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105TH CONGRESS
1st Session

SENATE

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Volume 1

DEVELOPMENTS IN AGING: 1996
VOLUME 1

REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 73, SEC. 19(c), FEBRUARY 13, 1995

Resolution Authorizing a Study of the Problems of the Aged and Aging

JUNE 24, 1997.—Ordered to be printed

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, 1997.

Hon. ALBERT A. GORE, Jr.,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 73, agreed to February 13, 1995, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 1996, volume 1.

Senate Resolution: 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions taken during 1996 by the Congress, the administration, and the U.S. Senate Special Committee on Aging, which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons and their families.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

CHARLES E. GRASSLEY, *Chairman.*

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DEVELOPMENTS IN AGING: 1996—VOLUME 1

JUNE 24, 1997.—Ordered to be printed

Mr. GRASSLEY, from the Special Committee on Aging, submitted the following

REPORT

Chapter 1

SOCIAL SECURITY—OLD AGE, SURVIVORS AND DISABILITY

OVERVIEW

Social Security has continued to be a topic of national debate. The largest legislative change which affected Social Security was granting the Social Security Administration (SSA) status as an independent agency. The Social Security Independence and Program Improvements Act of 1994 (P.L. 103–296) made SSA an independent agency in the executive branch of the Federal Government.

Legislation was also enacted in early 1994 to address the issue of taxing domestic workers. The Congress approved legislation liberalizing the rules for payment of taxes for domestic workers and President Clinton signed the legislation in October 1994. The issue came into national prominence because President Clinton's nominee for Attorney General, Zoe Baird, had failed to pay Social Security payroll taxes for a nanny she had hired who was also an illegal alien. Ultimately, the nomination had to be withdrawn in the ensuing furor. Other potential nominees faced harsh scrutiny and national headlines, and even President Clinton's nominee for Social Security Commissioner, Dr. Shirley Sears Chater, was criticized in the press for an incident in the early 1970's during which taxes were not paid.

Among the issues that carried over from 1993 were the persistent administrative problems in the disability programs run by the

Social Security Administration (SSA). These programs, including the Social Security Disability Insurance (SSDI) program, are becoming overwhelmed with growing workloads, backlogs, and delays.

Other popular Social Security legislative issues include the the so-called "notch" and the earnings test. Reform of the earnings test was realized by the enactment of H.R. 3136, the Contract with America Advancement Act (P.L. 104–121).

Social Security continued to build large reserves in its trust funds as the program benefit structure remained untouched. Despite discussions prompted by Office of Management and Budget (OMB) Director Leon Panetta that Cost-of-Living Adjustment (COLA) cuts might be included in the President's economic plan, no such proposal was made. In 1995, 1996, and 1997, Social Security beneficiaries received notice that cost of living adjustments of 2.8, 2.6, and 2.9, respectively, percent would be granted to offset inflation. These adjustments, based on the calculation of the Consumer Price Index (CPI), continued to be an issue as congressional policymakers explored possible inaccuracies in the CPI through a commission appointed by the Senate Finance Committee.

Many questioned why, after Congress removed Social Security from the Federal budget in 1990, SSA's administrative expenses continued to be considered part of the Federal budget. The Bush Administration assumed that administrative expenses, even though they are financed out of the trust funds, remained on budget. Although the Clinton Administration had an opportunity to change that assumption in its 1994 budget, it chose not to do so. A number of leaders in Congress, including the Chairmen of the Senate Aging and Budget Committees, argued that all trust fund expenditures, including administrative expenses, were taken off budget. Such a change would remove pressure to cut SSA's administrative expenses so that the trust funds can subsidize other Federal expenditures. Because OMB has not changed course, Congress may reconsider legislative remedies in 1995. This treatment of administrative expenses has had an effect on the numbers of disability reviews the SSA has performed. The backlog of these reviews also inspired congressional attention during the 104th Congress.

Other issues did emerge in 1994 when a presidential advisory committee, the Bipartisan Commission on Entitlement and Tax Reform, warned of the long-term financing problems of Social Security. The deliberations of the Commission focused on reforming Social Security, to protect the program from projected insolvency.

Debate over Social Security remained connected to concerns over the Nation's massive budget deficit. Although Social Security is a self-financing program, it nevertheless plays an enormous role in determining how the Federal Government finances the deficit. Until 1991, under the Gramm-Rudman-Hollings law, Social Security trust funds were factored into the deficit totals used to determine the deficit reduction targets that the Congress was required to meet to avoid across-the-board cuts in Federal spending. Because of this accounting method, the deficit totals were reduced on paper by the amount of the Social Security reserves. In 1994 alone, the inclusion of Social Security reserves offset an estimated $56 billion in the general revenue deficit.

Although provisions in the Omnibus Budget Reconciliation Act of 1990 assure that Social Security will no longer mask the Federal deficit, large Social Security trust fund surpluses continue to allow the Federal Government to borrow less from the public. This factor, some would argue, helps keep interest rates lower. Current law requires Social Security reserves to be invested in interest-paying Treasury securities. These assets are then used to finance other Federal programs. By borrowing from itself, the Government does not crowd out those in the private sector seeking financing.

Another factor that complicated matters for proposals to reform Social Security, were the rules Congress enacted in 1990, known as "fire wall" procedures, designed to make it difficult to diminish Social Security reserves. The Senate provision prohibits the consideration of a budget resolution calling for a reduction in Social Security surpluses and bars consideration of legislation causing the aggregate level of Social Security spending to be exceeded. The House provision creates a point of order which prohibits the consideration of legislation that would change the actuarial balance of the Social Security trust funds over a 5-year or 75-year period.

In 1994 and during the 104th Congress, concerns over the SSDI program centered on the financial status of the disability trust funds and a breakdown in the administration of the program. The annual report of the Social Security trustees warned that the SSDI trust fund could be depleted in 1995. Their forecast reflected rapid enrollment increases over the past few years and tax revenues constrained by a stagnant economy.

The growth in the SSDI program has also led to more active congressional oversight. The work of the Aging Committee and the House Ways and Means Committee produced a number of initiatives in 1995 and 1996 to protect SSDI benefits from fraud and abuse.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. BACKGROUND

Title II of the Social Security Act, the Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) program—together named the OASDI program—is designed to replace a portion of the income an individual or a family loses when a worker in covered employment retires, dies, or becomes disabled. Known more generally as Social Security, monthly benefits are based on a worker's earnings. In October 1995, $26 billion in monthly benefits were paid to Social Security beneficiaries, with payments to retired workers averaging $675 and those to disabled workers averaging $642. Administrative expenses were estimated to be $3.4 billion in 1996.

The Social Security program touches the lives of nearly every American. In 1995, there were 43 million Social Security beneficiaries. Retired workers numbered 31 million, accounting for 71 percent of all beneficiaries. Disabled workers and dependent family members numbered 5.8 million, comprising over 13 percent of the total, while surviving family members of deceased workers totaled over 12 million or 28 percent of all beneficiaries. During the same

period, about 142 million workers were in Social Security-covered employment, representing approximately 95 percent of the total American work force.

In 1996, Social Security contributions were paid on earnings up to $62,700, a wage cap that is annually indexed to keep pace with inflation. Workers and employees alike each paid Social Security taxes of 6.2 percent on earnings. In addition, workers and their employers paid 1.45 percent on earnings on all earnings for the Hospital Insurance (HI) part of Medicare. For the self-employed, the payroll tax is doubled, or 15.30 percent of earnings, counting Medicare. In 1997, the tax rates will remain the same, although the wage cap will rise to $65,400.

Social Security is accumulating large reserves in its trust funds. As a result of increases in Social Security payroll taxes mandated by the Social Security Act Amendments of 1983, the influx of funds into Social Security is increasingly exceeding the outflow of benefit payments. In 1994, the Social Security reserves totaled an estimated $566 billion, compared with $434 billion in 1994.

(A) HISTORY AND PURPOSE

Social Security emerged from the Great Depression as one of the most solid achievements of the New Deal. Created by the Social Security Act of 1935, the program continues to grow and become even more central to larger numbers of Americans. The sudden economic devastation of the 1930's awakened Americans to their vulnerability to sudden and uncontrollable economic forces with the power to generate massive unemployment, hunger, and widespread poverty. Quickly, the Roosevelt Administration developed and implemented strategies to protect the citizenry from hardship, with a deep concern for future Americans. Social Security succeeded and endured because of this effort.

Although Social Security is uniquely American, the designers of the program drew heavily from a number of well-established European social insurance programs. As early as the 1880's, Germany had begun requiring workers and employers to contribute to a fund first solely for disabled workers, and then later for retired workers as well. Soon after the turn of the century, in 1905, France also established an unemployment program based on a similar principle. In 1911, England followed by adopting both old age and unemployment insurance plans. Borrowing from these programs, the Roosevelt Administration developed a social insurance program to protect workers and their dependents from the loss of income due to old age or death. Roosevelt followed the European model: government-sponsored, compulsory, and independently financed.

While Social Security is generally regarded as a program to benefit the elderly, the program was designed within a larger generational context. According to the program's founders, by meeting the financial concerns of the elderly, some of the needs of young and middle-aged would simultaneously be alleviated. Not only would younger persons be relieved of the financial burden of supporting their parents, but they also would gain a new measure of income security for themselves and their families in the event of their retirement or death.

In the more than half a century since the program's establishment, Social Security has been expanded and changed substantially. Disability insurance was pioneered in the 1950's. Nevertheless, the underlying principle of the program—a mutually beneficial compact between younger and older generations—remains unaltered and accounts for the program's lasting popularity.

Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than do workers with lower earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating credit.

Social Security serves a number of essential social functions. First, Social Security protects workers from unpredictable expenses in support of their aged parents or relatives. By spreading these costs across the working population, they become smaller and more predictable.

Second, Social Security offers income insurance, providing workers and their families with a floor of protection against sudden loss of their earnings due to retirement, disability, or death. By design, Social Security only replaces a portion of the income needed to preserve the beneficiary's previous living standard and is intended to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker.

Third, Social Security provides the individual wage earner with a basic cash benefit upon retirement. Significantly, because Social Security is an earned right, based on contributions over the years on the retired or disabled worker's earnings, Social Security ensures a financial foundation while maintaining beneficiaries' self-respect.

Social Security provides a unique set of protections not available elsewhere. Some criticize Social Security for its mix of functions. Some argue that Social Security should be a welfare program, providing basic benefits to the poor and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRA's. Such an approach would undermine the widespread political support that has developed for the broad-based functions of the program.

The Social Security program came of age in the 1980's. In this decade, the first generation of lifelong contributors retired and drew benefits. Also during this decade, payroll tax rates and the relative value of monthly benefits finally stabilized at the levels planned for the system. Large reserves accumulating in the trust funds leave Social Security on a solid footing as it continues through the 1990's.

2. Financing and Social Security's Relation to the Budget

(A) FINANCING IN THE 1970'S AND EARLY 1980'S

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to weather any fluctuations in the economy affecting the

trust funds. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecasted. The energy crisis, high levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Act Amendments of 1972 had not only increased benefits by 20 percent across-the-board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974–75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "over-indexing" benefits for certain new retirees, and thereby created an additional drain on trust fund reserves.

In 1977, recognizing the rapidly deteriorating financial status of the Social Security trust funds, Congress responded with new amendments to the Social Security Act. The Social Security Act Amendments of 1977 increased payroll taxes beginning in 1979, reallocated a portion of the Medicare (HI) payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount. These changes were predicted to produce surpluses in the OASDI program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as predicted. The long-term deficit, which had not been fully reduced, remained. The stagflation occurring after 1979 resulted in annual CPI increases exceeding 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

The 96th Congress responded to this crisis by temporarily reallocating a portion of the DI tax rate to OASDI for 1980 and 1981. This measure was intended to postpone an immediate financing crisis in order to allow time for the 97th Congress to comprehensively address the impending insolvency of the OASDI trust funds. In 1981, a number of proposals were introduced to restore short- and long-term solvency to Social Security. However, the debate over the future of Social Security proved to be very heated and controversial. Enormous disagreements on policy precluded quick passage of comprehensive legislation. At the end of 1981, in an effort to break the impasse, the President appointed a 15-member, bipartisan, National Commission on Social Security Reform to search for a feasible solution to Social Security's financing problem. The Com-

mission was given a year to develop a consensus approach to financing the system.

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1.5 months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

The delay in the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. Nonetheless, the Commission did provide clear guidance to the new Congress on the exact dimensions of the various financing problems in Social Security, and on a viable package of solutions.

(B) THE SOCIAL SECURITY ACT AMENDMENTS OF 1983

Once the National Commission on Social Security Reform reached agreement on its recommendations, Congress moved quickly to enact legislation to restore financial solvency to the OASDI trust funds. This comprehensive package eliminated a major deficit which had been expected to accrue over 75 years.

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near-term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions from new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI Program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions included:

Coverage.—All Federal employees hired after January 1, 1984, were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.

Benefits.—COLA increases were shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A COLA fail-safe was set up so that whenever trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20 percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.

Taxation.—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—were made subject to income taxation, with the additional tax revenue being funneled back into the retirement trust fund.

Payroll Taxes.—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement Age Increases.—An increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between the years 2000 to 2022.

(C) TRUST FUND PROJECTIONS

In future years, the Social Security trust funds income and outgo are tied to a variety of economic and demographic factors, including economic growth, inflation, unemployment, fertility, and mortality. To predict the future state of the OASI and DI trust funds, estimates are prepared using three different sets of assumptions. Alternative I is designated as the most optimistic, followed by intermediate assumptions (II) and finally the more pessimistic alternative III. The intermediate II assumption is the most commonly used scenario. Actual experience, however, could fall outside the bounds of any of these assumptions.

One indicator of the health of the Social Security trust funds is the contingency fund ratio, a number which represents the ability of the trust funds to pay benefits in the near future. The ratio is determined from the percentage of 1 year's payments which can be paid with the reserves available at the beginning of the year. Therefore, a contingency ratio of 50 percent represents 6 months of outgo.

Trust fund reserve ratios hit a low of 11 percent at the beginning of 1983, but increased to approximately 117 percent by 1994. Based on intermediate assumptions, the contingency fund ratio is projected to increase to 127 percent by the beginning of 1995. Even under pessimistic assumptions, assets were projected to reach 129 percent by the beginning of 1996.

(D) OASDI NEAR-TERM FINANCING

Combined Social Security trust fund assets are expected to increase over the next 5 years. According to the 1996 Trustees Report, OASI and DI assets will be sufficient to meet the required benefit payments throughout and far beyond the upcoming 5-year period.

The projected expansion in the OASDI reserves is partly a result of recent payroll tax increases—from 6.06 percent (with an upper limit of $48,000) in 1989 to 6.2 percent in 1990. The OASDI reserves are expected to steadily build for the next 20 years as a result of both the 1990 tax increase and an anticipated leveling off in the growth rate of new retirees.

(E) OASDI LONG-TERM FINANCING

In the long run, the Social Security trust funds will experience two decades of rapid growth, followed by continuing annual deficits thereafter. Under the intermediate assumptions, over the next 75 years as a whole, the cost of the program is expected to exceed its income by 16 percent.

It should be emphasized that the OASDI trust fund experience in each of the three 25-year periods between 1994 and 2068 varies

considerably. In the first 25-year period—1994 to 2018—revenues are expected to exceed costs by 39 percent of taxable payroll. As a result of these surpluses, contingency fund ratios are expected to build to approximately 239 percent by the year 2010.

In the second 25-year period—2019 to 2043—the financial condition of OASDI is expected to begin to deteriorate and be insolvent by the end of the period. Trust fund reserves are expected to decline to 50 percent of outgo by 2028. Positive actuarial balances are expected through the year 2013, with negative balances occurring thereafter. Deficits are projected to peak around the year 2035, at 4.35 percent of taxable payroll. This combination of surpluses and deficits will result in an average deficit of 3.69 percent of taxable payroll over this 25-year period. By the end of this period, continuing deficits are expected to have depleted the trust funds. Under intermediate assumptions, exhaustion of reserves is projected to occur by 2029.

The third 25-year period—2044 to 2068—is expected to be one of continuous deficits. Program costs will continue to grow and remain above annual revenues. Annual OASDI deficits over the 25-year period are expected to average 4.88 percent of taxable payroll.

(1) Midterm Reserves

In the years between 1994 and 2019, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these reserves will be invested in interest-bearing Federal securities, and will be redeemable by Social Security in the years in which benefit expenditures exceed payroll tax revenues—2013 through 2068. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these reserve funds, and the political and economic implications they entail.

During the period in which Social Security trust fund reserves are accumulating, the surplus funds can be used to finance other Government expenditures. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

Though the net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two tax methods have vastly different distributional consequences. The significance lies with the fact that there is incentive to spend reserve revenues in the 1990's and cut back on underfunded benefits after 2020. The growing trust fund reserves enable the Congress to spend more money elsewhere without raising taxes or borrowing from private markets. At some point, however, either general revenues will have to be increased or spending will have to be drastically cut when the debt to Social Security has to be repaid.

(2) Long-Term Deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The expanding population of older persons is due to longer age spans, earlier retirements, and the unusually high birth rates after World War II, producing the so-called baby-boom generation who will retire beginning in 20 years. The eroding tax base in future years is forecast as a result of falling fertility rates.

This relative increase in the number of beneficiaries will pose a problem if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-third of payroll from Social Security taxes. This would be a substantial erosion of the Social Security tax base and along with the aging of the population and the retirement of the baby boom generation, the long-term solvency of the system will be threatened.

While the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not necessarily rise greatly over 1970's levels. Currently, Social Security benefits cost approximately 4.68 percent of the GDP. Under intermediate assumptions—with 1 percent real wage growth—Social Security is expected to rise to 6.86 percent of the GDP by 2070.

Although there is no question that reserves in the Social Security trust funds will build up well beyond the turn of the century, it nevertheless must be remembered that Social Security remains vulnerable to general economic conditions and should those conditions deteriorate, Congress will likely need to revisit the financing of the system.

(F) SOCIAL SECURITY'S RELATION TO THE BUDGET

Over the last decade, Social Security has repeatedly been entangled in debates over the Federal budget. While the inclusion of Social Security trust fund shortages in the late 1970's initially had the effect of inflating the apparent size of the deficit in general revenues, the reserve that has accumulated in recent years has served to mask its true magnitude. In fact, many Members of Congress contend that the inclusion of the surpluses has disguised the enormity of the Nation's fiscal problems and delayed true deficit reduction. For these same reasons, there has been increasing concern over the temptation to cut Social Security benefits to further reduce the apparent size of the budget deficit.

An amendment was included in the 1990 Omnibus Budget Reconciliation Act (P.L. 101–508), to remove the Social Security trust funds from the Gramm Rudman Hollings Act of 1985 (GRH) deficit reduction calculations. Many noted economists had advocated the

removal of the trust funds from deficit calculations. They argued that the current use of the trust funds contributes to the country's growing debt, and that the Nation is missing tremendous opportunities for economic growth. A January 1989 GAO report states that if the Federal deficit was reduced to zero, and the reserves were no longer used to offset the deficit, there would be an increase in national savings, and improved productivity and international competitiveness. The National Economic Commission, which released its report in March 1989, disagreed among its members over how to tame the budget deficit. Yet, the one and only recommendation upon which they unanimously agreed is that the Social Security trust funds should be removed from the GRH deficit reduction process.

Taking Social Security off-budget was partially accomplished by the 1983 Social Security Act Amendments and, later, by the 1985 GRH Act. The 1983 Amendments required that Social Security be removed by the unified Federal budget by fiscal year 1993, and the subsequent GRH law accelerated this removal to fiscal year 1986. To further protect the Social Security trust funds, Social Security was barred from any GRH across-the-board cut or sequester.

In OBRA 90, Social Security was finally removed from the budget process itself. It was excluded from being counted with the rest of the Federal budget in budget documents, budget resolutions, or reconciliation bills. Inclusion of Social Security changes as part of a budget resolution or reconciliation bill was made subject to a point of order which may be waived by either body.

However, administrative funds for SSA were not placed outside of the budget process by the 1990 legislation, according to the Bush Administration's interpretation of the new law. This interpretation is at odds with the intentions of many Members of Congress who were involved with enacting the legislation. It leaves SSA's administrative budget, which like other Social Security expenditures is financed from the trust funds, subject to pressures to offset spending in other areas of the Federal budget. Legislation was introduced in 1991 by Senators Sasser and Pryor to take the administrative expenses off-budget, but was not enacted. The Clinton Administration has continued to employ the same interpretation of the 1990 law.

(G) NEW RULES GOVERNING SOCIAL SECURITY AND THE BUDGET

Congess created new rules in 1990, as part of OBRA 90 (P.L. 101–508), known as "fire wall" procedures designed to make it difficult to diminish Social Security reserves. The Senate provision prohibits the consideration of a budget resolution calling for a reduction in Social Security surpluses and bars consideration of legislation causing the aggregate level of Social Security spending to be exceeded. The House provision creates a point of order to prohibit the consideration of legislation that would change the actuarial balance of the Social Security trust funds over a 5-year or 75-year period. These fire wall provisions will make it more difficult to enact changes in the payroll tax rates or in other aspects of the Social Security programs such as benefit changes.

3. Administrative Issues

For over a decade, staunch supporters of SSA have called for separating SSA from the Department of Health and Human Services. As a result of the signing of P.L. 103–296, SSA was separated from the HHS on March 31, 1995. With the passage of the law, proponents hope that more continuity of top management will lead to a better-run organization.

In recent years, Congress has monitored closely the performance of the SSA in carrying out its most basic mission—high-quality service to the public. In the 1950's and 1960's, SSA was viewed as a flagship agency, marked by high employee morale and excellence in management and services. In the past 15 years, however, many have contended that the agency has lost its edge, and the quality of service has declined. Factors cited as causing this decline include new agency responsibilities, including the creation of SSI in 1972, staff reductions in the 1980's, inadequate administrative budgets, and multiple reorganization efforts. Many claim that the agency has sacrificed the quality of service to the public in an effort to cut costs through technology, and that public confidence in the agency consequently has declined. Despite major investments by Congress, SSA remains troubled by computer, telephone, and other technological problems.

These criticisms have led Congress to intensify oversight of SSA, including numerous congressional hearings and requests for GAO investigations of SSA problems. One outcome has been an ongoing review of the agency by the GAO. During the past several years, GAO has released a series of reports on such things as SSA staff reductions and their effect on the quality of service provided to the public; problems with the agency's creation of a national 800-telephone number system; and fragmented leadership. SSA initiated projects to respond to these concerns which have been used to support arguments to make SSA an independent agency and to ensure that adequate resources are available to improve public service.

