more dependent persons. Serious questions exist about the viability of the Social Security system as it now operates. Medicare is likely to undergo

serious cuts, throwing more burden for medical expenses on the older individual. At the same time, employers are reneging on retirement medical benefits and ending or reducing defined-benefit pension plans, leaving employees responsible for self-managing investments for tax-deferred returns (Firman, 1994). There is no evidence future elderly persons will have better coverage of long-term care costs and with cuts in Medicaid projected, they may have less protection. At the same time, there is evidence that the middle-aged today are not or cannot save adequate amounts to secure their own financial security in old age.

Given that these trends continue, this country faces a significant portion of the population entering a time when "leisure" activities play a significant role in quality of life. We can also expect that many of these persons will reach very advanced ages. They will need appropriately designed opportunities for recreation, socialization, and a variety of social services, but may have little ability to financially support these services. At the same time, the demands on society for meeting the basic care needs of a high proportion of disabled persons may leave few public or private resources to fund less necessary, but very important, social and recreational opportunities.

FACTORS TO CONSIDER

Some very difficult decisions face old and young alike in the coming months and years. In order to make these decisions, a number of questions need to be proposed and debated regarding the basic values of our society and the trade-offs we are willing to

accept. Some of these questions are-- Of what importance are recreational, social, and cultural programs to a community and a society, beyond the enjoyment they provide to individuals? Does government have a role in supporting and fostering access to opportunities for cultural enrichment, social interaction, recreation, and entertainment for all persons in a society? Should tax payor dollars be used to support such activities? What other responsibilities reside in the government sector, such as facilitating access to places and activities though adequate public transportation systems, ensuring safe and barrier-free environments and so forth? What responsibility should individuals have in supporting the social and cultural life of their communities and their nation? Should cost-sharing by participants be mandated, based on ability to pay? What should be the role of businesses, corporations and foundations? What incentives can be used to encourage their continued and expanded participation in supporting a broad scope of activities geared to persons with special needs?

Some even more fundamental questions underlay the answers to those above. Given the purportedly resource-scarce society we now live in, should we continue to expect the range and richness of social and cultural opportunities now available? This is a particularly critical issue for all Americans as resources for programs of all kinds, including the most basic programs for food, shelter, and health care, are being restructured and, in many cases, stand to be significantly reduced. If substantial amounts of federal, state and local dollars are pulled out of social and cultural programs to reduce the federal deficit or fund basic human

services, will contributions from corporations, businesses, private philanthropists, the general public, and fees charged to those who participate be adequate to maintain the level and richness of programs now available? We must even question whether this base of support will continue. Increasingly, the private sector is being courted to address more and more of the social problems in this country. If basic human services come into direct competition with leisure and social activities for scarcer and scarcer resources, how will they fare?

Consideration must be given to what trade-offs are acceptable and which are not. What programs would be most likely to engender local support and survive without drastic alterations given there were a significant decrease in tax-based support? What programs are most well-suited to attract private sector and local government support? What programs would be significantly reduced or not survive without government support? Are these programs critical to ensuring a decent quality of life to some or all sectors of our population? If so, what are we, the American public, willing to do to ensure their survival?

The times ahead are challenging and fundamental issues about the core values of our society must be resolved. This country has many resources and the capacity to ensure the basic needs and the social opportunities needed for a high quality of life for all people. What now is needed is the vision and resolve to make the decisions and the sacrifices necessary to ensure this for current and future generations of young and old. In the end, this is how we all prosper.