(A) SOCIAL SECURITY AS AN INDEPENDENT AGENCY

Interest in making SSA independent dates back to the early 1970's, when Social Security's impact on fiscal policy was made more visible through the inclusion of the program in the Federal budget. Proponents of independence wanted to insulate Social Security from benefit cuts designed to meet short-term budget goals rather than policy concerns about Social Security. However, many argued that this outcome would be more likely to occur if SSA were run by an independent bipartisan board.

Opponents argued that Social Security, because of its huge revenue and outlays, should not be isolated from policy choices affecting other social programs covered by the HHS umbrella, and that its financial implications for the economy and its millions of recipients were too large to permit it to escape the "hard" choices of fiscal policymaking. They maintained that Social Security is by definition a social program, not a contractual pension system, and should be continuously evaluated in conjunction with other economic and social functions of the Government.

In the 103d Congress, the Senate Finance Committee approved a measure that would allow SSA to become independent and be run by a single administrator. The Ways and Means Committee reported out a bill that allowed SSA independence, but which utilized a three-member bipartisan board approach. Conferees reached an agreement in July 1994 under which SSA would be run by a single administrator appointed for a 6-year term, supported by a 7-member bipartisan advisory board. President Clinton signed the bill on August 15, 1994. In the spring of 1995, SSA officially became an independent agency.

(B) TELEPHONE SERVICE

Because of intense congressional oversight in the early 1990's, SSA has substantially improved its telephone service via the 800 toll-free number. A small number of issues went unaddressed legislatively in 1994. While the House had approved legislation to require SSA to reinstall phone lines to local offices that were disconnected when the 800 number was put in place, the provision was dropped from the final legislation in 1993. The agency has taken the initiative on its own, and installed phone lines to the local offices. The issue which remains is the access for clients—it is still very difficult to get through because there is often only one or two phone lines into the local offices. In late 1994, GAO was continuing its oversight of this problem in cooperation with the House Ways and Means Committee.

(C) COMPUTER MODERNIZATION

SSA has continued efforts to upgrade its computer operations through the Systems Modernization Plan (SMP), began in 1982. The SMP was intended to improve four major advanced data processing areas at the agency: (1) software and software engineering; (2) hardware, and therefore SSA's capacity; (3) data communications utility; and (4) data base integration. The main thrust of this modernization effort was software improvement.

While the SMP was originally designed as a 5-year modernization effort (1982–87), the project remains to be finalized. The design, testing, and implementation of the computer system will not be completed until some time in the 1990's. Despite SSA's failures, Congress has provided funding for large-scale automation efforts at SSA. In the fiscal year 1994 appropriations bill funding SSA (P.L. 103–112), Congress approved $300 million for automation related investments. At the same time, the 1993 report of the House and Senate Appropriations Committees that accompanied Public Law 103–112 expressed continuing concern about SSA's automation initiative.

It is important to note that SSA has made significant progress in certain areas of its modernization plan, including considerable hardware improvements and some software improvements. However, the agency has been criticized for hastily purchasing new hardware before its future needs were fully understood. In addition, crucial software modernization has been sluggish. These problems have received additional attention as SSA has made plans to revamp its disability determination process and install a new proc-

ess which will rely heavily on automated data processing and computer workstations.

4. Benefit and Tax Issues and Legislative Response

Social Security has a complex system of determining benefit levels for the millions of Americans who currently receive them, and for all who will receive them in the future. Over time, this benefit structure has evolved, with Congress mandating changes when it believed they were necessary. Given the focus of Congress in 1994 on paring back of spending, and the hostile environment toward expanding entitlement programs, proposals for benefit improvements made no progress in 1994. The major change in the financing of Social Security benefits was the reallocation of revenues from the OASI Trust Fund to the DI Trust Fund.

(A) TAXATION OF BENEFITS

On September 27, 1994, 300 Republican congressional candidates presented a "Contract with America" that listed 10 proposals they would pursue if elected. One of the proposals is the Senior Citizens Equity Act which includes a measure that would roll back the 85 percent tax on Social Security benefits for beneficiaries with higher incomes.

In 1993, as part of budget reconciliation, a provision raised the tax from 50 percent to 85 percent, effective January 1, 1994. The tax revenues under this provision were expected to raise $25 billion over the next 5 years. The revenues were specified to be transferred to the Medicare Hospital Insurance Trust Fund. During action on the budget resolution in May 1996, Senator Gramm offered a Sense of the Senate amendment that the increase should be repealed. His amendment was successfully passed but had no practical impact. In addition, the budget package was vetoed by President Clinton, nullifying any action in the Senate on the issue.

(B) COVERAGE OF DOMESTIC WORKERS

Recent events have brought unprecedented attention to the special Social Security coverage requirements of household workers, particularly those who provide child care. In 1994, Congress passed and the President signed legislation that changed social security coverage of household or domestic workers. Beginning in 1994, household service is considered covered for social security tax and benefit purposes only if the worker is paid $1,000 or more in cash by an employer during a calendar year. Prior to this change, the law provided that household service was considered covered for Social Security purposes if the worker was paid $50 or more in cash during a calendar quarter.

Domestic service is generally defined as work performed as part of household duties that contribute to the maintenance of an employer's residence or administers to the personal wants and comforts of the employer, members of the household, or guests. This includes, but is not limited to, work performed by housecleaners, maids, cooks, housekeepers, babysitters, gardeners, and handymen.

Domestic workers were first covered by the 1950 amendments to the Social Security Act. The $50 limit was chosen because it was

similar to the one that applied to homeworkers (employees who work in their own homes) and because it was then the amount workers needed to earn in a calendar quarter to receive a "quarter of coverage" (a certain number of which are necessary to be eligible for Social Security benefits). While the quarter of coverage test has changed over the years (in 1994, $620 of earnings), the $50 limit on household workers has remained constant.

The issue received little attention until early 1993, when several Cabinet nominees revealed that they had failed to report the wages they had paid to childcare providers. One of those nominees, Zoe Baird who was nominated for Attorney General, was forced to withdraw her nomination over the ensuing public outcry.

Subsequent media scrutiny made it apparent that underreporting of household wages was common. It also highlighted that householders were supposed to be reporting even occasional work such as babysitting and lawnmowing. As the threshold had not been changed in 43 years, a question naturally arose as to whether it should be updated to reflect wage and price growth.

On July 14, 1993, Chairman Moynihan introduced S. 1231, which raised the threshold to the same level as that needed to earn a quarter of coverage and would exempt from Social Security taxes the wages paid to domestic workers under the age of 18.

On March 22, 1994, Representative Andrew Jacobs introduced H.R. 4105, which would have raised the threshold to $1,250 a year in 1995, to be indexed thereafter to increase in average wages. This measure was included in H.R. 4278, approved by the House on May 12, 1994.

In October 1994, conferees agreed to a measure that raises the threshold for Social Security coverage of household workers to $1,000, effective in 1994. Workers and their employers who have paid the tax on earnings of less than $1,000 in 1994 will receive a refund, but there will be no loss of wage credits for the earnings. In the future, the threshold will rise, in $100 increments, in proportion to the growth in average wages in the economy. Domestic workers under age 18 are exempt except when they are regularly employed in a job that is their principal occupation. Persons employing household workers will report Social Security and unemployment taxes on their annual Federal tax returns. Beginning in 1998, employers of domestic workers earning more than the threshold will have to make estimated quarterly tax payments in order to avoid a tax penalty.

(C) SOCIAL SECURITY EARNINGS TEST

One of the most controversial issues in the Social Security program is the earnings test, which is a provision in the law that reduces OASDI benefits of beneficiaries who earn income from work above a certain sum. Proposals to liberalize or eliminate the earnings test are perennial. While legislative maneuvering over the earnings test was active in 1992, no legislation was enacted. The issue received renewed attention in late 1994, again because of the impact of the Republican Contract with America.

Under the law, in 1994, the earnings test reduces benefits for Social Security beneficiaries under age 65 by $1 for every $2 earned above $8,040. Beneficiaries age 65 to 69 will have benefits reduced

$1 for each $3 earned above $11,160 in 1994. The exempt amounts are adjusted each year to rise in proportion to average wages in the economy. The test does not apply to beneficiaries who have reached age 70.

The House Republican proposed would raise the earnings limit as follows:

1996	$15,000
1997	19,000
1998	23,000
1999	27,000
2000	30,000

The increase in benefit payments due to the measure over the period would result in a net effect of $6.6 billion.

The earnings test is among the least popular features of Social Security. In 1993, 17 bills affecting the earnings test were introduced. This benefit reduction is widely viewed as a disincentive to continued work efforts by older workers. Indeed, many believe that the earnings test penalizes those age 62 to 69 who wish to remain in the work force. Once workers reach age 70, they are not subject to the test. Opponents of the earnings test consider it an oppressive tax that can add 50 percent to the effective tax rate workers pay on earnings above the exempt amounts. Opponents also maintain that it discriminates against the skilled, and therefore, more highly paid, worker and that it can hurt elderly individuals who need to work to supplement meager Social Security benefits. They argue that although the test reduces Federal budget outlays, it also denies to the Nation valuable potential contributions of older, more experienced workers. Some point out that no such limit exists when the additional income is from pensions, interest, dividends, or capital gains, and that it is unfair to single out those who wish to continue working. Finally, some object because it is very complex and costly to administer.

Defenders of the earnings test say it reasonably executes the purpose of the Social Security program. Because the system is a form of social insurance that protects workers from loss of income due to the retirement, death, or disability of the worker, they consider it appropriate to withhold benefits from workers who show by their substantial earnings that they have not in fact "retired." They also argue that eliminating or liberalizing the test would primarily help relatively better-off individuals who need the help least. Furthermore, they point out that eliminating the earnings test would be extremely expensive. They find it difficult to justify draining the Federal budget by an additional $25 billion over 5 years in order to finance the test's immediate removal. Proponents of elimination counter that older Americans who remain in the work force persist in making contributions to the national economy and continue paying Social Security taxes.

In March 1996, Congress enacted H.R. 3136, which raised the earnings limit according to the following timetable:

1996	$12,500
1997	13,500
1998	14,500
1999	15,500
2000	17,000

2001	25,000
2002	30,000

The provision will result in about $5.6 billion in benefits paid out. The costs of raising the earnings limit were offset by other provisions in the bill. Social Security disability benefits to drug addicts and alcoholics were eliminated, as were benefits to non-dependent stepchildren. It is estimated that about 1 million recipients aged 65–69 will be affected by the new earnings test. Their incomes could increase by more than $5,000 in 2002 depending on the level of annual earnings.

(D) THE SOCIAL SECURITY "NOTCH"

The Social Security "notch" refers to the difference in monthly Social Security benefits between some of those born before 1916 and those born in the 5- to 10-year period thereafter. The controversy surrending the Social Security "notch" stems from a series of legislative changes made in the Social Security benefit formula, beginning in 1972. That year, Congress first mandated automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement, known as COLA's or cost-of-living adjustments. The intent was to eliminate the need for ad hoc benefit increases and to adjust benefit levels in relation to changes in the cost of living. However, the method of indexing the formula was flawed in that initial benefit levels were being indexed twice, for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the pre-retirement income of beneficiaries.

Prior to the effective date of the 1972 amendments, Social Security replaced 38 percent of pre-retirement income for an average worker retiring at age 65. The error in the 1972 amendments, however, caused an escalation of the replacement rate to 55 percent for that same worker. Without a change in the law, by the turn of the century, benefits would have exceeded a recipient's pre-retirement income. Financing this increase rather than correcting the over-indexing of benefits would have entailed doubling the Social Security tax rate. Concern over the program's solvency provided a major impetus for the 1977 Social Security amendments, which substantially changed the benefit computation for those born after 1916. To remedy the problem, Congress chose to partially scale back the increase in relative benefits for those born from 1917 to 1921 and to finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of pre-retirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high inflation in the late seventies and early eighties caused an exaggerated difference between the benefit levels of many of those born prior to 1917 and those born later. The difference has been perceived as a benefit reduction by those affected. Those born from 1917 to 1921, the so-called notch babies, have been the most vocal supporters of a "correction," yet these beneficiaries fare as well as those born later.

The Senate adopted an amendment to set up a Notch Study Commission. In subsequent conference with the House, an agreement was reached to establish a 12-member bipartisan commission with the President, the leadership of the Senate and the House each appointing 4 members. The measure was signed into law when the President signed H.R. 5488 (P.L. 102–393). The Commission was required to report to Congress by December 31, 1993. However, in 1993, Congress extended the due date for the final report until December 31, 1994, as part of the Treasury Department appropriations legislation (P.L. 103–123).

The Commission met seven times, including three public hearings, between April and December 1994. In late December 1994, the Notch Commission reported that "benefits paid to those in the "notch" years are equitable and no remedial legislation is in order."

The Commission's report notes that "when displayed on a vertical bar graph, those benefit levels from a kind of v-shaped notch, dropping sharply from 1917 to 1921, and then rising again. . . . To the extent that disparities in benefit levels exist, they exist not because those born in the Notch years received less than their due; they exist because those born before the notch babies receive substantially inflated benefits."

The report of the Commission seems to have put the Notch issue to rest as Congress grapples with other financing issues.

(E) FINANCING OF SOCIAL SECURITY TRUST FUNDS

The focus on the long-term solvency of the Social Security trust fund has nullified proposals to increase benefits or cut payroll taxes. Concern continued to grow in 1994 over the mushrooming expenditures of entitlement programs, including Social Security. As a result, proposals to tighten the financing of the program received the most scrutiny.

Members of Congress have continued to propose solutions to shore up the financing of the Social Security trust fund. These proposals range from wholesale restructuring of the program to more conservative adjustments of the program.

(I) RAISING THE RETIREMENT AGE

To help solve Social Security's long-range financing problems, it has been proposed that the retirement age be raised. Bills introduced in the 103d Congress would accelerate the phase-in of the increase to age 67, raise the early retirement age to 67, and raise the full retirement age to 70.

Originally, the minimum age of retirement for Social Security was 65. In 1956, Congress lowered the minimum age to age 62 for women, but also provided that benefits taken before age 65 would be permanently reduced to account for the longer period over which benefits would be paid. In 1983, Congress enacted legislation to address the financing problems of Social Security. Under that legislation, the full retirement age will increase by 2 months each year after 1999 until it reaches 66 for those who attain age 62 in 2005. It will increase again by 2 months for each year after 2016 that a person reaches age 62, until it reaches age 67 for those who attain age 62 in 2022 or later.

Since the Social Security financial picture has worsened, this solution has been the target of renewed interest. In November 1993, Representative J.J. Pickle introduced H.R. 3585. The bill included a provision which would raise the age for full retirement to 70. The Pickle legislation would gradually increase the full retirement age by 2 months for each year after 1999, until it reaches age 70 for those who attain age 62 in 2029 or later. Retirement and aged spouse benefits would still be available at age 62, but their actuarial reduction would be increased.

Representative Rostenkowski introduced H.R. 4245, the Social Security Long-Range Solvency Act of 1994, in April. The bill included a provision that would eliminate the current plateau in raising the retirement age from 65 to 67. Instead of keeping the retirement age at 66 for 12 years, the age would continue to increase until it reaches age 67.

Representative Penny introduced a bill in May 1994 that would gradually raise the full retirement age and the age for early retirement to 70 and 67, respectively. His bill increased the age for early and full retirement by 4 months a year beginning with those who attain age 62 in 1999, so that it would be fully phased-in for those attaining age 62 in 2013. The age for first eligibility for aged widow(er)s benefits would rise to age 65, and the age for first eligibility for disabled widow(er)s benefits would rise to 55 (it is age 50 under current law). Basic disability benefits are unaffected.

(II) AFFLUENCE, OR "MEANS TESTING" OF SOCIAL SECURITY BENEFITS

Social Security benefits are paid regardless of the recipient's economic status. Since the financing of Social Security has relied on the use of a mandatory tax on a worker's earnings and the amount of those earnings are used to determine the amount of the eventual benefit, a tie has been established between the taxes paid and benefits received. This link has promoted the perception that benefits are an earned right, and not a transfer payment. With the crisis in the financing of Social Security, interest in the issue of whether high-income beneficiaries should receive a full benefit surfaced. As a result, the 1983 reforms included a tax of 50 percent on benefits for higher income beneficiaries. (An indirect means test.)

The debate has continued as Federal budget deficits have grown. Some policymakers have recommended that the growth of entitlements be slowed. Some entitlement programs are means tested—eligibility is dependent on a person's income and assets. Means testing Social Security, the largest entitlement program, could reap substantial savings. The proposal receiving the most attention in 1994 was offered by the Concord Coalition, a non-profit organization created with the backing of former Senators Rudman and Tsongas. Their proposal would have reduced benefits by up to 85 percent on a graduated scale for families with incomes above $40,000 (the 85 percent rate would apply to families with incomes above $120,000).

Supporters of a means test for Social Security argue that all spending must be examined for ways to cut costs. Although the program is perceived as an annuity program, that is not the case. Beneficiaries receive substantially more in benefits than the value of the Social Security taxes paid. Means testing benefits for high

income recipients is a fair way to impose sacrifice. They point to data from the Congressional Budget Office which estimated that 4.4 million recipients have annual incomes over $50,000. These individuals could afford a cut in benefits.

Opponents of means testing believe that such a move would be the ultimate breach of the principle of Social Security. They believe that a means test would align the program with other welfare programs, a move that would weaken public support for the program. Opponents also believe that means testing is wrong on other grounds. They argue that Social Security is not contributing to deficits, it is currently creating a surplus. It would discourage people from saving because additional resources could disqualify them from receiving full benefits. Also, from a retiree's view, individuals should be able to maintain a certain level of income.

At the end of 1996, Congress had not made a move to support a means test or even approach the topic of Social Security insolvency.

B. SOCIAL SECURITY DISABILITY INSURANCE

1. BACKGROUND

In 1994 through 1996, Congress continued to raise concern over SSA's administration of the largest national disability program, Social Security Disability Insurance (SSDI). In particular, the Senate Aging Committee and other Members of Congress continued to scrutinize problems arising in the program. Evidence that was compiled by the Aging Committee pointed out disturbing evidence that some SSDI beneficiaries were using the benefit to purchase drugs and alcohol. As a result of an extensive investigation, Congress responded to the concerns raised by the investigation by placing a 3-year time limit on program benefits to drug addicts and alcoholics, extending requirements for treatment to SSDI recipients, and requiring SSDI recipients to have a representative payee.

Action was also taken to shore up the financing of the DI trust fund. The Social Security trustees, in the annual report to Congress, uttered an explicit warning that the DI trust fund would be depleted in 1995. Congress acted in late 1994 to take steps that would keep the DI trust fund solvent.

(A) RECENT HISTORY

Since the inception of SSDI, SSA has determined the eligibility of beneficiaries. In response to the concern that SSA was not adequately monitoring continued eligibility, Congress included a requirement in the 1980 Social Security amendments that SSA review the eligibility of nonpermanently disabled beneficiaries at least once every 3 years. The purpose of the continuing disability reviews (CDR's) was to terminate benefits to recipients who were no longer disabled.

Recently, SSA has drastically cut back on CDR's partly due to budget shortfalls that have left it unable to meet the mandated requirements for the number of CDR's it must perform. In addition, Congress continues to encounter evidence of a deterioration in the quality and timeliness of disability determinations being conducted

by SSA, even as the agency undertakes a system-wide disability redesign, intended to address backlogs and improve decisionmaking.

2. Issues and Legislative Response

(A) FINANCIAL STATUS OF DISABILITY INSURANCE TRUST FUND

The Social Security trustees warned in 1993 that the SSDI program is in financial trouble and that its trust fund may be depleted in 1995 or sooner. The trustees' 1993 report projected depletion by 1995. Their forecast reflects rapid enrollment increases over the past few years and tax revenues constrained by a stagnant economy.

The SSDI trust fund's looming insolvency has prompted proposals to reallocate taxes to it from Social Security's retirement program. Because the trustees projected that the Old Age and Survivors trust fund would be solvent until 2044, many have proposed to allocate a greater portion to SSDI. Projections issued in 1993 indicated that the two programs could still be kept solvent until 2036. Such a reallocation would eventually shift about 3 percent of the retirement programs' taxes to SSDI.

Most advocates of reallocation favored quick action to allay fears that the program is in danger and to provide time to assess whether an improving economy will alter the outlook. Others favor only a temporary reallocation to force a careful assessment of the factors driving up enrollment and whether there are feasible ways to constrain it.

In 1993, the House of Representatives approved a provision to deal with this issue, but it was dropped from the final version of the Omnibus Budget Reconciliation Act of 1993 along with other Social Security provisions for procedural reasons. Specifically, 0.275 percent of the employer and employee Social Security payroll tax rate, each, and 0.55 percent of the self-employment tax would be reallocated from the OASI trust fund to the DI trust fund. The total OASDI tax rate of 6.2 percent for employers and employees and 12.4 percent for the self-employed would remain unchanged.

Although the House provision was dropped, this was done for procedural reasons, not policy reasons. Widespread agreement exists in the House and the Senate to address this issue as soon as possible. Congress acted in late 1994 by enacting a reallocation as part of P.L. 103–387. The reallocation is expected to keep the DI trust fund solvent until 2015 and the retirement fund solvent until 2029.

(B) NEW RULES FOR DISABILITY BENEFITS

Concern over DI recipients who are drug addicts and alcoholics (DA&As) and how their benefits are sometimes used resulted in swift action in 1994 to curb abuse. The Minority Staff of the Aging Committee issued a report in March 1994, which charged that DA&As in both the SSI and the DI programs were abusing the programs by using their benefits to purchase drugs and alcohol rather than to take care of basic needs.

Since the inception of SSI, the law has required that the SSI payments to individuals who have been diagnosed and classified as drug addicts or alcoholics must be made to another individual, or

an appropriate public or private organization. The representative payee is responsible for managing the recipient's finances. Federal law did not require the use of representative payees for drug addicts and alcoholics enrolled in the DI program.

Criticism was also targeted at SSA's failure to monitor DA&A recipients in the SSI program who were required to undergo treatment. A report issued by the General Accounting Office revealed that SSA had established monitoring agencies in only 18 states even though the monitoring requirement had been in effect since the inception of the program.

The Social Security Independence and Program Improvements Act, P.L. 103–296 addressed these issues. The new law required that DI recipients whose drug addiction or alcoholism was a contributing factor material to their disability receive DI payments through a representative payee. The representative payee requirements were strengthened by creating a preference list for payees. SSA now selects the payee, with preference given to nonprofit social services agencies. Qualified organizations may charge DA&As a monthly fee equal to 10 percent of the monthly payment or $50, whichever is less.

Prior to the enactment of P.L. 103–296, only the SSI recipients were required to undergo appropriate treatment. There were no parallel requirements for DI recipients. With the new legislation, DI recipients were required to undergo substance abuse treatment. Benefits could be suspended for those recipients who failed to undergo or comply with required treatment for drug addiction or alcoholism.

Congress also tightened the provisions for monitoring and testing of the DA&A population. At the end of 1994, SSA was preparing to send out requests for proposals to set up referral and monitoring agencies (RMAs) in each State. Commissioner Chater reported that SSA had RMAs in place in 49 states at the end of 1995.

Before enactment of P.L. 103–296, DA&As in both the SSI and DI programs received program benefits as long as they remained disabled. The new law required that recipients whose drug addiction or alcoholism was a contributing factor material to SSA's determination that they were disabled be dropped from the rolls after receiving 36 months of benefits. The 36-month limit applies to DI substance abusers only for months when appropriate treatment was available.

With the Republican party gaining a majority in the elections of 1994, the issue of drug addicts and alcoholics in the Federal disability programs received renewed attention. The Personal Responsibility Act, part of the House Republican Contract With America, contained a provision which would wipe out benefits for DA&As in the SSI program. As the welfare reform debate evolved, proposals to raise the earnings limit were being rejected because there were no offsets to "pay for" the desired increase in the earnings limit. Senator McCain of Arizona and Congressman Bunning of Kentucky sponsored legislation to increase the earnings limit and included specific offsets to finance the change. H.R. 3136, signed by President Clinton, increased the earnings limit to $30,000 by the year 2002. One of the offsets included in the bill was the elimination of

drug addiction and alcoholism as a basis for disability in both the SSDI program and the SSI program.

This change in policy was enacted despite warnings that approximately 75 percent of the people in the DA&A program could requalify for benefits based on another disabling condition, such as a mental illness. Opponents warned that such a move would result in fewer people in treatment and increased abuse of benefits because of the relaxation of the representative payee requirements enacted in 1994. Early reports of the implementation of the law seem to bear out these predictions; however, more information will be needed in 1997 as the provision's requirements are fully implemented.

(C) DISABILITY DETERMINATION PROCESS

In 1994, SSA began to respond to congressional concern over problems in the administration of SSA's disability determination system. These problems were first identified in 1990 at hearings held in both Senate and House Aging Committees, and the Senate Aging Committee conducted a bipartisan investigation which culminated in a report which highlighted growing backlogs, delays, and mistakes. The issues raised in those investigations continued to worsen thereafter largely because SSA lacked adequate resources to process its workload.

Recognizing the enormity of SSA's administrative burden, Congress earmarked $320 million for disability case processing in fiscal year 1994 in the 1993 appropriations measure for SSA (P.L. 103–112). However, despite language in the Appropriations Committee report, it is unclear if SSA will use the funds as intended to hire staff to deal with the workloads. Because of an overall reduction in the Federal work force mandated by President Clinton, which includes staff cuts at HHS, SSA may not be in a position to use the funds in the most efficient manner to deal with the backlogs. While SSA has requested authority to hire 1,000 additional workers, this request is unlikely to be approved.

Acknowledging that the problem must be addressed with or without additional staff, SSA set up a "Disability Process Reengineering Project" in 1993. A series of committees were established to review the entire process, beginning with the initial claim and continuing through the disability allowance or the final administrative appeal. The effort targets the SSDI program and the disability component of the Supplemental Security Income (SSI) program.

The project began in October 1993, when a special team composed of 18 Federal and State Disability Determination Services (DDS) employees was assembled at SSA headquarters in Baltimore, MD. The SSA effort does not attempt to change the statutory definition of disability, or affect in any way the amount of disability benefits for which individuals are eligible, or to make it more difficult for individuals to file for and receive benefits. SSA plans to reengineer the process in a way that will, in fact, make it much easier for individuals to file for and, if eligible, to receive disability benefits promptly and efficiently, and that will minimize the need for multiple appeals.

In September 1994, SSA released a report describing the new process. Under the new proposal, claimants will be offered a range

of options for filing a claim. Claimants who are able to do so will play a more active role in developing their claims. In addition, claimants will have the opportunity to have a personal interview with decisionmakers at each level of the process.

The process will also be redesigned to include two basic steps, instead of the current four-level process. The success of the new process will depend on SSA's ability to implement the simplified decision method and provide consistent direction and training to all adjudicators. It is also dependent on better collection of medical evidence, and the development of an automated claim processing system. SSA expected to begin demonstration projects of the new process in late 1994 and 1995.

The concerns that were raised in Congress regarding administrative backlogs and the growing incidence of abuse are likely to continue into 1997. Despite additional resources, more flexibility in staffing will be needed for concerns to be resolved. There is hope that the reengineering process can provide new efficiencies so that limited resources can be deployed more effectively.

(D) CONTINUING DISABILITY REVIEWS

As concern over program growth has mounted, the need to protect the integrity of the program has moved to the forefront. This movement has been demonstrated by the inquiries into the payment of disability benefits to drug addicts and alcoholics, as well as concerns over the small number of people who are rehabilitated through the efforts of SSA. (See Chapter 5: Supplemental Security Income). Another important duty of SSA which has been target of congressional interest is the continuing disability review (CDR) process.

In recent years, SSA has had difficulty ensuring that people receiving disability benefits under DI program are still eligible for benefits. By law, SSA is required to conduct CDRs to determine whether beneficiaries have medically improved to the extent that the person is no longer disabled. The Aging Committee and House Ways and Means Committee commissioned a study by the GAO to report on the CDR backlog, analyze whether there are sufficient resources to conduct CDRs, and how to improve the CDR process.

GAO released its findings in October 1996. The reports found that about 4.3 million DI and SSI beneficiaries are due or overdue for CDRs in fiscal year 1996. GAO found that SSA has already embarked on reforms that will improve the CDR process, although the agency found that the proposal will not address all of the problems.

The timing of these reports were very important given the passage of the Contract With America Advancement Act which increased the earnings limit for Social Security. This Act also provided for a substantial increase in the funding for CDRs—more than $4 billion over the next 7 years. It is very likely that Congress will act early in the 105th session to introduce legislation that will permit SSA to conduct CDRs in the most cost-effective manner as possible.

C. PROGNOSIS

The 105th Congress promises to be an important year on the legislative front. Although no major Social Security bill addressing the financial problems of Social Security is expected to be considered, hearings and focus groups will continue to meet to analyze possible solutions.

Another area of debate that took place in 1994 and in the 104th Congress, is certain to spill into the future is over the role of entitlements in the Federal budget. President Clinton established by executive order the Bipartisan Commission on Entitlement Reform on November 5, 1993. The Commission issued its report in mid-December of 1994 with a small number of Commissioners recommending specific proposals to contain entitlements. Some of the members will continue to come forward with legislation in 1997 which mirrors the Commission recommendations.

In addition, the current Commissioner, Shirley Chater resigned at the end of 1996 so a new leader for the agency must be found. Other administrative problems will also require the attention of Congress, including the CDR backlog and the disability redesign proposals now under way.

Other substantive changes to disability policy could be addressed through changes in the SSDI and SSI work incentive provisions.

However, the Social Security system retains the overwhelming support of the general public, the elderly, and many in the Congress. Given this support and adequate current financing, Social Security can be expected to retain its identity during 1997.

Chapter 2

EMPLOYEE PENSIONS

OVERVIEW

Many employees receive retirement income from sources other than Social Security. Numerous pension plans are available to employees from a variety of employers, including companies, unions, Federal, State, and local governments, the U.S. military, National Guard, and Reserve forces. The importance of the income these plans provide to retirees accounts for the notable level of recent congressional interest

In 1994 through 1996, Congress took steps to improve the efficiency and effectiveness of pension administration and funding. Congress strengthened the requirements governing employer contributions to assure adequate levels of assets for employee pension benefits. Congress also increased the insurance premiums paid by under-funded pension plans to bolster the financial health of the Pension Benefit Guaranty Corporation (PBGC). Finally, Congress moved to address concern over the growing complexity of pension plan administration with the passage of the Small Business Protection Act, P.L. 104–188.

A. PRIVATE PENSIONS

1. Background

Employer-sponsored pension plans provide many retirees with a needed supplement to their Social Security income. Most of these plans are sponsored by a single employer and provide employees credit only for service performed for the sponsoring employer. Other private plan participants are covered by "multi-employer" plans which provide members of a union with continued benefit accrual while working for any number of employers within the same industry and/or region. Almost two out of every three workers are covered by a pension plan. Assets totaled $3.2 trillion at the end of 1993. Employees of larger firms are far more likely to be covered by an employer-sponsored pension plan than are employees of small firms.

Most private plan participants are covered under a defined-benefit pension plan. Defined-benefit plans generally base the benefit paid in retirement either on the employee's length of service or on a combination of his or her pay and length of service. Large private defined-benefit plans are typically funded entirely by the employer.

Defined-contribution plans, on the other hand, specify a rate at which annual or periodic contributions are made to an account.

Benefits are not specified but are a function of the account balance, including interest, at the time of retirement.

Some large employers supplement their defined-benefit plan with one or more defined-contribution plans. When supplemental plans are offered, the defined-benefit plan is usually funded entirely by the employer, and the supplemental defined-contribution plans are jointly funded by employer and employee contributions. Defined-benefit plans occasionally accept voluntary employee contributions or require employee contributions. However, fewer than 3 percent of defined-benefit plans require contributions from employees.

Private pensions are provided voluntarily by employers. Nonetheless, the Congress has always required that pension trusts receiving favorable tax treatment benefit all participants without discriminating in favor of the highly paid. Pension trusts receive favorable tax treatment in three ways: (1) Employers can deduct their current contributions even though they do not provide immediate compensation for employees; (2) income earned by the trust fund is tax-exempt; and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax advantages, however, are the tax-free accumulation of trust interest (inside build-up) and the fact that benefits are often taxed at a lower rate in retirement.

For decades, the Congress has used special tax treatment to encourage private pension coverage. In the Employee Retirement Income Security Act (ERISA) of 1974, Congress first established minimum standards for pension plans to ensure a broad distribution of benefits and to limit pension benefits for the highly paid. ERISA also established standards for funding and administering pension trusts and added an employer-financed program of Federal guarantees for pension benefits promised by private employers.

Title XI of the Tax Reform Act of 1986 made major changes in pension and deferred compensation plans in four general areas. The Act:

(1) limited an employer's ability to "integrate" or reduce pension benefits to account for Social Security contributions;

(2) reformed coverage, vesting, and nondiscrimination rules;

(3) changed the rules governing distribution of benefits; and

(4) modified limits on the maximum amount of benefits and contributions in tax-favored plans.

In 1987, Congress strengthened pension plan funding rules. These rules were tightened further by the Retirement Protection Act of 1994, and insurance premiums were increased for underfunded plans.

The increased oversight of pension administration and funding was revisited in 1996 with the passage of the Small Business Protection Act. Legislative and regulatory actions over the last 20 years had improved pensions, but the resulting complexity of the rules were blamed for the stagnation in the number of plans being offered. For example, these rules resulted in higher administrative costs to the plans which reduced the assets available to fund benefits. In addition, a plan administrator who failed to accurately apply the rules could be penalized by the failure to comply with legal requirements.

The Small Business Protection Act of 1996 is intended to begin rectifying some of the perceived over-regulation of pension plans. While commentators seem to agree that the Act will not result in an increase in defined benefit plans, it could increase the number of defined contribution plans offered, particularly by small businesses.

2. Issues and Legislative Responses

(A) COVERAGE

Employers who offer pension plans do not have to cover every employee. The law governing pensions—ERISA—permits employers to exclude part-time, newly hired, and very young workers from the pension plan.

The ability to exclude certain workers from participation in the pension plan led to the enactment of safeguards to prevent an employer from tailoring a plan to only the highly compensated employees. In 1986, the Tax Reform Act increased the proportion of an employer's work force that must be covered under a company pension plan. Employers who were unwilling to meet the straightforward percentage test found substantial latitude under the classification test to exclude a large percentage of lower paid workers from participating in the pension plan. Under the percentage test, the plan(s) had to benefit 70 percent of the workers meeting minimum age and service requirements (56 percent of the workers if the plan made participation contingent upon employee contributions). A plan could avoid this test if it could show that it benefited a classification of employees that did not discriminate in favor of highly compensated employees. The classifications actually approved by the Internal Revenue Service, however, permitted employers to structure plans benefiting almost exclusively highly compensated employees.

While Congress and the IRS have sought to restrict the abuse that can stem from allowing certain employees to defer taxation on "benefits" in a pension plan, these tests have become confusing and difficult to administer. Many pension fund managers have claimed that this confusion has led to the tapering off in the growth of pension plan coverage—particularly in smaller companies. The Small Business Protection Act of 1996 was enacted to combat some of these problems.

Beginning in 1999, salary deferral plans will be exempt from these coverage rules if the plan adopts a "safe-harbor" design authorized under the new law. In addition, the coverage rules will apply only to DB plans. Another important change is the repeal of the family aggregation rules. Under current law, related employees are required to be treated as a single employee. Congress also addressed another complaint of pension plan administrators in the Act by changing the definition of who is a highly-compensated employee (HCE).

Simply because a worker may be covered by a pension plan does not insure that he or she will receive retirement benefits. To receive retirement benefits, a worker must vest under the company plan. Vesting entails remaining with a firm for a requisite number of years and thereby earning the right to receive a pension.

To enable more employees to vest either partially or fully in a pension plan, the 1986 Tax Reform Act required more rapid vesting. The new provision, which applied to all employees working as of January 1, 1989, require that, if no part of the benefit is vested prior to 5 years of service, then benefits fully vest at the end of 5 years. If a plan provides for partial vesting before 5 years of service, then full vesting is required at the end of 7 years of service.

(1) Access

Most noncovered workers work for employers who do not sponsor a pension plan. Nearly three-quarters of the noncovered employees work for small employers. Small firms often do not provide pensions because pension plans can be administratively complex and costly. Often these firms have low profit margins and uncertain futures, and the tax benefits of a pension plan for the company are not as great for small firms.

Projected trends in future pension coverage have been hotly debated. The expansion of pension coverage has slowed over the last decade. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. One of the goals of the Small Business Protection Act is to increase the number of employers who offer defined contribution plans to their employees. This reflects the preference for defined contribution plans by employers because of their low cost and flexibility. This preference is demonstrated by the growth in the number DC plans. The 1993 Current Population Survey (CPS) shows that the percentage of private-sector workers reporting that they were offered a 401(k) plan increased from 7 percent in 1983 to 35 percent in 1993.

The Act will increase access to DC plans by permitting nonprofit organizations the right to sponsor 401(k) plans. The Tax Reform Act of 1986 had ended the ability of nonprofits to offer these plans. State and local government entities will still be prohibited from offering 401(k) plans.

The new law also authorizes a "savings incentive match plan for employees" or SIMPLE. This plan will replace the "salary reduction simplified employee pension (SARSEP) plans. The SIMPLE plan can be adopted by firms with 100 or fewer employees that have no other pension plan in place. An employer offering SIMPLE can choose to use a SIMPLE retirement account or a 401(k) plan. These plans will not be subject to nondiscrimination rules for tax-qualified plans. In a SIMPLE plan, an employee can contribute up to $6,000 a year, indexed yearly for inflation in $500 increments. The employer must meet a matching requirement and vest all contributions at once.

(2) Benefit Distribution and Deferrals

Vested workers who leave an employer before retirement age generally have the right to receive vested deferred benefits from the plan when they reach retirement age. Benefits that can only be paid this way are not "portable" because the departing worker may not transfer the benefits to his or her next plan or to a savings account.

Many pension plans, however, allow a departing worker to take a lump-sum cash distribution of his or her accrued benefits. Federal policy regarding lump-sum distributions has been inconsistent. On the one hand, Congress formerly encouraged the consumption of lump-sum distributions by permitting employers to make distributions without the consent of the employee on amounts of $3,500 or less, and by providing favorable tax treatment through the use of the unique "10-year forward averaging" rule. On the other hand, Congress has tried to encourage departing workers to save their distributions by deferring taxes if the amount is rolled into an individual retirement account (IRA) within 60 days. IRA rollovers, however, have attracted only a minority of lump-sum distributions.

Workers that receive lump-sum distributions tend to spend them rather than save them. Thus, distributions appear to reduce retirement income rather than increase it. Recent data indicate that only 5 percent of lump-sum distributions are saved in a retirement account and only 32 percent are retained in any form. Even among older and better educated workers, fewer than half roll their pre-retirement distributions into a retirement savings account.

The Small Business Protection Act eliminates the five-year averaging of lump-sum pension distributions. The 10-year averaging for the "grandfathered" class is maintained.

(B) TAX EQUITY

Private pensions are encouraged through tax benefits, estimated by the Treasury to be $69.4 billion in fiscal year 1995. In return, Congress regulates private plans to prevent over-accumulation of benefits by the highly paid. Congressional efforts to prevent the discriminatory provision of benefits have focused on voluntary savings plans and on the effectiveness of current coverage and discrimination rules.

(1) Limitations on Tax-Favored Voluntary Savings

The Tax Reform Act of 1986 tightened the limits on voluntary tax-favored savings plans. The Act repealed the deductibility of contributions to an IRA for participants in pension plans with adjusted gross incomes (AGIs) in excess of $35,000 (individuals) or $50,000 (joint)—with a phased-out reduction in the amount deductible for those with AGIs above $25,000 or $40,000, respectively. It also reduced the dollar limit on the amount employees can elect to contribute through salary reduction to an employer plan from $30,000 to $7,000 per year for private sector 401(k) plans and to $9,500 per year for public sector and nonprofit 403(b) plans. In 1995, the limit on contributions to a 401(k) plan is $9,240. These limits are now subject to annual inflation adjustments rounded down to the next lowest multiple of $500.

The Small Business Act included a major expansion of IRAs. The Act will allow a non-working spouse of an employed person to contribute up to the $2,000 annual limit on IRA contributions. Prior law applied a combined limit of $2,250 to the annual contribution of a worker and non-working spouse.

(C) PENSION FUNDING

The contributions that plan sponsors set aside in pension trusts are invested to build sufficient assets to pay benefits to workers throughout their retirement. The Federal Government, through the Employee Retirement Income Security Act of 1974 (ERISA), regulates the level of funding and the management and investment of pension trusts. Under ERISA, plans that promise a specified level of benefits (defined-benefit plans) must either have assets adequate to meet benefit obligations earned to date under the plan or must make additional annual contributions to reach full funding in the future. Under ERISA, all pension plans are required to diversify their assets, are prohibited from buying, selling, exchanging, or leasing property with a "party-in-interest," and are prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Prior to ERISA, participants in underfunded pension plans lost some or all of their benefits when employers went out of business. To correct this problem, ERISA established a program of termination insurance to guarantee the vested benefits of participants in single-employer defined-benefit plans. This program guaranteed benefits up to $30,886 a year in 1995 (adjusted annually). The single-employer program is funded through annual premiums paid by employers to the Pension Benefit Guaranty Corporation (PBGC)—a Federal Government agency established in 1974 by title IV of ERISA to protect the retirement income of participants and beneficiaries covered by private sector, defined-benefit pension plans. When an employer terminates an underfunded plan, the employer is liable to the PBGC for up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multi-employer defined-benefit plans, using a lower annual premium, but guaranteeing only a portion of the participant's benefits.

The past years have brought increasing concern that the single-employer termination insurance program is inadequately funded. A major cause of the PBGC's problem has been the ease with which economically viable companies could terminate underfunded plans and unload their pension liabilities on the termination insurance program. Employers unable to make required contributions to the pension plan requested funding waivers from the IRS, permitting them to withhold their contributions, and thus increase their unfunded liabilities. As the underfunding grew, the company terminated the plan and transferred the liability to the PBGC. The PBGC was helpless to prevent the termination and was also limited in the amount of assets that it could collect from the company to help pay for underfunding to 30 percent of the company's net worth. PBGC was unable to collect much from the financially troubled companies because they were likely to have little or no net worth.

During 1986, several important changes were enacted to improve PBGC's financial position. First, the premium paid to the PBGC by employers was increased per participant. In addition, the circumstances under which employers could terminate underfunded pension plans and dump them on the PBGC were tightened consid-

erably. A distinction is now made between "standard" and "distress" terminations. In a standard termination, the employer has adequate assets to meet plan obligations and must pay all benefit commitments under the plan, including benefits in excess of the amounts quaranteed by the PBGC that were vested prior to termination of the plan. A "distress" termination allows a sponsor that is in serious financial trouble to terminate a plan that may be less than fully funded.

While significant accomplishments were made in 1986, these changes did not solve the PBGC's financing problems. As a remedy, a provision in OBRA 87 (P.L. 100–203) called for a PBGC premium increase in 1989 and an additional "variable-rate premium" based on the amount that the plan is underfunded.

In OBRA 90, Congress increased the flat premium rate to $19 a participant. Additionally, it increased the variable rate to $9 per $1,000 of unfunded vested benefits. Also, the Act increased the per participant cap on the additional premium to $53.

The financial viability of the PBGC continued to be an issue in 1991. This concern was demonstrated in the Senate's refusal to pass the Pension Restoration Act of 1991, a bill that would have extended PBGC's pension guarantee protection to individuals who had lost their pension benefits before the enactment of ERISA in 1974.

The Retirement Protection Act of 1994 (RPA) was implemented in response to PBGC's growing accumulated deficit of $2.9 billion and because pension underfunding continued to grow despite previous legislative changes. While private sector pension plans are generally well funded, the gap between assets and benefit liabilities in underfunded plans has increased for 6 years in a row. According to the PBGC, a shortfall of about $71 billion in assets exists, a large part in plans concentrated in the steel, airline, tire, and automobile industries. About three-quarters of the underfunding is in plans sponsored by financially healthy firms and does not necessarily present risk to PBGC or plan participants. However, the remaining plans are sponsored by financially troubled companies. PBGC reports that these plans, covering an estimated 1.2 million participants, are underfunded by about $18 billion.

The RPA is expected to improve funding of underfunded single-employer pension plans, with the fastest funding by those plans that are less than 60 percent funded for vested benefits to more than 85 percent. The agency also expects its accumulated deficit to be erased within 10 years.

3. Prognosis

It is clear that private pension plan coverage rates have not increased in recent years. The high concentration of small firms in the expanding service industry and the low coverage rates among service industry workers portend stability or, perhaps, a further slight drop in the portion of the private labor force covered by private pension plans. These trends suggest that the rate of private pension receipts may decline among future generations of retirees, making them more dependent on Social Security and other forms of retirement savings.

There is also a shift away from traditional defined benefit plans toward discretionary employee retirement savings arrangements. Of concern are the implications of this trend on retirement income security. Some analysts think that the decline in defined benefit plans reflects the highly regulated nature of the voluntary pension system. Others feel that it reflects changes in the economy and worker preferences. Many think it is both.

As the Federal budget deficit has mounted, so too has the clamor to cut back on some of the preferential treatment (so called "tax expenditures") woven into our tax system. One target is the estimated $69.4 billion tax expenditure related to tax-favored pension plans in fiscal year 1995—the largest tax expenditure in the Federal budget. Steps have been taken over the last decade to reduce pension largess and to ensure that tax-favored plans are broadly based and nondiscriminatory. But an issue of future concern is what effect further actions to raise revenue will have on the future of pensions.

The issue of pension portability also promises to receive some attention. Pension benefit portability involves the ability to preserve the value of an employees' benefits upon a change in employment. Proponents argue that the mobility of today's work force demands benefit portability.

Sweeping demographic changes have led many experts to question whether our Nation can provide retirement income and medical benefits to the future elderly at levels comparable to those of today. There is concern that the baby boom is not saving adequately for retirement, yet it is unlikely that Social Security benefits will be increased. To the contrary, the age for unreduced benefits will rise to 67 early in the next century, amounting to a benefit reduction, and further cuts are being contemplated. Lawmakers, economists, consultants, and others concerned about retirement income security will likely continue to seek reforms in the private pension system because the Small Business Act falls short of true simplification and increased access.

Last, the role that pension funds can play in improving the economy and public infrastructure has been hotly debated in recent years because of the huge amount of money accumulated in both public and private pension funds and the budgetary constraints that limit the ability of Federal and State governments to address certain economic problems. Proposals to attract public and private pension fund investment in financing the rebuilding of our roads, bridges, highways and other public infrastructure have aroused concerns that the Nation's $4 trillion in pension funds may be placed at risk. Fueling the concern is the release of an interpretative bulletin by the U.S. Department of Labor (DoL) outlining the Department's views on private pension funds investing in "economically targeted investments" (ETIs). The Administration has backed away from active advocation of ETIs because of opposition in Congress. However, if the market continues to perform at its current rate, leading to more investment, investing in ETIs may receive renewed public attention.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. BACKGROUND

Pension funds covering 15.7 million State and local government workers and retirees currently hold assets worth about $1.2 trillion; those assets may reach $1 trillion by 1993. Although some public plans are not adequately funded, most State plans and large municipal plans have substantial assets to back up their benefit obligations. At the same time, State and local governments are facing crushing fiscal problems, and some are seeking relief by reducing or deferring contributions into their pension plans to free up cash for other purposes. Those who are concerned that these actions may jeopardize future pension benefits suggest that the Federal Government should regulate State and local government pension fund operations to ensure adequate funding.

State and local pension plans intentionally were left outside the scope of Federal regulation under ERISA in 1974, even though there was concern at the time about large unfunded liabilities and the need for greater protection for participants. Although unions representing State and municipal employees from the beginning have supported the application of ERISA-like standards to these plans, opposition from local officials and interest groups thus far have successfully counteracted these efforts, arguing that the extension of such standards would be unwarranted and unconstitutional interference with the right of State and local governments to set the terms and conditions of employment for their workers.

(A) TAX REFORM ACT OF 1986

Public employee retirement plans were affected directly by several provisions of the Tax Reform Act of 1986. The Act made two changes that apply specifically to public plans: (1) The maximum employee elective contributions to voluntary savings plans (401(k), 403(b), and 457 plans) were substantially reduced, and (2) the once-favorable tax treatment of distributions from contributory pension plans was eliminated.

(B) ELECTIVE DEFERRALS

The Tax Reform Act set lower limits for employee elective deferrals to savings vehicles, coordinated the limits for contributions to multiple plans, and prevented State and local governments from establishing new 401(k) plans. The maximum contribution permitted to an existing 401(k) plan was reduced from $30,000 to $7,000 a year and the nondiscrimination rule that limits the average contribution of highly compensated employees to a ratio of the average contribution of employees who do not earn as much was tightened. With inflation adjustments, this has since increased to $9,240 (in 1995). The maximum contribution to a 403(b) plan (tax-sheltered annuity for public school employees) was reduced to $9,500 a year and employer contributions for the first time were made subject to nondiscrimination rules. In addition, pre-retirement withdrawals were restricted unless due to hardship. The maximum contribution to a 457 plan (unfunded deferred compensation plan for a State or local government) remained at $7,500, but

is coordinated with contributions to a 401(k) or 403(b) plan. In addition, 457 plans are required to commence distributions under uniform rules that apply to all pension plans. The lower limits were effective for deferrals made on or after January 1, 1987, while the other changes generally were effective January 1, 1989.

(C) TAXATION OF DISTRIBUTIONS

The tax treatment of distributions from public employee pension plans also was modified by the Tax Reform Act of 1986 to develop consistent treatment for employees in contributory and noncontributory pension plans. Before 1986, public employees who had made after-tax contributions to their pension plans could receive their own contributions first (tax-free) after the annuity starting date if the entire contribution could be recovered within 3 years, and then pay taxes on the full amount of the annuity. Alternately, employees could receive annuities in which the portions of noticeable contributions and taxable pensions were fixed over time. The Tax Reform Act repealed the 3-year basis recovery rule that permitted tax-free portions of the retirement annuity to be paid first. Under the new law, retirees from public plans must receive annuities that are a combination of taxable and nontaxable amounts.

The tax treatment of pre-retirement distributions was changed for all retirement plans in an effort to discourage the use of retirement money for purposes other than retirement. A 10 percent penalty tax applies to any distribution before age 59.5 other than distributions in the form of a life annuity at early retirement at or after age 55, in the event of the death of the employee, or in the event of medical hardship. In addition, refunds of after-tax employee contributions and payments from 457 plans are not subject to the 10 percent penalty tax. The Tax Reform Act of 1986 also repealed the use of the advantageous 10-year forward-averaging tax treatment for lump-sum distributions received prior to age 59.5, and provides for a one-time use of 5-year forward-averaging after age 59.5.

2. Issues and Legislative Response

(A) FEDERAL REGULATION

Issues surrounding Federal regulation of public pension plans have changed little in the past 20 years. A 1978 report to Congress by the Pension Task Force on Public Employee Retirement Systems concluded that State and local plans often were deficient in funding, disclosure, and benefit adequacy. The Task Force reported many deficiencies that still exist today.

Government retirement plans, particularly smaller plans, frequently were operated without regard to generally accepted financial and accounting procedures applicable to private plans and other financial enterprises. There was a general lack of consistent standards of conduct.

Open opportunities existed for conflict-of-interest transactions, and frequent poor plan investment performance. Many plans were not funded on the basis of sound actuarial principles and assumptions, resulting in adequate funding that could place future beneficiaries at risk of losing benefits altogether. There was a lack of

standardized and effective disclosure, creating a significant potential for abuse due to the lack of independent and external reviews of plan operations.

Although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans, covering 20 percent of plan participants, did not meet ERISA's minimum vesting standard. There remains considerable variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the antidiscrimination and tax qualification requirements of the Internal Revenue Code. While most administrators seem to follow the broad outlines of ERISA benefit standards, they are not required to do so. The sheer size of the investment funds suggests that a Federal standard might be prudent.

However, the need for improved standards has not obscured the latent constitutional question posed by Federal regulation. In *National League of Cities* v. *Usery,* the U.S. Supreme Court held that extension of Federal wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th Amendment. State and local governments have argued that any extension of ERISA standards would be subject to court challenge on similar grounds. However, the Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority* overruling *National League of Cities* largely has resolved this issue in favor of Federal regulation.

Perhaps in part because of the lingering question of constitutionality, the focus of Congress has been fixed on regulation of public pensions with respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be improved by greater disclosure.

A definitive statement on financial disclosure standards for public plans was issued in 1986 by the Government Accounting Standards Board (GASB). Statement No. 5 on "Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Governmental Employers" established standards for disclosure of pension information by public employers and public employee retirement systems (PERS) in notes in financial statements and in required supplementary information. The disclosures are intended to provide information needed to assess the funding status of PERS, the progress made in accumulating sufficient assets to pay benefits, and the extent to which the employer is making actuarially determined contributions. In addition, the statement requires the computation and disclosure of a standardized measure of the pension benefit obligation. The statement further suggests that 10-year trends on assets, unfunded obligations, and revenues be presented as supplementary information.

3. Prognosis

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation. There is also concern about cash-strapped governments "raiding" pension plan assets and tinkering with the assumptions used in determining plan contributions. Critics of this position generally believe that the diversity of plan design and regulation is necessary to meet diver-

gent priorities of different localities and is the strength, not weakness, of what is collectively referred to as the State and local pension system. While State and local governments consistently opposed Federal action, increased pressures to improve investment performance, coupled with the call for investing in public infrastructure and economically targeted investments (ETIs), may lessen some of the opposition of State and local plan administrators to some degree of Federal regulation.

C. FEDERAL CIVILIAN EMPLOYEE RETIREMENT

1. BACKGROUND

From 1920 until 1984 the Civil Service Retirement System (CSRS) was the retirement plan covering most civilian Federal employees. In 1935 Congress enacted the Social Security system for private sector workers. Congress extended Social Security coverage to State and local governments in the early to mid-1950's, and in 1983, when the Social Security system was faced with insolvency, the National Commission on Social Security Reform recommended, among other things, that the Federal civil service be brought into the Social Security system in order to raise revenues by imposing the Social Security payroll tax on Federal wages. Following the National Commission's recommendation, Congress enacted the Social Security amendments of 1983 (P.L. 98–21) which mandated that all workers hired into permanent Federal positions on or after January 1, 1984, be covered by Social Security.

Because Social Security duplicated some existing CSRS benefits, and because the combined employee contribution rates for Social Security and CSRS were scheduled to reach more than 13 percent of pay, it was necessary to design an entirely new retirement system using Social Security as the base. (See Chapter 1 for a description of Social Security eligibility and benefit rules.) The new system was crafted over a period of 2 years, during which time Congress studied the design elements of good pension plans maintained by medium and large private sector employers. An important objective was to model the new Federal system after prevailing practice in the private sector. In Public Law 99–335, enacted June 6, 1986, Congress created the Federal Employees' Retirement System (FERS). FERS now covers all Federal employees hired on or after January 1, 1984, and those who voluntarily switched from CSRS to FERS during an "open season" in 1987. The CSRS will cease to exist when the last employee or survivor in the system dies.

CSRS and the pension component of FERS are "defined benefit" pension plans. This means that retirement benefits are determined by a formula established in law. Although employees are required to pay into the system, the amount workers pay is unrelated to retirement benefits.

Civil service retirement is classified in the Federal budget as an entitlement, and, in terms of budget outlays, represents the fourth largest Federal entitlement program.

(A) FINANCING CSRS AND FERS

The Federal retirement systems are employer-provided pension plans similar to plans provided by private employers for their em-

ployees. Like other employer-provided defined benefit plans, the Federal civil service plans are financed mostly by the employer. The employer of Federal Government workers is the American taxpayer. Thus, tax revenues finance most of the cost of Federal pensions.

The Government maintains an accounting system for keeping track of ongoing retirement benefit obligations, revenues earmarked for the retirement system, benefit payments, and other expenditures. This system operates through the Civil Service Retirement and Disability Fund, which is a Federal trust fund. However, this trust fund system is different from private trust funds in that no cash is deposited in the fund for investment outside the Federal Government. The trust fund consists of special nonmarketable interest-bearing securities of the U.S. Government. These special securities are sometimes characterized as "IOUs" the Government writes to itself. The cash to pay benefits to current retirees and other costs come from general revenues and mandatory contributions paid by employees enrolled in the retirement systems. Executive branch employee contributions are 7 percent of pay for CSRS enrollees and 0.8 percent of pay for FERS enrollees; these contributions cover about 13 percent of the annual cost of benefits to current annuitants.

The trust fund provides automatic budget authority for the payment of benefits to retirees and survivors without the Congress having to enact annual appropriations. As long as the "balance" of the securities in the fund exceeds the annual cost of benefit payments, the Treasury has the authority to write annuity checks without congressional action. At the end of fiscal year 1993, the value of trust fund holdings was $311.8 billion. Because interest and other payments are credited to the fund annually, the fund continues to grow, and the system faces no shortfall of authority to pay benefits well into the future.

Nevertheless, the balance in the fund does not cover every dollar of future pension benefits to which everyone who is, or ever was, a vested Federal worker will have a right from now until they die. That full amount is roughly estimated to be about $852 billion. This amount exceeds the balance in the fund by about $540 billion, which represents the unfunded liability of the retirement systems.[1]

Critics of the Federal pension plans sometimes cite the unfunded liability of the plans as a threat to future benefits or the viability of the systems; they note that Federal law requires private employers to pre-fund their pension liabilities. However, there is an important difference between private plans and Federal plans. Private employers may become insolvent or go out of business; therefore, they must have on hand the resources to pay, at one time, the present value of all future benefits to retirees and vested employees. In contrast, the Federal Government is not going to go out of business. The estimated Federal pension plan liabilities represent a long-term, rolling commitment that never comes due at one time. The Government's obligation to pay Federal pensions is spread over the retired lifetimes of past and current Federal workers, including

[1] *Civil Service Retirement and Disability Fund,* An annual Report to Comply with the Requirements of P.L. 95–595, Sept. 30, 1992, U.S. Office of Personnel Management, March, 1993. Table 1, page 29.

very elderly retirees who retired many years ago and younger workers who only recently began their Federal service and who will not be eligible for benefits for another 30 years or so.

The trust fund has no effect on the annual Federal budget or the deficit. The only costs of the Federal retirement system that show up as outlays in the budget, and which therefore contribute to the deficit, are payments to retirees, survivors, separating employees who withdraw their contributions, plus certain administrative expenses. Any future increase in the cost of the retirement program will result from: (a) A net increase in the number of retirees (new and existing retirees and survivors minus decedents); (b) increases in Federal pay, which affect the final pay on which pensions for new retirees are determined; and (c) cost-of-living adjustments to retirement benefits. Also, as the number of workers covered under CSRS declines, a growing portion of the Federal workforce will be covered under FERS, and, because FERS employee contributions are substantially lower than those from CSRS enrollees, employee contributions will, over time, offset less of the annual costs.

Nevertheless, the special securities held in the fund represent money the Government owes for current and future benefits; thus, the securities represent an indebtedness of the U.S. Government and constitute part of the national debt. However, this is a debt the Government owes itself, and it will never have to be paid-off from the Treasury, as do other U.S. Government securities, such as bonds or Treasury bills, which must be paid, with interest, to the private individuals who purchase them.

In summary, the trust fund is an accounting ledger used to keep track of revenues earmarked for the retirement programs, benefits paid under those programs, and money that is owed by the Government for estimated future benefit costs. The concept of an unfunded liability as a sum that might come due at one time is largely irrelevant to the Federal retirement system.

(B) CIVIL SERVICE RETIREMENT SYSTEM

CSRS Retirement Eligibility and Benefit Criteria.—Workers enrolled in CSRS may retire and receive an immediate, unreduced annuity at the following minimum ages—age 55 with 30 years of service; age 60 with 20 years of service; age 62 with 5 years of service. Workers who separate from service before reaching these age and service criteria may leave their contributions in the system and draw a "deferred annuity" at age 62.

CSRS benefits are determined according to a formula that pays retirees a certain percentage of their preretirement Federal salary. The preretirement salary benchmark is a worker's annual pay averaged over the highest-paid 3 consecutive years, the "high-3". Under the CSRS formula, a worker retiring with 30 years of service receives an initial annuity of 56.25 percent of high-3; at 20 years the annuity is 36.25 percent; at 10 years it is 16.25 percent. The maximum initial benefit of 80 percent of high-3 is reached after 42 years of service.

Employee Contributions.—All executive branch CSRS enrollees pay into the system 7 percent of their gross Federal pay. This amount is automatically withheld from workers' paychecks but is included in an employee's taxable income. Employees who separate

before retirement may withdraw their contributions (no interest is paid if the worker completed more than 1 year of service), but by doing so the individual relinquishes all rights to retirement benefits. If the individual returns to Federal service the withdrawn sums may be redeposited with interest, and retirement credit is restored for service preceding the separation. Alternatively, workers may accept a reduced annuity as repayment of any withdrawn amounts.

Survivor Benefits.—Surviving spouses (and certain former spouses) of Federal employees who die while still working in a Federal job may receive an annuity of 55 percent of the annuity the worker would have received had he or she retired rather than died, with a minimum survivor benefit of 22 percent of the worker's high-3 pay. This monthly annuity is paid for life unless the survivor remarries before age 55.

Spouse survivors of deceased retirees receive a benefit of 55 percent of the retiree's annuity at the time of death, unless the couple waives this coverage at the time of retirement or elects a lesser amount; it is paid as a monthly annuity unless the survivor remarries before age 55. (Certain former spouses may be eligible for survivor benefits if the couple's divorce decree so specifies.) To partially pay for the cost of a survivor annuity, a retiree's annuity is reduced by 2.5 percent of the first $3,600 of his or her annual annuity plus 10 percent of the annuity in excess of that amount.

Unmarried children under the age of 18 (age 22 if a full-time student) of a deceased worker or retiree receive an annuity of $3,811 per year in 1995 ($4,588 if there is no surviving parent). Certain unmarried, incapacitated children may receive a survivor annuity for life.

CSRS Disability Retirement.—The only long-term disability program for Federal workers is disability retirement. Eligibility for CSRS disability retirement requires that the individual be (a) a Federal employee for at least 5 years, and (b) unable, because of disease or injury, to render useful and efficient service in the employee's position and not qualified for reassignment to a vacant position in the agency at the same grade or pay level and in the same commuting area. Thus, the worker need not be totally disabled for any employment. This determination is made by the Office of Personnel Management (OPM).

Unless OPM determines that the disability is permanent, a disability annuitant must undergo periodic medical reevaluation until reaching age 60. A disability retiree is considered restored to earning capacity and benefits cease if, in any calender year, the income of the annuitant from wages or self-employment, or both, equal at least 80 percent of the current rate of pay of the position occupied immediately before retirement.

A disabled worker is eligible for the greater of: (1) the accrued annuity under the regular retirement formula, or (2) a "minimum benefit." The minimum benefit is the lesser of: (a) 40 percent of the high-3, or (b) the annuity that would be paid if the worker continued working until age 60 at the same high-3 pay, thereby including in the annuity computation formula the number of years between the onset of disability and the date on which the individual will reach age 60.

Cost-of-Living Adjustments. Permanent law provides annual retiree cost-of-living adjustments (COLAs) payable in the month of January. COLAs are based on the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI–W). The adjustment is made by computing the average monthly CPI–W for the third quarter of the current calender year (July, August, and September) and comparing it with that of the previous year. The Omnibus Budget Reconciliation Act of 1993 (P.L. 103–66) temporarily delays the payment date for COLAs for all annuitants (including disability and survivor annuitants) to April 1 in 1994, 1995, and 1996. In 1997 the payment date will again the January.

(C) FEDERAL EMPLOYEES' RETIREMENT SYSTEM

FERS has three components: Social Security, a defined-benefit plan, and a Thrift Savings Plan. Congress designed FERS to replicate retirement systems typically available to employees of medium and large private firms.

(1) FERS Retirement Eligibility and Benefit Criteria

Workers enrolled in FERS may retire with an immediate, unreduced annuity under the same rules that apply under CSRS, that is, age 55 with 30 years of services; age 60 with 20 years of service; age 62 with 5 years of service. In addition, FERS enrollees may retire and receive an immediate reduced annuity at age 55 with 10 through 29 years of service. The annuity is reduced by 5 percent for each year the worker is under age 62 at the time of separation. The "minimum retirement age" of 55 will gradually increase to 57 for workers born in 1970 and later. Like the CSRS, a deferred benefit is payable at age 62 for workers who voluntarily separate before eligibility for an immediate benefit, provided they leave their contributions in the system. An employee separating from service under FERS may withdraw his or her FERS contributions, but such a withdrawal permanently cancels all retirement credit for the years preceding the separation with no option for repayment.

FERS retirees under age 62 who are eligible for unreduced benefits are paid a pension supplement approximately equal to the amount of the Social Security benefit to which they will become entitled at age 62 as a result of Federal employment. This supplement is also paid to involuntarily retired workers between age 55 and 62. The supplement is subject to the Social Security earnings test.

Benefits from the pension component of FERS are based on high-3 pay, as are CSRS benefits. A FERS annuity is 1 percent of high-3 pay for each year of service if the worker retires before age 62 and are 1.1 percent of high-3 for workers retiring at age 62 or over. Thus, for example, the benefit for a worker retiring at age 62 with 30 years of service would be 33 percent of the worker's high-3 pay; for a worker retiring at age 60 with 20 years of service the benefit would be 20 percent of high-3 pay plus the supplement until age 62.

(2) Employee Contributions

Unlike CSRS participants, employees participating in FERS are required to contribute to Social Security. The tax rate for Social Security is 6.2 of gross pay up to the taxable wage base of $61,200 (in 1995). The wage base is indexed to the annual growth of wages in the national economy. Executive branch employees enrolled in FERS contribute the difference between 7 percent of gross pay and the Social Security tax rate. Thus, in 1995, FERS participants contribute 0.8 percent of wages up to $61,200 and 7 percent on wages over $61,200.

(3) Survivor Benefits

If an employee participating in FERS dies while still working in a Federal job and after completing at least 18 months of service but fewer than 10 years, spouse survivor benefits are payable in two lump sums: $20,208 (in 1995, indexed annually to inflation) plus one-half of the employee's annual pay at the time of death. This benefit can be paid in a single lump sum or in equal installments (with interest) over 36 months, at the option of the survivor. However, if the employee had at least 10 years of service, an annuity is paid in addition to the lump sums. The spouse survivor annuity is equal to 50 percent of the employee's earned annuity.

Spouse survivors of deceased FERS annuitants are not eligible for the lump-sum payments, but are eligible for an annuity of 50 percent of the deceased retiree's annuity at the time of death unless, at the time of retirement, the couple jointly waives the survivor benefit or elects a lesser amount. FERS retiree annuities are reduced by 10 percent to partially pay for the cost of the survivor benefit.

Dependent children (defined as under the CSRS) of deceased FERS employees or retirees may receive Social Security child survivor benefits, or, if greater, the children's benefits payable under the CSRS.

(4) FERS Disability Retirement

FERS disability benefits are substantially different from CSRS disability benefits because FERS is integrated with Social Security. Eligibility for Social Security disability benefits requires that the worker be determined by the Social Security Administration to have an impairment that is so severe he or she is unable to perform any job in the national economy. Thus, a FERS enrollee who is disabled for purposes of carrying out his or her Federal job but who is capable of other employment would receive a FERS disability annuity alone. A disabled worker who meets Social Security's definition of disability might receive both a FERS annuity and Social Security disability benefits subject to the rules integrating the two benefits.

For workers under age 62, the disability retirement benefit payable from FERS in the first year of disability is 60 percent of the worker's high-3 pay, minus 100 percent of Social Security benefits received, if any. In the second year and thereafter, FERS benefits are 40 percent of high-3 pay, minus 60 percent of Social Security

disability payments, if any. FERS benefits remain at that level (increased by COLAs) until age 62.

At age 62, the FERS disability benefit is recalculated to be the amount the individual would have received as a regular FERS retirement annuity had the individual not become disabled but continued to work until age 62. The annuity is 1 percent of high-3 pay (increased by COLAs) for each year of service before the onset of the disability, plus the years during which disability was received. The 1 percent rate applies only if there are fewer than 20 years of creditable service. If the total years of creditable service equal 20 or more, the annuity is 1.1 percent of high-3 for each year of service. At age 62 and thereafter, there is no offset of Social Security benefits. If a worker becomes disabled at age 62 or later, only regular retirement benefits apply.

(5) FERS Cost-of-Living Adjustments

COLAs for FERS annuities are calculated according to the CSRS formula, and are payable to regular retirees age 62 or over, to disabled retirees of any age (after the first year of disability), and to survivors of any age. Thus, FERS nondisability retirees are ineligible for a COLA as long as they are under age 62.

(6) Thrift Savings Plan (TSP)

FERS supplements the defined benefits plan and Social Security with a contribution plan that is similar to the 401(k) plans used by private employers. Employees accumulate assets in the TSP in the form of a savings account that either can be withdrawn in a lump sum or converted to an annuity when the employee retires. One percent of pay is automatically contributed to the TSP by the employing agency. Employees can contribute up to 10 percent of their salaries to the TSP, not to exceed $8,994 in 1993. The employing agency will match the first 3 percent of pay contributed on a dollar-for-dollar basis and match the next 2 percent of pay contributed at the rate of 50 cents per dollar. The maximum matching contribution to the TSP by the Federal agency will equal 4 percent of pay plus the 1 percent automatic contribution. Therefore, employees contributing 5 percent or more of pay will receive the maximum employer match. An open season is held every 6 months to permit employees to change levels of contributions and direction of investments. Employees are allowed to borrow from their accumulated TSP for the purchase of a primary residence, educational or medical expenses, or financial hardship.

FERS originally contained restrictions on optional investment opportunities, such as fixed-income securities or a stock index fund, phasing-in the funds over a 10-year period. Public Law 101–335 eliminated the 10-year, phase-in period for FERS TSP participants and for the first time allowed CSRS TSP participants to invest in these funds. The legislation also exempted TSP annuities from State and local premium taxes, as was done for the Federal Employees Group Life Insurance Program in 1981.

2. Issues and Legislative Response

(A) COST-OF-LIVING ADJUSTMENTS

The full and automatic COLAs generally payable to CSRS retirees has long been the target of criticisms by those who contend that, because private pension plan benefits are generally not fully and automatically indexed to inflation, Federal pension benefits should follow that precedent. Indeed, Congress limited COLAs for FERS pensions in order to achieve comparability with private plans. Nevertheless, Social Security benefits are fully and automatically indexed and are a basic component of private pension plans and FERS. CSRS retirees do not receive Social Security for their Federal service.

(B) RETIREMENT AGE

The age at which an employer permits workers to voluntarily retire with an immediate pension is generally established to achieve workforce management objectives. There are many factors to consider in establishing a retirement age. An employer's major concern is to encourage retirement at the point where the employer would benefit by retiring an older worker and replacing him or her with a younger one. For example, if the job is one for which initial training is minimal but physical stamina is required, an early retirement age would be appropriate. Such a design would result in a younger, lower-paid workforce. If the job requires substantial training and experience but not physical stamina, the employer would want to retain employees to a later age, thereby minimizing training costs and turnover and maintaining expertise.

The Federal Government employs individuals over an extremely wide range of occupations and skills, from janitors to brain surgeons. Therefore, when Congress carried out a thorough review of Federal retirement while designing FERS, it concluded that a broadly flexible pension system would best suit this diverse workforce. As a result, the FERS system allows workers to leave with an immediate (but reduced) annuity as early as age 55 with 10 years of service, but it also provides higher benefits to those who remain in Federal careers until age 62. Allowing workers to retire at younger ages with immediate, but reduced benefits is common in private pension plan design; by including such a provision in FERS, Congress addressed the problem of the CSRS sometimes referred to as the "golden handcuffs" which is created by requiring CSRS workers to stay in their Federal jobs until age 60 unless they have a full 30 years of Federal service before the age. Nevertheless, recognizing the increasing longevity of the population, the FERS system raised the minimum retirement age from 55 to 57, gradually phasing-in the higher age; workers born in 1970 and later will have a minimum FERS retirement age of 57. In addition, the age of full Social Security benefits is scheduled to rise gradually from 65 to 67, with the higher age for full benefits effective for workers born in 1955 and later.

In general, although retirement ages and benefit designs applicable under non-Federal plans are important reference points in designing a Federal plan, the unusual nature of the Federal

workforce and appropriate management of turnover and retention are equally important considerations.

(C) TSP MATCHING

The Federal matching rate for TSP deposits by FERS participants was established to achieve a number of objectives, including allowing higher paid workers enrolled in FERS to achieve replacement rates comparable to those of CSRS participants and to replicate employer matching under similar private sector plans. Critics of the current matching rates say that it is overly generous by either of these measures, although there are no definitive analyses currently available to prove or disprove that contention.

(D) SOCIAL SECURITY GOVERNMENT PENSION OFFSET (GPO)

Social Security benefits payable to spouses of retired, disabled, or deceased workers generally are reduced to take into account any public pension the spouse receives from government work not covered by Social Security. The amount of the reduction equals two-thirds of the government pension. In other words, $2 of the Social Security benefit is reduced for every $3 of pension income received. Workers with at least 5 years of FERS coverage are not subject to the offset.

According to a 1988 General Accounting Office report entitled: "Federal Workforce—Effects of Public Pension Offset on Social Security Benefits of Federal Retirees," 95 percent of Federal retirees had their Social Security spousal or survivor benefits totally eliminated by the offset.

The GPO is intended to place retirees whose government employment was not covered by Social Security and who are eligible for a Social Security spousal benefit in approximately the same position as other retirees whose jobs were covered by Social Security. Social Security retirees are subject to an offset of spousal benefits according to that program's "dual entitlement" rule. That rule requires that a Social Security retirement benefit earned by a worker be subtracted from his or her Social Security spousal benefit, and the resulting difference, if any, is the amount of the spousal benefit paid. Thus, workers retired under Social Security may not collect their own Social Security retirement benefit as well as a full spousal benefit.

The GPO replicates the Social Security dual entitlement rule by assuming that two-thirds of the government pension is approximately equivalent to the Social Security retirement benefit a worker would receive if his or her job had been covered by Social Security.

(E) SOCIAL SECURITY WINDFALL ELIMINATION PROVISION

Workers who have less than 30 years of Social Security coverage and a pension from non-Social Security covered employment are subject to the windfall penalty formula when their Social Security benefit is computed. The windfall penalty was enacted as part of the Social Security Amendments of 1983 in order to reduce the disproportionately high benefit "windfall" that such workers would otherwise receive from Social Security. Because the Social Security

benefits formula is weighted, low-income workers and workers with fewer years of covered service receive a higher rate of return on their contributions than high income workers who are more likely to also have private pension or other retirement income. However, the formula did not distinguish between workers with low-income earnings and workers with fewer years of covered service which resulted in a windfall to the latter group. To eliminate this windfall, Congress adopted the windfall benefit formula and then modified the formula before it was fully phased-in.

Under the regular Social Security benefit formula, the basic benefit is determined by applying three factors (90 percent, 32 percent, and 15 percent) to three different brackets of a person's average indexed monthly earnings (AIME). These dollar amounts increase each year to reflect the increase in wages. The formula for a worker who turns age 62 in 1994 is 90 percent of the first $426 in average monthly earnings, plus 32 percent of the amount between $426 and $2,567, and 15 percent of the amount over $2,567.

Under the original 1983 windfall benefit formula, the first factor in the formula was 40 percent rather than 90 percent with the 32 percent and 15 percent factors remaining the same. With the passage of the Technical Corrections and Miscellaneous Revenue Act of 1988, Congress modified the windfall reduction formula and created the following schedule:

Years of Social Security coverage:	*Percent*
20 or fewer	40
21	45
22	50
23	55
24	60
25	65
26	70
27	75
28	80
29	85
30 or more	90

Under the windfall benefit provision, the windfall formula will reduce the Social Security benefit by no more than 50 percent of the pension resulting from noncovered service.

3. Prognosis

Increasing concern about the cost of all Federal entitlement programs is likely to draw the attention of the Congress to Federal retirement systems. In the Omnibus Budget Reconciliation Act of 1993 (P.L. 103–66) Congress called for a temporary 3-month delay in the payment of retiree COLAs (from January to April in 1994, 1995, and 1996), thereby achieving immediate deficit reduction. In addition, Congress has recently discussed a variety of changes to the basic eligibility and benefit features of the retirement programs that would reduce benefits and costs over the long term. These proposals include: (a) permanently eliminating or reducing COLAs to CSRS retirees under age 62; (b) gradually raising the retirement age; and (c) reducing the Government matching rate for TSP deposits for FERS participants; and (d) requiring increased employee contributions to the retirement system.

D. MILITARY RETIREMENT

1. Background

For more than four decades following the establishment of the military retirement system at the end of World War II, the retirement system for servicemen remained virtually unchanged. However, the enactment of the Military Retirement Reform Act of 1986 (P.L. 99–348) brought major reforms to the system. The Act affected the future benefits of servicemembers first entering the military on or after August 1, 1986. Because a participant only becomes entitled to military retired and retainer pay after 20 years of service, the first nondisability retirees affected by the new law will be those with 20 years of service retiring on August 1, 2006.

In fiscal year 1993, 1.7 million retirees and survivors received military retirement benefits. For fiscal year 1993, total Federal military retirement outlays have been estimated at $25.7 billion. Three types of benefits are provided under the system: Nondisability retirement benefits (retirement for length of service after a career), disability retirement benefits, and survivor benefits under the Survivor Benefit Plan (SBP). With the exception of the SBP, all benefits are paid by contributions from the employing branch of the armed service, without contributions by the participants.

Servicemembers who retire from active duty receive monthly payments based on a percentage of their retired pay computation base. For persons who entered military service before September 8, 1980, the computation base is the final monthly base pay being received at the time of retirement. For those who entered service on or after September 8, 1980, the retired pay computation base is the average of the highest 3 years of base pay. Base pay comprises approximately 65–70 percent of total pay and allowances.

Retirement benefits are computed using a percentage of the retired pay computation base. The retirement benefit for someone entering military service prior to August 1, 1986, is determined by multiplying the years of service by a multiple of 2.5. Under this formula, the minimum amount of retired pay to which a retiree is entitled after a minimum of 20 years of service is 50 percent of base pay. A 25-year retiree receives 62.5 percent of base pay, with a 30-year retiree receiving the maximum—75 percent of base pay.

The Military Retirement Reform Act of 1986 (P.L. 99–348) changed the computation formula for military personnel who enter military service on or after August 1, 1986. For retirees under age 62, retired pay will be computed at the rate of 2 percent of the retired pay computation base for each year of service through 20, and 3.5 percent for each year of service from 21 through 30. Under the new formula, a 20-year retiree under age 62 will receive 40 percent of his or her basic pay, 57.5 percent after 25 years, and 75 percent after 30 years. Upon reaching 62, however, all retirees have their benefits recomputed using the old formula. The changed formula, therefore, favors the longer serving military careerist to a greater extent than the previous formula, providing an incentive to remain on active duty longer before retiring. Since most military personnel retire after 20 years, the cut from 2.5 percent to 2 percent will cut program costs. These changes in the retired pay computation for-

mula apply only to active duty nondisability retirees. Disability retirees and Reserve retirees are not affected.

Benefits are payable immediately upon retirement from military service (with the exception of reserve retirees), regardless of age, and without taking into account other sources of income, including Social Security. By statute, all benefits are fully indexed for changes in the CPI. Under the Military Retirement Reform Act of 1986, however, COLAs will be held at 1 percentage point below the CPI for military personnel beginning their service after August 1, 1986.

2. Issues and Legislative Response

(A) COST

Prior to 1986, the military retirement system was repeatedly criticized for providing overly generous benefits that cost too much. The Military Retirement Reform Act of 1986 was enacted in response to these criticisms. The Act's purpose was to contain the costs of the military retirement system and provide incentives for experienced military personnel to remain on active duty.

Approximately 1.7 million retired officers, enlisted personnel, and their survivors received nearly $25.7 billion in annuity payments in fiscal year 1993. At the current rate of growth, this expenditure will reach an estimated $34.6 billion annually by the year 2000. Cost growth projections have been dropping, due to the post-Cold War downsizing of the military. In fiscal year 1992, military retirees received an average of $14,900 in annuities.

Four features of the military retirement system contribute to its cost:

(1) Full benefits begin immediately upon retirement; the average retiring enlisted member begins drawing benefits at 43, the average officer at 46. Benefits continue until the death of the participant.

(2) Military retirement benefits are generally indexed for inflation.

(3) The system is basically noncontributory, although the participant must make some contribution if electing to provide survivor protection.

(4) Military retirement benefits are not integrated with Social Security benefits. (They may, however, be integrated with other benefits earned as a result of military service, i.e., Veterans benefits, or may be subject to reductions under dual compensation laws.)

Supporters of the current military retirement scheme have identified several characteristics unique to military life that justify relatively more liberal benefits to military retirees than other Federal retirees:

(1) All retired personnel are subject to involuntary recall in the event of a national emergency; retirement pay is considered part compensation for this exigency. Several thousand military retirees were recalled to active duty involuntarily for Operations Desert Shield and Desert Storm.

(2) Military service places different demands on military personnel than civilian employment, including higher levels of stress and danger and more frequent separation from family.

(3) The benefit structure has provided a significant incentive for older personnel to leave the service and maintain "youth and vigor" in the armed services. In this respect, it has been largely successful. Almost 90 percent of military retirees are under age 65, 50 percent under the age of 50.

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the Survivor Benefit Program. Very few of the studies conducted in the past decade have recommended contributions by individuals. As a result, no refunds of contributions are available to those leaving the military before the end of 20 years. The full cost of the program appears as an agency expense in the budget, unlike the civilian retirement system where four-fifths of the retirement plan costs appear in the agency budgets.

Since the beginning of full Social Security coverage for military personnel in 1957, military retirement benefits have been paid without any offset for Social Security. Taking into account the frequency with which military personnel in their mid-forties retire after 20 years of service, it is not unusual to find them retiring from a second career with a pension from their private employment along with their military retirement and a full Social Security benefit. Lack of integration of military retirement and Social Security benefits may add to the perception that military retirement benefits are overly generous.

Military retirement is fully indexed for inflation, as are Social Security and the Civil Service Retirement System, a feature that retirees traditionally have considered central to the adequacy of retirement benefits. In recent years, full indexing of military and other Federal retirement benefits has been the object of deficit-reduction measures. As a result of the original provisions of the Gramm-Rudman-Hollings Act, the 1986 military retiree COLA was cancelled. Since that time, however, legislation was enacted that excluded the COLA from sequestration.

The Omnibus Budget Reconciliation Act of 1993, the FY 1995 National Defense Authorization Act and the FY 1995 DoD Appropriation Act postponed the payment of military retirement COLAs during 1994–96.

(B) RETIREMENT ADEQUACY

The pivotal issue in evaluating the military retirement system in the appropriate balance among costs to the Government, benefits to the individual retiree, and the qualitative and quantitative manpower needs of the Armed Forces. Some have alleged that the major features of the military retirement system that differentiate it from civilian retirement systems—20-year retirement with an immediate annuity—are essential to recruiting and retaining sufficient high-quality career military personnel who can withstand the rigors of wartime services and high-stress peacetime training. Others allege that the system simply costs too much, has lavish bene-

fits, and contributes to inefficient military personnel management because no vesting is available before the 20-year mark.

Commentators periodically have called for shorter vesting schedules, comparable to those required for private plans under ERISA or for the Federal service jobs. Some military manpower experts have argued that such a change would adversely impact the ability to maintain a vigorous and youthful military force. On the other hand, some military manpower analysts argue that the need for youth and vigor is overstated in view of new technologies that put a premium on technical skills rather than physical endurance.

(C) THE MILITARY SURVIVOR BENEFIT PLAN

The Military Survivor Benefit Plan (SBP) was created in 1972 by Public Law 92–425. Under the plan, a military retiree can have a portion of his or her retired pay withheld to provide a survivor benefit to a spouse, spouse and child(ren), child(ren) only, a former spouse, or a former spouse and child(ren). Under the SBP, a military retiree can provide a benefit of up to 55 percent of his or her own military retired pay at the time of death to a designated beneficiary. A retiree is automatically enrolled in the SBP at the maximum rate unless he or she (with spousal or former spousal written consent) opts to participate or to participate at a reduced rate. SBP benefits are protected by inflation under the same formula used to determine cost-of-living adjustments for military retired pay.

The benefit payable to a spouse or former spouse may be modified when a respective survivor reaches age 62 under one of two circumstances.

(1) Survivor Social Security Offset

Coverage of military service under Social Security entitles the surviving spouse of a military retiree to receive Social Security survivor benefits based on contributions made to Social Security during the member's/retiree's military service. For certain surviving spouses, military SBP is integrated with Social Security. For those survivors subject to those provisions, military SBP benefits are offset by the amount of Social Security survivor benefits earned as a result of the retiree's military service. This offset occurs when the survivor reaches age 62 and is limited to 40 percent of the military survivor benefit. Taken together, the post-62 SBP benefit and the offsetting Social Security benefit must be no less than 55 percent of base military retired pay. In essence, this offset recognizes the Government's/taxpayer's contributions to both Social Security and the military SBP and thereby prevents duplication of benefits based on the same period of military service.

(2) The Two-Tiered SBP

For retirees who decide to participate in the SBP, the amount of Social Security at the time of death (i.e., the amount available for offset purposes) is unknown. Thus, retirees must decide to provide a benefit at a certain level subject to an unknown offset level. For this reason (and the fact that the offset formula is terribly complicated) Congress modified SBP provisions. Under these modified provisions, known as the "two-tier" SBP, a surviving spouse is eligi-

ble to receive 55 percent of base retired pay. When this survivor reaches age 62, the benefit is reduced to 35 percent of base retired pay. This reduction occurs regardless of any benefits received under Social Security and thereby eliminates the integration of Social Security and any subsequent offset. With the elimination of the Social Security offset, a military retiree will know the exact amount of SBP benefits he/she is purchasing at the time of retirement.

Under the rules established by Congress, two selected groups will have their SBP payments calculated under either the pre-two-tier plan (including the Social Security offset) or the two-tier plan, depending upon which is more financially advantageous to the survivor. The first group includes those beneficiaries (widows or widowers) who were receiving SBP benefits on October 1, 1985. The second group includes the spouse or former spouse of military personnel who were qualified for or were already receiving military retired pay on October 1, 1985. The spouses or former spouses of military personnel who were not qualified to receive military retired pay on October 1, 1985 (i.e., those who had not been on active duty with 20 or more years of creditable service) will have their SBP benefits calculated using the two-tier method. Levels of participation in the SBP have increased since the introduction of the two-tier method.

(3) Survivor Benefit Plan High Option

Beneficiary dissatisfaction with both the Social Security offset and the two-tier method has prompted Congress once again to consider modifying the military SBP. Under this option, certain retirees and retirement-eligible members of the armed services can opt to increase withholdings from military retired pay to reduce or eliminate any reduction occurring when the survivor reaches age 62. (Retirees must be under the two-tier plan to participate in the High Option). The costs of these additional benefits are actuarially neutral—participants will pay the full cost of this option. Thus, under the high option, certain personnel and retirees can insure that limited or no reductions to SBP benefits occur when the survivor reaches age 62.

(4) Cost-of-Living Adjustment

Military disability retirees, and survivor benefit recipients, along along with Social Security and other Federal retirees, received a 2.8 percent COLA effective January 1, 1995. Military retirees without a disability will receive a 2.8 percent COLA on April 1, 1995.

3. PROGNOSIS

Fiscal pressures and the work of the Bipartisan Commission on Entitlement and Tax Reform may fuel efforts to reduce military retirement costs, and hence benefits, in 1995. These may well involve both (1) reduced costs and (2) more fundamental changes in the retirement system.

E. RAILROAD RETIREMENT SYSTEM

1. Background

The Railroad Retirement System is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with Social Security. The system was authorized in 1935, prior to the creation of Social Security, and remains the only federally administered pension program for a private industry. It covers all railroad firms and distributes retirement and disability benefits to employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of vested so-called "dual" or "windfall" benefits, which are paid with annually appropriated Federal general revenue funds through a special account.

In fiscal year 1993, $7.9 billion in railroad retirement, disability, and survivor benefits were paid to 834,000 beneficiaries. As of January 1994, the railroad retirement equivalent of Social Security (Tier I) is 2.6 percent higher as a result of the Cost-of-Living Adjustment (COLA) applied to those benefits. The industry pension component (Tier II) is 0.8 higher than the automatic adjustment (32.5 percent of the Tier I COLA) to that benefit. As of January 1994, the average regular railroad retirement annuity amounted to $1,073 per month, and the combined benefits for an employee and spouse averaged $1,592. Aged survivors averaged $643 per month.

2. Issues and Legislative Response

(A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

In the final quarter of the 19th century, railroad companies were among the largest commercial enterprises in the Nation and were marked by a high degree of centralization and integration. As first established in 1934, the Railroad Retirement System was designed to provide annuities to retirees based on rail earnings and length of service. However, the present Railroad Retirement System was a result of the Railroad Retirement Act of 1974, which fundamentally reorganized the program. Most significantly, the Act created a two-tier benefit structure in which Tier I was intended to serve as a equivalent to Social Security and Tier II as a private pension.

Tier I benefits of the Railroad Retirement System are computed on credits earned in both rail and nonrail work, while Tier II is based solely on railroad employment. The total benefit continued traditional railroad annuities and eliminated duplicate Social Security coverage for nonrail and rail employment.

The Bush Administration, as the Reagan Administration before it, proposed to dismantle the Railroad Retirement System and replace it with a combination of direct Social Security coverage and a privately administered rail pension. Past Congresses have not taken the proposal under consideration on the grounds that it could lead to a cut in benefits for present and future retirees and undermine confidence in the system.

(1) National Performance Review's Proposal to End the Board's Functions

Although the Clinton Administration proposed a radical administrative restructuring, the report of the National Performance Review (NPR), a task force directed by Vice President Gore, recommended that principal functions of the Railroad Retirement Board be transferred to other agencies. The NPR report, "Creating A Government That Works Better and Costs Less," stated that it made "no sense" for a separate agency to administer the retirement, unemployment, and sickness benefits earned in a single industry.

The NPR report recommended that benefits equivalent to Social Security be administered by the Social Security Administration, that unemployment insurance be made part of the State unemployment insurance programs, and that sickness benefits be administered by Medicare. Although no details of this proposal were provided, and no legislation to accomplish the objectives was introduced or sent to Congress by the Administration, a grass roots rebellion of those affected by the system sprung up. Members of Congress were contacted to thwart any attempt to do away with the current structure.

The NPR proposal was not new. Similar proposals had been advanced by several previous Administrations, but none had success in persuading Congress to consider them. Aside from heavy political opposition engendered by efforts to end the board system, there are other impediments to enactment of such a proposal. First, the problems are complex, and substantial investments of legislative time and resources would be required by several committees in order to complete Congressional action. Second, the rail industry portion of the benefits would become insecure, given that the benefits are primarily funded from current revenues. Third, the unemployment program is designed as a daily benefit, consistent with the industry's intermittent employment practices evolving over the past century. State programs are based on unemployment measured by weeks instead of days. Fourth, costs of the programs' benefits and administration are borne by the industry through payroll taxes, and dismantling the Federal administration would not save taxpayers money. Finally, in the face of these obstacles there is no clear constituency exhibiting a consistent and persistent interest in ending Federal administration of railroad retirement. For these reasons, the Gore proposal is unlikely to be taken up by Congress.

(B) FINANCING RAILROAD RETIREMENT, UNEMPLOYMENT, AND SICKNESS BENEFITS

The railroad industry is responsible for the financing of (1) all Tier II benefits, (2) any Tier I benefits paid under different criteria from those of Social Security (unrecompensed benefits), (3) supplemental annuities paid to long-service workers, and (4) benefits payable under the unemployment and sickness program.

The Federal Government finances windfall benefits under an arrangement established by the 1974 Act, the legislation by which the current structure of railroad retirement was created. The principle of Federal financing of the windfall through the attrition of

the closed group of eligible persons has been reaffirmed by Congress on several occasions since that date.

With the exception of the dual benefit windfalls, the principle guiding railroad retirement and unemployment benefits financing is that the rail industry is responsible for a level of taxation upon industry payroll sufficient to pay all benefits earned in industry employment. Rail industry management and labor officials participate in shaping legislation that establishes the system's benefits and taxes. In this process, Congress weighs the relative interests of railroads, their current and former employees, and Federal taxpayers. Then it guides, reviews, and to some extent instructs a collective bargaining activity, the results of which are reflected in new law. Thus, railroad retirement benefits are earned in and paid by the railroad industry, established and modified by Congress, and administered by the Federal Government.

(1) Retirement Benefits

Tier I benefits are financed by a combination of payroll taxes and financial payments from the Social Security Trust Funds. The payroll tax for Tier I is exactly the same as collected for the Old Age, Survivors, and Disability Insurance (OASDI) Social Security program. In 1994, the tax is 6.2 percent of pay for both employers and employees up to a maximum taxable wage of $60,600.

A common cause of confusion about the Federal Government's involvement in the financing of railroad retirement benefits is the system's complex relationship with Social Security. Each year since 1951, the two programs—railroad retirement and Social Security—have determined what taxes and benefits would have been collected and paid by Social Security had railroad employees been covered by Social Security rather than railroad retirement. When the calculations have been performed and verified after the end of a fiscal year, transfers are made between the two accounts, called the "financial interchange." The principle of the financial interchange is that Social Security should be in the same financial position it would have occupied had railroad employment been covered at the beginning of Social Security. The net interchange has been in the direction of railroad retirement in every year since 1957, primarily because of a steady decline in the number of rail industry jobs.

Because a lag between the end of the accounting period and actual payment affected the RRA's capacity to meet benefit demands, the Railroad Retirement Solvency Act of 1983 (the 1983 Act) gradually placed the relationship between the programs on a current or month-to-month basis. The 1983 Act also established the Social Security Equivalent Benefit (SSEB) Account which manages revenues and expenditures for benefits that would be managed by Social Security if railroad retirement did not exist.

Tier II benefits are also financed by a payroll tax. In 1994, the payroll tax is 16.10 percent for employers and 4.90 percent for employees on the first $45,000 of a worker's covered railroad wages. The relative share of employer and employee financing of Tier II benefits is collectively bargained, and reflects compromises not directly related to retirement—compensation tradeoffs inherent in reaching labor-management agreements.

When Congress, with rail labor and management support, eliminated future opportunities to qualify for windfall benefits in 1974, it also agreed to use general revenues to finance the cost of phasing out the dual entitlement values already held by a specific and limited group of workers. The historical record suggests that congressional acceptance of a Federal obligation for the costs of phasing out the windfalls rests on the view that it was imperative that the advantages be eliminated prospectively and that no other alternative to general fund financing was satisfactory. It was successfully argued that railroad employers should not be required to pay for phasing out dual entitlements, because those benefit rights were earned by employees who had left the rail industry, and that rail employees should not be expected to pick up the costs of a benefit to which they could not become entitled.

Congressional acceptance of the Federal responsibility for the cost of windfall phaseout also caused some people to believe that the Federal Government should assume the retroactive responsibility for windfall costs borne by railroad retirement from 1954 through 1974. This argument has never been widely accepted because it is generally believed that the taxpayer should not bear the cost of an advantage in social insurance benefits for which only a limited group of employees in one industry is eligible. Indeed, administration analysts have made this point in arguing that the Federal Government should not have agreed to finance the phaseout of windfalls in the 1974 legislation.

The actual procedure by which the RRA was reimbursed for windfall phaseout payments meant that from 1975 to 1981 windfall payments exceeded Treasury reimbursement. The growing deficit between windfall benefit outlays and Federal Treasury reimbursement to the RRA became controversial as the account began to be threatened with insolvency. By 1983, this deficit, plus an imputed lost interest, had reached $1.9 billion. The 1983 Act repaid this outstanding reimbursement in three annual installments, beginning January 1984.

Supplemental annuities are financed on a current-cost basis, by a cents-per-hour tax on employers, adjusted quarterly to reflect payment experience. Some railroad employers (mostly railroads owned by steel companies) have a negotiated supplemental benefit paid directly from a company pension. In such cases, the company is exempt from the cents-per-hour tax for such amounts as it pays to the private pension, and the retiree's supplemental annuity is reduced for private pension payments paid for by those employer contributions to the private pension fund.

(2) Unemployment and Sickness Benefits

The benefits for eligible railroad workers when they are sick or unemployed are paid through the Railroad Unemployment Insurance Account (RUIA). The RUIA is financed by taxes on railroad employers. Employers pay a tax rate based on their employees' use of the program funds, up to a maximum.

During the rapid decline in industry employment in 1981 and 1982, the RUIA experienced substantial borrowing from the pension funds, reaching a peak level of $850 million at the end of 1986. Legislation in 1983, 1986, and 1988 (P.L. 98–76, 99–272, and 100–

647) enacted special taxes to facilitate repayment of the RUIA debt to the retirement funds, and all outstanding loans, including interest, were repaid by June 30, 1993.

(C) TAXATION OF RAILROAD RETIREMENT BENEFITS

Tier I benefits are subject to the same Federal income tax treatment as Social Security. Under those rules, up to 85 percent of the Tier I benefit is subject to income taxes if the adjusted gross income (AGI) of an individual exceeds $34,000 ($44,000 for a married couple). Proceeds from this tax are transferred from the General Fund to the Social Security Trust Funds to help finance Social Security and railroad retirement Tier I benefits.

Unrecompensed Tier I benefits (Tier I benefits paid in circumstances not paid under Social Security) and Tier II benefits are taxed as ordinary income, on the same basis as all other private pensions. The proceeds from this tax were, until September 30, 1992, transferred to the railroad retirement Tier II account to help defray its costs under temporary legislation enacted as part of the 1983 Act. The transfer of taxes on Tier II benefits to the Tier II account had been extended several times, and although Congress passed legislation making the transfer permanent on October 5, 1992 (H.R. 11, the Revenue Act of 1992), President Bush vetoed the bill. That legislation was reintroduced in the 103rd Congress, but was not enacted in 1993. Nevertheless, supporters of the provision are optimistic that an extension (probably permanent) will be enacted and applied retroactively.

This transfer is a direct General Fund subsidy to the Tier II account's financial outlook, a unique taxpayer subsidy for a private industry pension. Yet, the importance of the rail industry to the national heritage and economy is widely recognized in Congress, as is the probability that some costs of the rail industry may well have to be "socialized across the rest of the economy" (in the words of former OMB Director David Stockman) if the rail industry is to remain viable in the future.

Furthermore, because the financial outlook for the Tier II account is optimistic for the next decade at least, these transferred taxes on Tier II benefits do not actually result in immediate Federal budget outlays; they remain on the account balances as unspent budget authority. As such, there will be no impact on this transfer on Federal taxpayers or on the Federal budget deficit. However, positive balance could encourage benefit increases without corresponding increases in the Tier II tax rate, or an otherwise necessary tax rate increase could be delayed because the account balance is perceived to be high enough to forgo it. If the ratio of taxes-to-benefits is insufficient to maintain a growing, or at least level, account balance, the program will begin to add to annual Federal budget deficits.

(D) THE OUTLOOK FOR FINANCING FUTURE BENEFITS

The Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203) created the Commission on Railroad Retirement Reform to examine and review perceived problems in the railroad benefit programs. The Commission reported its findings in September 1990. In addition to several technical recommendations, the Commission con-

cluded that railroad retirement financing is sound for the intermediate term and probably sound for the 75 years of the actuarial valuation.

The combinations of RUIA and retirement taxes projected by the RRB, the Federal agency responsible for administering the railroad retirement and unemployment/sickness insurance programs, exceed the industry's obligations for total payments from these programs over the next decade. If the Board's assumptions are a reasonably dependable yardstick of the future economic position of the rail industry, then it would follow that the current benefit/tax relationship of the two programs considered together is adequate. Of course, as employment in the industry declines, the mechanical relationship between payroll tax income and rail employment levels darkens the outlook for both programs. Benefit increases in either program without corresponding increases in railroad industry taxes to the program would have a similar effect.

Because revenue to support industry benefits is raised through taxes on industry payroll, there is a direct link between railroad retirement financing and the actual number of railroad employees. Thus, when the number of industry employees falls, retirement program revenue drops as well. It should be kept in mind, however, that a decline in employment may result from improvements in efficiency as well as diminished demands for railroad services. Thus, the industry's capacity to generate adequate revenues to the program cannot be determined solely by reference to industry employment levels.

The program, in spite of the direct relationship between benefit payments and money raised through a tax on worker payroll, is not a transfer between generations, at least not in the same sense that current Social Security benefits are financed by taxes on today's workers. Since the burden for generating sufficient revenue to support rail industry benefits is upon the industry as a whole, the payroll tax is primarily a method for distributing through the industry the operating expense of retirement benefits incurred by individual rail carriers. The industry could adopt some other method for distributing the costs among its components and, indeed, from time-to-time alternatives are proposed. Yet, inevitably there exists an ongoing bargaining tension over the amount of industry revenue to be claimed by competing labor sectors—the active, unemployed, and retired workers—and the amount to be claimed by the railroad companies themselves.

3. Prognosis

The Railroad Retirement and Unemployment Programs will likely remain in the present form for the foreseeable future. The proposal in Vice President Gore's National Performance Review to end Federal administration of Railroad Retirement is unlikely to be acted upon largely due to determined opposition from railroad retirees.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

The Federal tax code has historically recognized the special needs of older Americans. Helping to preserve a standard of living threatened by reduced income and increases in nondiscretionary expenditures such as health expenditures, has been a primary tax policy objective for elderly Americans.

Until 1984, both Social Security and Railroad Retirement benefits, like veterans' pensions, were fully exempt from Federal taxation. To help restore financial stability to Social Security, up to one-half of Social Security and Railroad Retirement Tier I benefits of higher income taxpayers became taxable under a formula contained in the Social Security Act Amendments of 1983 (P.L. 98–21). Under a provision included in the Omnibus Budget Reconciliation Act of 1993 (P.L. 103–66) up to 85 percent of Social Security benefits are taxable in the case of higher income elderly. Those Federal taxes collected on Social Security income are returned to the Social Security trust funds.

The Tax Reform Act of 1986 (P.L. 99–514) resulted in a number of changes to tax laws affecting older men and women. While the Act repealed some longstanding tax advantages for elderly persons, it increased others. For example, the elderly lost the extra personal exemption for the aged, which was replaced by an extra standard deduction amount available to many. This additional standard deduction amount was combined with the increased standard deduction for taxpayers in general provided by the 1986 act. Thus, the Congress was attempting to target the tax benefits to lower and moderate income elderly taxpayers through the substitution.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) also made a number of changes to the tax laws that may affect the tax burden of the general population including elderly persons. These include the addition of a third tax rate bracket and increases in a number of excise taxes such as those on gasoline, alcohol, and tobacco.

A. TAXES

1. BACKGROUND

A number of longstanding provisions in the tax code are of special significance to older men and women. These include the exclusion of Social Security and Railroad Retirement Tier I benefits for low and moderate income beneficiaries, the tax credit for the elderly and permanently and totally disabled, the one-time exclusion of

up to $125,000 in capital gains from the sale of a home for persons at least 55 years of age, and the tax treatment of below-market interest loans to continuing care facilities.

The Tax Reform Act of 1986 altered many provisions of the Internal Revenue Code including a number of tax provisions of importance to older persons. For example, the extra personal exemption for the aged was removed, but replaced by a larger personal exemption amount for taxpayers in general (which is now adjusted for inflation) and an additional standard deduction amount for elderly and/or blind taxpayers who do not itemize this provision is also annually adjusted for inflation.

(A) TAXATION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

For more than four decades following the establishment of Social Security, benefits were exempt from Federal income tax. Congress did not explicitly exclude those benefits from taxation. Rather, their tax-free status arose from a series of rulings in 1938 and 1941 from what was then called the Bureau of Internal Revenue. These rulings were based on the determination that Congress did not intend for Social Security benefits to be taxed, as implied by the lack of an explicit provision to tax them, and that the benefits were intended to be in the form of "gifts" and gratuities, not annuities which replace earnings, and therefore were not to be considered as income for tax purposes.

In 1983, the National Commission on Social Security Reform recommended that up to one-half of the Social Security benefits of higher income beneficiaries be taxed, with the revenue put back into the Social Security trust funds. The proposal was part of a larger set of recommendations entailing financial concessions by employees, employers, and retirees alike to rescue Social Security from insolvency.

Congress acted on this recommendation with the passage of the Social Security Act Amendments of 1983. As a result, up to one-half of Social Security and Tier 1 Railroad Retirement benefits for beneficiaries whose other income plus one-half their Social Security benefits exceed $25,000 ($32,000 for joint filers) became subject to taxation. (Tier 1 Railroad Retirement benefits are those provided by the railroad retirement system that are equivalent to the Social Security benefit that would be received by the railroad worker were he or she covered by Social Security.)

The limited application of the tax on Social Security and Tier 1 Railroad Retirement benefits reflects the congressional concern that lower and moderate income taxpayers not be subject to this tax. Because the tax thresholds are not indexed, however, with time, beneficiaries of more modest means will also be affected.

In computing the amount of Social Security income subject to tax, otherwise tax-exempt interest (e.g., from municipal bonds) is included in determining by how much the combination of one-half of benefits plus other income exceeds the income thresholds. Thus, while the tax-exempt interest itself remains free from taxation, it can have the effect of making more of the Social Security benefit subject to taxation.

In the Omnibus Budget Reconciliation Act of 1993, Congress subjected up to 85 percent of Social Security benefits to tax. Starting January 1, 1995, up to 85 percent of benefits are taxable for recipients whose other income plus one-half their social security benefits exceed $34,000 ($44,000 for joint filers). Recipients with combined incomes over $25,000 ($32,000 for joint filers) but not over $34,000 ($44,000 for joint filers) are taxable at the 50 percent rate.

Revenues from the taxation of Social Security benefits have continued to increase. In 1984, approximately $3 billion in taxes were paid into the Social Security trust funds. In 1996, that figure rose to $6.9 billion. By the year 2000, they will reach an estimated $9.0 billion.

(B) ELDERLY TAX CREDIT

The tax credit for the elderly and the permanently and totally disabled, was formerly known as the retirement income credit and the tax credit for the elderly. Congress established the credit to correct inequities in the taxation of different types of retirement income. Prior to 1954, retirement income generally was taxable, while Social Security and Railroad Retirement (Tier I) benefits were tax-free. The congressional rationale for this credit is to provide roughly similar treatment to all forms of retirement income.

The credit has changed over the years with the current version enacted as part of the Social Security Amendments of 1983. Individuals who are age 65 or older are provided a tax credit of 15 percent of their taxable income up to the initial amount, described below. Individuals under age 65 are eligible only if they are retired because of a permanent or total disability and have disability income from either a public or private employer based upon that disability. The 15-percent credit for the disabled is limited only to disability income up to the initial amount.

For those persons age 65 and retired, all types of taxable income are eligible for the credit, including not only retirement income but all investment income. The initial amount for computing the credit is $5,000 for a single taxpayer age 65 or over, $5,000 for a married couple filing a joint return where only one spouse is age 65 or over filing separate return. In the case of a married couple filing a joint return where both spouses are qualified individuals the initial amount is $7,500. A married individual filing a separate return has an initial amount of $3,750. The initial amount must be reduced by tax-exempt retirement income, such as Social Security. The initial amount must also be reduced by $1 for each $2 if the taxpayer's adjusted gross income exceeds the following levels: $7,500 for single taxpayers, $10,000 for married couples filing a joint return, and $5,000 for a married individual filing a separate return.

Although the tax credit for the elderly does afford some elderly taxpayers receiving taxable retirement income some measure of comparability with those receiving tax-exempt (or partially tax-exempt) Social Security benefits, because of the adjusted gross income phaseout feature it does so only at low income levels. Social Security recipients with higher levels of income always continue to receive at least a portion of their Social Security income tax free. Such is not the case for those who must use the tax credit.

(C) ONE-TIME EXCLUSION OF CAPITAL GAINS ON THE SALE OF A HOME

A taxpayer may elect to exclude from gross income up to a $125,000 gain from the sale of a residence, provided: (1) the taxpayer was at least 55 years of age before the date of the sale or exchange, and (2) he owned and occupied the property as his principal residence for a period totalling at least 3 years within the 5-year period ending on the date of the sale. Short periods of absence, such as for vacations, even if rented during those periods, are counted toward the 3-year required period. Taxpayers meeting both requirements can elect to exclude from gross income the entire capital gain from the sale or exchange if the capital gain is less the $125,000, or the first $125,000 profit if the gain is greater. If the property is held in joint name and both spouses file a joint return, they qualify for the exclusion even though only one spouse has attained the age of 55, provided he or she also satisfies the holding and use requirements. The election may be made only once in a lifetime. If either spouse has previously made an election (individually, jointly, or from a previous marriage), then neither is eligible to elect the exclusion.

The Revenue Act of 1964 provided the first exclusion from taxation for capital gains on the sale of a primary residence by the elderly. The House Committee on Ways and Means stated in its report that "an individual may desire to purchase a less-expensive home or move to an apartment or to a rental property at another location. He may also require some or all of the funds obtained from the sale of the old residence to meet his and his wife's living expenses. Nevertheless, under present law, such an individual must tie up all of his investment from the old residence in a new residence, if he is to avoid taxation on any of the gain which may be involved. Your committee concluded that this is an undesirable burden on our elderly taxpayers."

The Committee was primarily concerned with the average and smaller home selling for $20,000 or less. Therefore, it limited the application of the provision so that a full exclusion of gain would be attributable only to the first $20,000 of the sales price. Above that level, a ratio was to be used to determine the gain subject to taxation. This ratio was such that the lower the adjusted sales price, the greater the benefits derived from the exclusion. Over the years, Congress raised the maximum excludable gain to $125,000 to reflect increases in inflation and average market prices for housing. It also lowered to 55 the age at which the exclusion can be taken due to decreasing retirement ages.

(D) BELOW MARKET INTEREST LOANS TO CONTINUING CARE FACILITIES

Special rules exempt loans made by elderly taxpayers to continuing care facilities from the imputed interest provisions of the Code. Thus, the special exemption is relevant to elderly persons who loan their assets to facilities and receive care and other services in return instead of cash interest payments. The imputed interest rules require taxpayers to report interest income on loans even if interest is not explicitly stated or is received in noncash benefits. In order to qualify for this exception to the rules, either the taxpayer or the taxpayer's spouse must be 65 year of age or older. The loan must

be made to a qualified continuing care facility. The law provides that substantially all of the facilities used to provide care must be either owned or operated by the continuing care facility and that substantially all of the residents must have entered into continuing care contracts. Thus, a qualified facility holds the proceeds of the loan and in turn provides care under a continuing care contract.

Under a continuing care contract the individual and/or spouse must be entitled to use the facility for the remainder of their life/lives. Initially, the taxpayer must be capable of independent living with the facility obligated to provide personal care services. Long-term nursing care services must be provided if the resident(s) is no longer able to live independently. Further, the facility must provide personal care services and long-term nursing care services without substantial additions in cost.

The amount that may be loaned to a continuing care facility is inflation adjusted. In 1997 a taxpayer may lend up to $131,300 before being subject to the imputed interest rules.

(E) TAX REFORM ACT OF 1986

The Tax Reform Act of 1986 made such sweeping changes to the Internal Revenue Code that the Congress chose to issue the Code as a completely new edition—the first recodification since 1954. As a result of the 1986 Act, the elderly like other taxpayers saw many changes in their taxes. The following is a brief summary of some of the tax changes which had an impact on many aged taxpayers.

(1) Extra Personal Exemption for the Elderly

The extra personal exemption for elderly persons was enacted in 1948. The Senate Finance Committee report stated the reason for the additional exemption was that "The heavy concentration of small incomes among such persons reflects the fact that, as a group, they are handicapped at least in an economic sense. They have suffered unusually as a result of the rise in cost-of-living and the changes in the tax system which occurred since the beginning of the war. Unlike younger persons, they have been unable to compensate for these changes by accepting full-time jobs at prevailing high wages. Furthermore, this general extension appears to be a better method of bringing relief than a piecemeal extension of the system of exclusions for the benefit of particular types of income received primarily by aged persons." At that time, this provision removed an estimated 1.4 million elderly taxpayers and others (blind persons also were provided the extra personal exemption) from the tax rolls, and reduced the tax burden for another 3.7 million.

With the passage of the 1986 Act, the extra personal exemption was eliminated due to a dramatic increase in the personal exemption amount, the provision of future inflation adjustments, and the addition of an extra standard deduction amount for those elderly taxpayers who do not itemize.

(2) Deduction of Medical and Dental Expenses

The Health Care Financing Administration (HCFA) recently developed a new chartbook in celebration of the 30th anniversary of the implementation of the Medicare program. The HCFA is part of the Department of Health and Human Services. The Medicare program has grown from 19 million to 38 million today. Bruce C. Vladeck, Administrator of the Health Care Financing Administration stated that "Older Americans now enjoy better health, longer lives, and improved quality of life, in part because of Medicare. Over the last 3 decades, life expectancy at age 65 has increased by nearly 3 years for both men and women. The elderly over age 80 also have a longer life expectancy in the U.S. than in other industrialized countries. Medicare's per enrollee rate of spending growth compares favorably to the private sector. From 1969 to 1993 Medicare's average annual per enrollee spending growth was lower than that of the private sector. Furthermore, Medicare's administrative expenses are very low—2 percent—compared to private sector administrative expenses of 10 percent or more."

The chartbook shows that the elderly spend a greater proportion of their total household after-tax income on health than do the non-elderly. As a group, the non-elderly spend 5 percent of income on health whereas the elderly spend 18 percent. In 1994 it was found that elderly households with less than $11,000 in after-tax income spent 24 percent for health expenditures; those whose incomes ranged between $11,000 to $21,000 spent 18 percent on health expenditures; those whose income fell between $21,000 and $34,000 spent 12 percent; those whose incomes were between $34,000 and $54,000 spent 8 percent; while elderly households with after-tax incomes greater than $54,000 spend just 4 percent for health expenditures.

Under prior law, medical and dental expenses, including insurance premiums, co-payments, and other direct out-of-pocket costs were deductible to the extent that they exceeded 5 percent of a taxpayer's adjusted gross income. The 1986 Act raised the threshold to 7.5 percent. The determination of what constitutes medical care for purposes of the medical expense deduction is of special importance to the elderly. Two special categories are enumerated below.

(F) RESIDENCE IN A SANITARIUM OR NURSING HOME

If an individual is in a sanitarium or nursing home because of physical or mental disability, and the availability of medical care is a principal reason for his being there, the entire cost of maintenance (including meals and lodging) may be included in medical expenses for purposes of the medical expense deduction.

(G) CAPITAL EXPENDITURES

Capital expenditures incurred by an aged individual for structural changes to his personal residence (made to accommodate a handicapping condition) are fully deductible as a medical expense. The *General Explanation of the Tax Reform Act of 1986* prepared by the Joint Committee on Taxation states that examples of qualifying expenditures are construction of entrance and exit ramps, enlarging doorways or hallways to accommodate wheelchairs, install-

ment of railings and support bars, the modification of kitchen cabinets and bathroom fixtures, and the adjustments of electric switches or outlets.

(3) Contributory Pension Plans

Prior to 1986, retirees from contributory pension plans (meaning plans requiring that participants make after-tax contributions to the plan during their working years) generally had the benefit of the so-called 3-year rule. The Federal Civil Service Retirement System and most State and local retirement plans are contributory plans. The effect of this rule was to exempt, up to a maximum of 3 years, pension payments from taxation until the amount of previously taxed employee contributions made during the working years was recouped. Once the employee's share was recouped, the entire pension became taxable.

Under the 1986 Act, the employer's contribution and previously untaxed investment earnings of the payment are calculated each month on the basis of the worker's life expectancy, and taxes are paid on the annual total of that portion. Retirees who live beyond their estimated lifetime then must begin paying taxes on the entire annuity. The rationale is that the retiree's contribution has been recouped and the remaining payments represent only the employer's contribution. For those who die before this point is reached, the law allows the last tax return filed on behalf of the estate of the deceased to treat the unrecouped portion of the pension as a deduction.

As a result of repeal of the 3-year rule, workers retiring from contributory pension plans are in higher tax brackets in the first years after retirement. However, any initial tax increases are likely to be offset over the long run because they have lower taxable incomes in the later years.

(4) Personal Exemptions, Standard Deductions, and Additional Standard Deduction Amounts

The Treasury Department annually adjusts personal exemptions, standard deductions, and additional standard deduction amounts for inflation. The personal exemption a taxpayer may claim on a return for 1996 is $2,550. The personal exemption amount will rise to $2,650 for tax year 1997. The standard deduction is $4,000 for a single person, $5,900 for a head of household, $6,700 for a married couple filing jointly, and $3,350 for a married person filing separately. For tax year 1997, the standard deduction amounts rise to $4,150 for a single person, $6,050 for a head of household, $6,900 for a married couple filing jointly, and $3,450 for a married person filing separately. The additional standard deduction amount for an elderly single taxpayer is $1,000 while married individuals (whether filing jointly or separately) may each receive an additional standard deduction amount of $800. These amounts will remain stable for tax year 1997.

(5) Filing Requirements and Exemptions

The 1986 Act and indexation of various tax provisions has raised the levels below which persons are exempted from filing Federal in-

come tax forms. For tax year 1996, single persons age 65 or older do not have to file a return if their income is below $7,550. For married couples filing jointly, the limit is $12,600 if one spouse is age 65 or older. Single persons who are age 65 or older or blind and who are claimed as dependents on another individual's tax return do not have to file a tax return unless their unearned income exceeds $1,650 ($2,650 if 65 or older and blind), or their gross income exceeds the larger of $650 or the filer's earned income (up to $4,000), plus $1,000 ($2,000 in the case of being 65 or older and blind. Married persons who are age 65 or older or blind and who are claimed as dependents on another individual's tax return must file a return if their earned income exceeds $4,150 ($4,950 if 65 or older and blind), their unearned income exceeds $1,450 ($2,250 if 65 or older and blind), or their gross income was more than the larger of $650 or their earned income (up to $3,350), plus $800 ($1,600 if 65 or older and blind). All these amount rise for tax year 1997.

(6) The Impact of Tax Reform of 1986

Jane G. Gravelle, a Senior Specialist in Economic Policy at CRS wrote in the *Journal of Economic Perspectives* an article entitled the "Equity Effects of the Tax Reform Act of 1986" (Vol. 6, No. 1—Winter 1992). In discussing life cycle incomes and intergenerational equity she found that little change was made in the intergenerational tax distribution from passage of this act. Her findings suggest that the Tax Reform Act reduced taxes on wage incomes which tends to benefit younger workers relative to older individuals. Thus, younger workers "gained slightly more than the average" since older individuals income involves a smaller share of earned income. However, older individuals also were found to have "gained slightly more than average because of the gains in the value of existing capital." The implications of these findings were that the Act results in "a long-run revenue loss" and how this "revenue loss is recouped will also affect the distribution among generations."

B. SAVINGS

1. BACKGROUND

There has been considerable emphasis on increasing the amount of resources available for investment. By definition, increased investment must be accompanied by an increase in saving and foreign inflows. Total national saving comes from three sources: individuals saving their personal income, businesses capital consumption allowances and retained profits, and Government saving when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal saving and capital accumulation have been enacted in recent years.

Retirement income experts have suggested that incentives for personal saving be increased to encourage the accumulation of greater amounts of retirement income. Many retirees are dependent primarily on Social Security for their income. Thus, some analysts favor a better balance between Social Security, pensions, and

personal savings as sources of income for retirees. The growing financial crisis that faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their pre-retirement saving efforts.

The life-cycle theory of saving has helped support the sense that personal saving is primarily saving for retirement. This theory postulates that individuals save little as young adults, increase their saving in middle age, then consume those savings in retirement. Survey data suggests that saving habits are largely dependent on available income versus current consumption needs, an equation that changes over the course of most individuals' lifetimes.

The consequences of the life-cycle saving theory raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those who are already saving at above-average incomes, and subject to relatively high marginal tax rates. Whether this group presently is responding to these incentives by saving at higher rates or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject of disagreement among policy analysts.

For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Raising the saving rate in this group necessitates a trade-off of increased saving for current consumption, a behavior which they are not under most circumstances inclined to pursue. As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially for those at the lower end of the income spectrum.

The dual interest of increased capital accumulation and improved retirement income adequacy has sparked an expansion of tax incentives for personal retirement saving over the last decade. However, in recent years, many economists have begun to question the importance and efficiency of expanded tax incentives for personal saving as a means to raise capital for national investment goals, and as a way to create significant new retirement savings. These issues received attention in 1986 as part of the effort to improve the fairness, simplicity, and efficiency of Federal tax incentives.

The role of savings in providing for retirement income for the elderly population is substantial. In 1995, about two-thirds of those aged 65 and over had property income while only about one-third received income from pensions. Nearly 18 percent of all elderly income was accounted for by interest, dividends, or other forms of property income.

Some differences emerge when the population is broken down by race. Property income accounted for about 18 percent of the total income of white households. Property income accounted for 9 percent and 6 percent of black and Hispanic household income, respectively.

The median net worth of all families in 1995 was $56,400. The median net worth for white families was $73,900, while the median net worth for other families was $16,500. The wealthiest age group included those families headed by someone between the age of 55 and 64, whose median net worth was $110,800.

The effort to increase national investment springs from a perception that governmental, institutional, and personal saving rates are lower than the level necessary to support a more rapidly growing

economy. Except for a period during World War II when personal saving approached 25 percent of income, the personal saving rate in the United States has ranged between 4 percent and 9 percent of disposable income. Many potential causes for these variations have been suggested, including demographic shifts in the age and composition of families and work forces, and efforts to maintain levels of consumption in the face of inflation. Personal saving rates in the United States historically have been substantially lower than in other industrialized countries. In some cases, it is only one-half to one-third of the saving rates in European countries.

For 1996, Commerce Department figures indicate that the personal savings rate was 3.6 percent, compared to 3.4 percent for 1995. For the 1970's and 1980's, the rates averaged 5.5 percent and 4.7 percent respectively.

Even assuming present tax policy creates new personal savings critics suggest this may not guarantee an increase in total national savings available for investment. Federal budget surpluses constitute saving as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal saving being generated. Under this analysis, net national saving would be increased only when net new personal saving exceeded the Federal tax revenue foregone as a result of tax-favored treatment.

Recent studies of national retirement policy have recommended strengthening individual saving for retirement. Because historical rates of after-tax saving have been low, emphasis has frequently been placed on tax incentives to encourage saving in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of the President's Commission on Pension Policy issued in 1981 recommended several steps to improve the adequacy of retirement saving, including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution limits for IRAs. In that same year, the Committee for Economic Development—an independent, nonprofit research and educational organization—issued a report which recommended a strategy to increase personal retirement savings that included tax-favored contributions by employees covered by pension plans to IRAs, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased saving opportunities. In each Congress since the passage of the Employee Retirement Income Security Act (ERISA) in 1974, there have been expansions in tax-preferred saving devices. This continued with the passage of the Economic Tax Recovery Act of 1981 (ERTA). From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRAs, simplified employee pensions, Keogh accounts, and employee stock ownership plans (ESOP's). ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined contribution plans.

The evaluation of Congress' attitude toward expanded use of tax incentives to achieve socially desirable goals holds important impli-

cations for tax-favored retirement saving. When there is increasing competition among Federal tax expenditures, the continued existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy.

2. Issues

(A) INDIVIDUAL RETIREMENT ACCOUNTS (IRA'S)

(1) Pre-1986 Tax Reform

The extension of IRAs to pension-covered workers in 1981 by ERTA resulted in dramatically increased IRA contributions. In 1982, the first year under ERTA, IRS data showed 12 million IRA accounts, over four times the 1981 number. In 1983, the number of IRAs rose to 13.6 million, 15.2 million in 1984, and 16.2 million in 1985. In 1986, contributions to IRAs totaled $38.2 billion. The Congress anticipated IRA revenue losses under ERTA of $980 million for 1982 and $1.35 billion in 1983. However, according to Treasury Department estimates, revenue losses from IRA deductions for those years were $4.8 billion and $10 billion, respectively. By 1986, the estimated revenue loss had risen to $16.8 billion. Clearly, the program had become much larger than Congress anticipated.

The rapid growth of IRAs posed a dilemma for employers as well as Federal retirement income policy. The increasingly important role of IRAs in the retirement planning of employees began to diminish the importance of the pension bond which links the interests of employers and employees. Employers began to face new problems in attempting to provide retirement benefits to their work forces.

A number of questions arose over the efficiency of the IRA tax benefit in stimulating new retirement savings. First, does the tax incentive really attract savings from individuals who would be unlikely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional saving or does it merely redirect existing savings to a tax-favored account? Third, are IRAs retirement savings or are they tax-favored saving accounts used for other purposes before retirement?

Evidence indicated that those who used the IRA the most might otherwise be expected to save without a tax benefit. Low-wage earners infrequently used IRA's. The participation rate among those with less than $20,000 income was two-fifths that of middle-income taxpayers ($20,000 to $50,000 annual income) and one-fifth that of high-income taxpayers ($50,000 or more annual income). Also, younger wage earners, as a group, were not spurred to save by the IRA tax incentive. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties. Those without other retirement benefits also appear to be less likely to use an IRA. Employees with job tenures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups

than for those who are covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.

Though a low proportion of low-income taxpayers utilize IRAs relative to higher income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than pre-existing savings. High-income taxpayers apparently are more often motivated to contribute to IRAs by a desire to reduce their tax liability than to save for retirement.

One of the stated objectives in the creation of IRAs was to provide a tax incentive for increased saving among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. However, the likelihood that a taxpayer will establish an IRA increases with job and income stability. Thus, the tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive. As a matter of tax policy, IRAs could be an inefficient way of improving the retirement income of low-income taxpayers.

An additional issue was whether all IRA savings are in fact retirement savings or whether IRAs were an opportunity for abuse as a tax shelter. Most IRA savers probably view their account as retirement savings and are inhibited from tapping the money by the early 10 percent penalty on withdrawals before age 59 and a half. However, those who do not intend to use the IRA to save for retirement, can still receive tax benefits from an IRA even with early withdrawals. Most analysts agree that the additional buildup of earnings in the IRA, which occurs because the earnings are not taxed, will surpass the value of the 10-percent penalty after only a few years, depending upon the interest earned. Some advertising for IRA savings emphasized the weakness of the penalty and promoted IRAs as short-term tax shelters. Although the tax advantage of an IRA is greatest for those who can defer their savings until retirement, they are not limited to savings deferred for retirement.

(2) Post-1986 Tax Reform

The IRA provisions of the 1986 Tax Reform Act were among the most significant changes affecting individual savings for retirement. To focus the deduction more effectively on those who need it, the Act repealed the deductibility of IRA contributions for pension plan participants and their spouses, with an adjusted gross income (AGI) in excess of $35,000 (individuals) or $50,000 (family). For pension-covered workers and their spouses with AGIs between $25,000 and $35,000 (individual) or $40,000 and $50,000 (family), the maximum deductible IRA contribution is reduced in relation to their incomes. Workers in families without pensions, and pension-covered workers with AGIs below $25,000 (individual) and $40,000 (family) retain the full $2,000 per year IRA contribution. Even with the loss of the IRA deduction for some workers, however, all IRA accounts, even those receiving only after-tax contributions, continue to accumulate earnings tax free. Nevertheless, the number of tax returns reporting IRA contributions fell to 7.3 million in 1987; 6.4 million in 1988; 5.8 million in 1989; 5.2 million in 1990; 4.7 mil-

lion in 1991; 4.5 million in 1992; 4.4 million in 1993; and 4.3 million in 1994.

Prior to the passage of the Small Business Tax Act in 1996 some were concerned that the IRA was not equally available to all taxpayers who might want to save for retirement. Before 1997, nonworking spouses of workers saving in an IRA could contribute only an additional $250 a year. The Small Business Tax Act modified the rule to allow spousal contributions of up to $2,000 if the combined compensation of the married couple is at least equal to the contributed amount. Prior to this change, some contended that the lower $250 amount created an inequity between two-earner couples who could contribute $4,000 a year and one-earner couples who could contribute a maximum of $2,250 in the aggregate. They argued that it arbitrarily reduces the retirement income of spouses, primarily women, who spend part or all of their time out of the paid work force. Those who opposed liberalization of the contribution rules contended that any increase would primarily advantage middle and upper income taxpayers, because the small percentage of low-income taxpayers who utilized IRAs often did not contribute the full $2,000 permitted them each year.

A provision included in the Health Insurance Portability and Accountability Act of 1996 permits withdrawals from IRAs for medical expenses. Under this provision, amounts withdrawn for medical expenses in excess of 7.5 percent of a taxpayer's adjusted gross income will not be subject to the 10 percent penalty tax for early withdrawals. In addition, persons on unemployment for at least 12 weeks may make withdrawals to pay for medical insurance without being subject to the 10 percent penalty tax for early withdrawals.

There are proposals to enhance IRAs and to use them either directly or as models to support other individual saving goals. Some congressional leaders have proposed increased tax benefits for IRA contributions to restore tax benefits taken away by the Tax Reform Act of 1986, to increase the national saving rate, and to facilitate desirable social goals such as homeownership. Opponents argue that these proposals would use Federal revenue to help mainly higher income people and that they would achieve little in the way of increased savings.

Some proposals to modify IRA contribution and withdrawal rules would expand the deductibility of contributions or tax contributions but allow for tax-free retirement withdrawals. Other proposals would loosen the restrictions on early withdrawals if IRA funds were used for certain purposes, such as the purchase of a first-time residence, or educational expenses. Some proposals call for entirely new individual savings accounts to encourage saving for selected purposes. The potential for expanded IRAs to boost the national saving rate has become a central issue in this policy debate.

(B) RESIDENTIAL RETIREMENT ASSETS

Tax incentives, which have long promoted the goal of home ownership, include the income tax deductions for real estate taxes and home mortgage interest. The other major homeowner incentives include the ability to "rollover" the gains (profits) from the sale of a principal residence without paying taxes if a more expensive home is purchased and, for taxpayers who are age 55 or older, a one-time

tax-free exclusion on up to $125,000 of capital gains from the sale of a primary residence.

Prior to 1986, there was no limit on the amount of mortgage interest that could be deducted. Under current law, the amount of mortgage interest that can be deducted on a principal or secondary residence (on loans taken out after 1987) is limited to the interest paid on the combined debt on these homes of up to $1.1 million. The $1.1 million limit on debt includes up to $100,000 of home equity loans that are often used for other purposes.

Now that interest on personal loans is no longer deductible, more homeowners are taking out home equity lines of credit and using the proceeds to pay off or take on new debt for autos, vacations, educational and medical expenses, or to make payments on credit card purchases. In effect, homeowners are converting nondeductible personal interest into tax deductible home mortgage interest deductions.

Aside from the fairness issues (for example, that renters cannot take advantage of this tax provision), there is concern that some homeowners may find it too easy to spend their home equity (retirement savings in many cases) on consumer items or for college expenses and first-home down payments for their children. At the same time, many elderly homeowners are finding home equity conversion programs useful because they make it easier to convert the built up equity in a home into much needed supplemental retirement income. A section that describes in detail home equity conversions is contained in chapter 13 of this committee print. Others are using this build up in equity to pay for property taxes, home repairs, and entrance into retirement communities or nursing homes. Some fear that the inappropriate use of home equity loans in the early or mid-years of life could mean that for some, substantial mortgage payments might continue well into later life with the possible result being less retirement security than originally planned.

C. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) made a number of substantial changes to the Internal Revenue Code. It replaced the previous two rates with a 3-tiered statutory rate structure: 15 percent, 28 percent, and 31 percent. In 1997, the 31 percent rate applies to single individuals with taxable income (not gross income) between $59,750 and $124,650. It applies to joint filers with taxable income between $99,600 and $151,750, and to heads of households with taxable income between $83,350 and $138,200. The Act sets a maximum tax rate of 28 percent on the sale of capital assets.

The Act also repealed the so-called "bubble" from the Tax Reform Act of 1986 whereby middle income taxpayers paid higher marginal tax rates on certain income as personal exemptions and the lower 15 percent rate were phased out. However, in place of the "bubble," OBRA 90 provided for the phasing out of personal exemptions and limiting itemized deductions for high income taxpayers. The phase out of personal exemptions for 1997 begins at $121,200 for single filers, $181,800 for joint filers, $151,500 for heads of households, OBRA 90 also provided a limitation on itemized deductions. Allowable deductions were reduced by 3 percent of the amount by which

a taxpayer's adjusted gross income exceeds $121,200. Deductions for medical expenses, casualty and theft losses, and investment interest are not subject to this limitation.

Additionally, the Act raised excise taxes on alcoholic beverages, tobacco products, gasoline, and imposed new excise taxes on luxury items such as expensive airplanes, yachts, cars, furs, and jewelry. With the exception of the tax on luxury cars, all of the other luxury taxes have since been repealed.

The Act provided a tax credit to help small businesses attempting to comply with the Americans With Disabilities Act of 1990. The provision, sponsored by Senators Pryor, Kohl, and Hatch, allows small businesses a nonrefundable 50-percent credit for expenditures of between $250 and $10,250 in a year to make their businesses more accessible to disabled persons. Such expenditures can include amounts spent to remove physical barriers and to provide interpreters, readers, or equipment that make materials more available to the hearing or visually impaired. To be eligible, a small business must have grossed less than $1 million in the preceding year or have no more than 30 full-time employees. Full-time employees are those that work at least 30 hours per week for 20 or more calendar weeks during the tax year.

At the time of passage, estimates made by the Congressional Budget Office, found that most elderly persons should be for the most part untouched by the changes made by the OBRA 90. However, as might be expected, some high-income elderly will pay higher Federal taxes. Some of the excise taxes were found to have a negative effect on the elderly, in particular the 5 cents a gallon increase on gasoline. Like all changes of the tax laws, certain individuals may be negatively affected, but as a class, the elderly will probably pay the same in Federal income taxes as a result of the passage of OBRA 90.

D. UNEMPLOYMENT COMPENSATION AMENDMENTS OF 1992

While the main purpose of this Act was to extend the emergency unemployment compensation program it contained a number of tax related provisions. The Act extended the temporary phaseout of the personal exemption deduction for high income taxpayers as well as revised the estimated tax payment rules for large corporations. This Act changed rules on pension benefit distributions and included the requirement that qualified plans must include optional trustee-to-trustee transfers of eligible rollover distributions.

E. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The Omnibus Budget Reconciliation Act of 1993, added a new 36-percent tax rate applicable in 1997 to single individuals with taxable incomes between $124,650 and $271,050 ($151,750/$271,050 for joint filers), and an additional 10-percent surtax for a top rate of 39.6 percent applicable to individuals or joint filers with taxable incomes in excess of $271,050. It also made permanent the 3-percent limitation on itemized deductions and the phaseout of personal exemptions for higher income taxpayers. This Act also increased the alternative minimum tax rate for individuals and repealed the

Medicare health insurance tax wage cap. As mentioned earlier in this print, an increase was provided in the taxation of Social Security benefits for higher income taxpayers. Changes were also enacted to energy taxes, including adding 4.3 cents per gallon on most transportation fuel and the temporary extension of a 2.5 cents per gallon motor fuels tax enacted under OBRA 90.

F. SOCIAL SECURITY DOMESTIC EMPLOYMENT REFORM ACT OF 1994

Changes were made in this Act (P.L. 103–387) to the Social Security program. The Act simplified and increased the threshold above which domestic workers are liable for Social Security taxes from $50 per quarter to $1,000 per year. Also, a reallocation of a portion of the Social Security tax was provided to the Disability Insurance Trust Fund. Finally, the Act extended a limitation for payments of Social Security benefits to felons and the criminally insane who are confined to institutions by court order.

G. STATE TAXATION OF PENSION INCOME ACT OF 1995

This Act (P.L. 104–95) amended Federal law to prohibit a State from levying its income tax on retirement income previously earned in the State but now received by people who are retired in other States. For purposes of the Act, "State" includes the District of Columbia, U.S. possessions, and any political subdivision of a State. Thus, the prohibition against taxing nonresident pension income also applies to income taxes levied by cities or counties. The new law protects most forms of retirement income and covers both private and public sector employees. The law does not restrict a State's ability to tax its own residents on their retirement income.

H. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

There were several provisions included in this Act (P.L. 104–191) of interest to older Americans. In general, the Act provides for the same tax treatment for long-term care contracts as for accident and health insurance contracts. The Act also provides that employer-provided long-term care insurance be treated as a tax free fringe benefit. However, long-term care coverage cannot be provided through a flexible spending arrangement and to the extent such coverage is provided under a cafeteria plan the amounts are included in the employee's income. Payments from long-term care plans which pay or reimburse actual expense are tax free. The law provides for a $175 per day tax-free benefits payment with inflation adjustments in future years. Amounts above the $175 per day amount may also be received tax free to the extent of actual costs. Premiums qualify as medical expenses for those that itemized deductions (although this amount is limited depending on the insured age). In addition to this provision, the Act provides that accelerated life insurance benefits can be tax-free. Accelerated death benefits are exempt from income tax in the case of a terminally or chronically ill individual. Also excluded from taxation are amounts received from viatical settlement companies for amounts received on the sale of a life-insurance contract. In the case of chronically ill

individuals, the maximum exclusion is $175 per day in the case of per diem policies. Indemnity policies are not included under this provision.

Chapter 4

EMPLOYMENT

A. AGE DISCRIMINATION

1. Background

Older workers continue to face numerous obstacles to employment, including negative stereotypes about aging and productivity; job demands and schedule constraints that are incompatible with the skills and needs of older workers; and management policies that make it difficult to remain in the labor force, such as corporate downsizing brought on by recession.

Age discrimination in the workplace plays a pernicious role in blocking employment opportunities for older persons. The development of retirement as a social pattern has helped to legitimize this form of discrimination. Although there is no agreement on the extent of age-based discrimination, nor how to remedy it, few would argue that the problem exists for millions of older Americans.

The forms of age discrimination range from the more obvious, such as age-based hiring or firing, to the more subtle, such as early retirement incentives. Other discriminatory practices involve relocating an older employee to an undesirable area in the hopes that the employee will instead resign, or giving an older employee poor evaluations to justify the employee's later dismissal. The pervasive belief that all abilities decline with age has fostered the myth that older workers are less efficient than younger workers. Since younger workers, rather than older workers, tend to receive the skills and training needed to keep up with technological changes, the myth continues. However, research has shown that although older people's cognitive skills are slower, they compensate with improved judgment.

Too often employers wrongly assume that it is not financially advantageous to retrain an older worker because they believe that a younger employee will remain on the job longer, simply because of his or her age. In fact, the mobility of today's work force does not support this perception. According to the Bureau of Labor Statistics, in 1996, the median job tenure for a current employee was as little as 3.8 years.

Age-based discrimination in the workplace poses a serious threat to the welfare of many older persons who depend on their earnings for their support. While the number of older persons receiving maximum Social Security benefits is increasing, most retirees receive less than the maximum.

According to 1996 Bureau of Labor Statistics (BLS), the unemployment rate was 3.3 percent for workers age 55 to 64, 4.0 percent for workers age 65 to 69, and 3.2 percent for workers age 70 and

over. Although older workers as a group have the lowest unemployment rate, these numbers do not reflect those older individuals who have withdrawn completely from the labor force due to a belief that they cannot find satisfactory employment.

Duration of unemployment is also significantly longer among older workers. As a result, older workers are more likely to exhaust available unemployment insurance benefits and suffer economic hardships. This is especially true because many persons over 45 still have significant financial obligations.

Prolonged unemployment can often have mental and physical consequences. Psychologists report that discouraged workers can suffer from serious psychological stress, including hopelessness, depression, and frustration. In addition, medical evidence suggests that forced retirement can so adversely affect a person's physical, emotional, and psychological health that lifespan may be shortened.

Despite the continuing belief that older workers are less productive, there is a growing recognition of older workers' skills and value. In 1988 the Commonwealth Fund began a 5-year study, "Americans Over 55 at Work," examining the economic and personal impact of what the fund saw as a "massive shift toward early retirement that occurred in the 1970s and 1980s." The fund estimates that over the past decade, involuntary retirement has cost the economy as much as $135 billion a year. The study concludes older workers are both productive and cost-effective, and that hiring them makes good business sense.

Many employers also have reported that older workers tend to stay on the job longer than younger workers. Some employers have recognized that older workers can offer experience, reliability, and loyalty. A 1989 AARP survey of 400 businesses reported that older workers generally are regarded very positively and are valued for their experience, knowledge, work habits, and attitudes. In the survey, employers gave older workers their highest marks for productivity, attendance, commitment to quality, and work performance.

In the early 1990's there was a steady increase in the number of complaints received by the EEOC. The number of complaints rose from 14,526 in fiscal year 1990 to 19,350 in fiscal year 1992. Since that time, however, preliminary data show the number of complaints has declined to 15,665 in fiscal year 1996.

2. The Equal Employment Opportunity Commission

The EEOC is responsible for enforcing laws prohibiting discrimination. These include: (1) Title VII of the Civil Rights Act of 1964; (2) The Age Discrimination in Employment Act of 1967; (3) The Equal Pay Act of 1963; (4) Sections 501 and 505 of the Rehabilitation Act of 1973; and (5) the Americans With Disabilities Act of 1990.

When originally enacted, enforcement responsibility for the ADEA was placed with the Department of Labor (DOL) and the Civil Service Commission. In 1979, however, the Congress enacted President Carter's Reorganization Plan No. 1, which called for the transfer of responsibilities for ADEA administration and enforcement to the EEOC, effective July 1, 1979.

The EEOC has been praised and criticized for its performance in enforcing the ADEA. In recent years, concerns have been raised over EEOC's decision to refocus its efforts from broad complaints against large companies and entire industries to more narrow cases involving few individuals. Critics also point to the large gap between the number of age-based complaints filed and the EEOC's modest litigation record. In fiscal year 1996, preliminary data show that the EEOC received 15,665 ADEA complaints and filed suit in less than one percent of these complaints.

3. The Age Discrimination in Employment Act

(A) BACKGROUND

Over two decades ago, the Congress enacted the Age Discrimination in Employment Act of 1967 (ADEA) (P.L. 90–202) "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment."

In large part, the ADEA arose from a 1964 Executive Order issued by President Johnson declaring a public policy against age discrimination in employment. Three years later, the President called for congressional action to eliminate age discrimination. The ADEA was the culmination of extended debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the right of older workers to be free from age discrimination in employment with the employer's prerogative to control managerial decisions. The provisions of the ADEA attempt to balance these competing interests by prohibiting arbitrary age-based discrimination in the employment relationship. The law provides that arbitrary age limits may not be conclusive in determinations of nonemployability, and that employment decisions regarding older persons should be based on individual assessments of each older worker's potential or ability.

The ADEA prohibits discrimination against persons age 40 and older in hiring, discharge, promotions, compensation, term conditions, and privileges of employment. The ADEA applies to private employers with 20 or more workers; labor organizations with 25 or more members or that operate a hiring hall or office which recruits potential employees or obtains job opportunities; Federal, State, and local governments; and employment agencies.

Since it's enactment in 1967, the ADEA has been amended a number of times. The first set of amendments occurred in 1974, when the law was extended to include Federal, State, and local government employers. The number of workers covered also was increased by limiting exemptions for employers with fewer than 20 employees. (Previous law exempted employers with 25 or fewer employees.) In 1978, the ADEA was amended by extending protections to age 70 for private sector, State and local government employers, and by removing the upper age limit for employees of the Federal Government.

In 1982, the ADEA was amended by the Tax Equity and Fiscal Responsibility Act (TEFRA) to include the so-called "working aged" clause. As a result, employers are required to retain their over-65

workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. TEFRA reversed the situation, making Medicare the payer of last resort.

Amendments to the ADEA were also contained in the 1984 reauthorization of the Older Americans Act (P.L. 98–459). Under the 1984 amendments, the ADEA was extended to U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation stemmed from the belief that such workers should not be subject to possible age discrimination just because they are assigned abroad. Also, the executive exemption was raised from $27,000 to $44,000, the annual private retirement benefit level used to determine the exemption from the ADEA for persons in executive or high policymaking positions.

The Age Discrimination in Employment Act Amendments of 1986 contained provisions that eliminated mandatory retirement altogether. By removing the upper age limit, Congress sought to protect workers age 40 and above against discrimination in all types of employment actions, including forced retirement, hiring, promotions, and terms and conditions of employment. The 1986 Amendments to the ADEA also extended through the end of 1993 an exemption from the law for institutions of higher education and for State and local public safety officers (these issues are discussed below).

In 1990, Congress amended the ADEA by enacting the Older Workers Benefit Protection Act (P.L. 101–433). This legislation restored and clarified the ADEA's protection of older workers' employee benefits. In addition, it established new protections for workers who are asked to sign waivers of their ADEA rights.

The Age Discrimination in Employment Amendments of 1996 (P.L. 104–208) amends the 1986 amendments to restore the public safety exemption. This allows police and fire departments to use maximum hiring ages and mandatory retirement ages as elements of their overall personnel policies.

(B) TENURED FACULTY EXEMPTION

Provisions in the 1986 amendments to the ADEA to temporarily exempt universities from the law reflect the continuing debate over the fairness of the tenure system in institutions of higher education. During consideration of the 1986 amendments, several legislative proposals were made to eliminate mandatory retirement of tenured faculty, but ultimately a compromise allowing for a temporary exemption was enacted into law.

The exemption allowed institutions of higher education to set a mandatory retirement age of 70 years for persons serving under tenure at institutions of higher education. This provision was in effect for 7 years, until December 31, 1993. The law also required the EEOC to enter into an agreement with the National Academy of Sciences to conduct a study to analyze the potential consequences of the elimination of mandatory retirement for institutions of higher education reporting the findings to the President and Congress. The National Academy of Sciences formed the Committee on Mandatory Retirement in Higher Education (the Committee) to conduct the study.

Proponents of mandatory retirement at age 70 argue that without it, institutions of higher education will not be able to continue to bring in those with fresh ideas. The older faculty, it is claimed, would prohibit the institution from hiring younger teachers who are better equipped to serve the needs of the school. They also claim that allowing older faculty to teach or research past the age of 70 denies women and minorities access to the limited number of faculty positions.

Opponents of the exemption claim that there is little statistical proof that older faculty keep minorities and women from acquiring faculty positions. They cite statistical information gathered at Stanford University and analyzed in a paper by Allen Calvin which suggests that even with mandatory retirement and initiatives to hire more minorities and women, there was only a slight change in the percentage of tenured minority and women. In addition, they argue that colleges and universities are using mandatory retirement to rid themselves of both undesirable and unproductive professors, instead of dealing directly with a problem that can affect faculty members of any age. The use of performance appraisals, they argue, is a more reliable and fair method of ending ineffectual teaching service than are age-based employment policies.

Based upon its review, the Committee recommended "that the ADEA exemption permitting the mandatory retirement of tenured faculty be allowed to expire at the end of 1993." On December 31, 1993 this exemption expired.

The Committee reached two key conclusions:

> At most colleges and universities, few tenured faculty would continue working past age 70 if mandatory retirement is eliminated because most faculty retire before age 70. In fact, colleges and universities without mandatory retirement that track the data on the proportion of their faculty over age 70 report no more than 1.6 percent; and
>
> At some research universities, a high proportion of faculty may choose to work past age 70 if mandatory retirement is eliminated. A small number of research universities report that more than 40 percent of the faculty who retire each year have done so at the current mandatory retirement age of 70. The study suggests that faculty who are research oriented, enjoy inspiring students, have light teaching loads, and are covered by pension plans that reward later retirement are more likely to work past 70.

The Committee examined the issue of faculty turnover and concluded that a number of actions can be taken by universities to encourage, rather than mandate selected faculty retirements. Although some expense may be involved, the proposals are likely to enhance faculty turnover. Most prominent among them is the use of retirement incentive programs. The Committee recommended Congress, the Internal Revenue Service, and the EEOC "permit colleges and universities to offer faculty voluntary retirement incentive programs that are not classified as an employee benefit, include an upper age limit for participants, and limit participation on the basis of institutional needs." The Committee also recommended policies that would allow universities to change their pension,

health, and other benefit programs in response to changing faculty behavior and needs.

(C) STATE AND LOCAL PUBLIC SAFETY OFFICERS

In 1983 the Supreme Court in *EEOC* v. *Wyoming,* 460 U.S. 226, rejected a mandatory retirement age for State game wardens, holding that States were fully subject to the ADEA. In two cases in 1985 the Court outlined the standards for proving a "bona fide occupational qualification" (BFOQ) defense for public safety jobs, *Western Air Lines* v. *Criswell,* 472 U.S. 400 (rejecting mandatory retirement age for airline flight engineers), and *Johnson* v. *Baltimore,* 472 U.S. 353 (rejecting mandatory retirement age for firefighters). The Court made clear that age may not be used as a proxy for safety-related job qualifications unless the employer can satisfy the narrow BFOQ exception.

Criswell's discussion of the BFOQ defense holds that the State's interest in public safety must be balanced by its interest in eradicating age discrimination. In order to use age as a public safety standard, the employer must prove that it is "reasonably necessary to the normal operation of the business." This may be proven only if the employer is "compelled" to rely upon age because either (a) it has reasonable cause to believe that all or substantially all persons over that age would be unable to safely do the job; or (b) it is highly impractical to deal with older persons individually.

In subsequent years, some States and localities with mandatory retirement age policies below age 70 for public safety officers were concerned about the impact of these decisions. By March 1986, 33 States or localities had been or were being sued by the EEOC for the establishment of mandatory retirement hiring age laws.

In 1986, the ADEA was amended to eliminate mandatory retirement based upon age in the United States. As part of a compromise that enabled this legislation to pass, Congress established a 7-year exemption period during which State and local governments that already had maximum hiring and retirement ages in place for public safety employees could continue to use them. It's purpose was to give public employers time to phase in compliance without having to worry about litigation.[1]

Supporters of a permanent exemption for State and local public safety officers argue that the mental and physical demands and safety considerations for the public, the individual, and co-workers who depend on each other in emergency situations, warrant mandatory retirement ages below 70 for these State and local workers. Also, they contend that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under that ADEA. Because of the conflicting case law on BFOQ, this would entail costly and time-consuming litigation. They note that jurisdictions wishing to retain the hiring and retirement standards that they established for public safety officers prior to the Wyoming decision are forced to engage in costly medical studies to support their standards. Finally, they question the feasibility of individual employee evaluations, some citing the difficulty involved in administering the tests because of technological limitations con-

[1] Senator Howard Metzenbaum, *Congressional Record,* S. 16852–53, Oct. 16, 1986.

cerning what human characteristics can be reliably evaluated, the equivocal nature of test results, and economic costs. They do not believe that individualized testing is a safe and reliable substitute for pre-established age limits for public safety officers.

Those who oppose an exemption contend that there is no justification for applying one standard to Federal public safety personnel and another to State and local public safety personnel. They believe that exempting State and local governments from the hiring and retirement provisions of the ADEA will give them the same flexibility that Congress granted to Federal agencies that employ law enforcement officers and firefighters.

As an additional argument against exempting public safety officers from the ADEA, opponents note that age affects each individual differently. They note that tests can be used to measure the effects of age on individuals, including tests that measure general fitness, cardiovascular condition, and reaction time. In addition, they cite research on the performance of older law enforcement officers and firefighters which supports the conclusion that job performance does not invariably decline with age and that there are accurate and economical ways to test physical fitness and predict levels of performance for public safety occupations. All that the ADEA requires, they argue, is that the employer make individualized assessments where it is possible and practical to do so. The only fair way to determine who is physically qualified to perform police and fire work is to test ability and fitness.

Last, those arguing against an exemption state that mandatory retirement and hiring age limits for public safety officers are repugnant to the letter and spirit of the ADEA, which was enacted to promote employment of older persons based on their ability rather than age, and to prohibit arbitrary age discrimination in employment. They believe that it was Congress' intention that age should not be used as the principal determinant of an individual's ability to perform a job, but that this determination, to the greatest extent feasible, should be made on an individual basis. Maximum hiring age limitations and mandatory retirement ages, they contend, are based on notions of age-based incapacity and would represent a significant step backward for the rights of older Americans.

The 1986 amendments to the ADEA also required the EEOC and the Department of Labor to jointly conduct a study to determine: (1) whether physical and mental fitness tests are valid measures of the ability and competency of police and firefighters to perform the requirements of their jobs; (2) which particular types of tests are most effective; and (3) to develop recommendations concerning specific standards such tests should satisfy. Congress also directed the EEOC to promulgate guidelines on the administration and use of physical and mental fitness tests for police officers and firefighters. The 5-year study completed in 1992 by the Center for Applied Behavioral Sciences of the Pennsylvania State University (PSU) concluded that age is not a good predictor of an individual's fitness and competency for a public safety job. The study expressed the view that the best, but admittedly imperfect, predictor of on-the-job fitness is periodic testing of all public safety employees, regardless of age. No recommendations with respect to the specific standards that physical and mental fitness tests should measure

were developed. Instead, the study discussed a range of tests that could be used. EEOC did not promulgate guidelines to assist State and local governments in administering the use of such tests.

The issue of mandatory retirement for public safety officers was addressed in two bills introduced in the House of Representatives. On July 23, 1993, Representative Major R. Owens, together with Representative Austin J. Murphy and 15 other cosponsors, introduced H.R. 2722, "Age Discrimination in Employment Amendments of 1993." It is similar but not identical to H.R. 2554, "Firefighters and Police Retirement Security Act of 1993," that Representative Murphy introduced on June 29, 1993.

H.R. 2554 sought to amend the Age Discrimination in Employment Amendments of 1986 to repeal the provision which terminated an exemption for certain bona fide hiring and retirement plans applicable to State and local firefighters and law enforcement officers. H.R. 2554 would have preserved the exemption beyond 1993.

H.R. 2722 sought to amend section 4 of the ADEA to allow, but not require, State and local bona fide employee benefit plans that used age-based hiring and retirement policies as of March 3, 1983 to continue to use such policies; and to allow State and local governments that either did not use or stopped using age-based policies to adopt such policies provided that the mandatory retirement age is not less than 55 years of age. In addition, H.R. 2722 once again directed the EEOC to identify particular types of physical and mental fitness tests that are valid measures of the ability and competency of public safety officers to perform their jobs and to promulgate guidelines to assist State and local governments in the administration and use of such tests.

On March 24, 1993, the Subcommittee on Select Education and Civil Rights conducted an oversight hearing on the issue of the use of age for hiring and retiring law enforcement officers and firefighters. On March 24, 1993, the Subcommittee held a markup of H.R. 2722 and approved it by voice vote. The Committee on Education and Labor considered H.R. 2722 for markup on October 19, 1993. The Committee accepted two amendments by voice vote, including an amendment offered by Representative Thomas C. Sawyer. A quorum being present, the Committee, by voice vote, ordered the bill favorably reported, as amended.

On November 8, 1993, H.R. 2722, as amended, passed in the House by voice vote, under suspension of the rules (two-thirds vote required). On November 9, 1993, H.R. 2722 was referred to the Senate Committee on Labor and Human Resources. There was no further action on H.R. 2722 in the 103rd Congress.

On September 30, 1996, exemption was restored under the Omnibus Consolidated Appropriations for fiscal year 1997 (P.L. 104–208), thereby allowing police and fire departments to use maximum hiring ages and mandatory retirement ages as elements in their overall personnel policies.

(D) THE SUPREME COURT

The Supreme Court addressed the elements of an ADEA prima facie case in *O'Connor* v. *Consolidated Coin Caterers Corp.,* 116 S. Ct. 1307 (1996). The Court held that a prima facie case is not made

out by simply showing that an employee was replaced by someone outside of the class. The plaintiff must show that he was replaced because of his age.[1] The Court evaluated whether the prima facie elements evinced by the Fourth Circuit Court of Appeals were required to establish a prima facie case. The Fourth Circuit held that a prima facie case is established under the ADEA when the plaintiff shows that: "(1) He was in the age group protected by the ADEA; (2) he was discharged or demoted; (3) at the time of his discharge or demotion, he was performing his job at a level that met his employer's legitimate expectations; and (4) following his discharge or demotion, he was replaced by someone of comparable qualifications outside of the protected class."[2] The Court held that the fourth prong, replacement by someone outside of the class, is not the only manner in which a plaintiff can prove a prima facie case under the ADEA.[3] A violation can be shown even if the person was replaced by someone who also falls within the protected class. For example, replacing a 76-year-old with a 45-year-old may be a violation of the ADEA, if the person was replaced because of his age.

The U.S. Supreme Court ruled on two cases in 1993 that affect the aging community. Burden of proof problems formed the heart of the controversy in both employment discrimination cases.

In *Hazen Paper Co.* v. *Biggins,* 113 S.Ct. 1701 (1993), the Court unanimously held there can be no violation of the ADEA when the employer's allegedly unlawful conduct is motivated by some factor other than the employee's age. Therefore, the fact that a protected age employee's discharge occurred a few weeks before his pension was due to vest did not per se establish a violation of the statute.

A family-owned company hired an employee in 1977 and discharged him in 1986, when he was 62 years old. The discharge, which was the culmination of a dispute with the company over his refusal to sign a confidentiality agreement, occurred a few weeks prior to the end of the 10-year vesting period for his pension. The employee sued the employer under the ADEA and the Employee Retirement Income Security Act (ERISA). At trial, the jury found that the company had violated ERISA and "willfully" violated the ADEA. The district court granted judgment notwithstanding the verdict on the finding of willfulness. The First Circuit Court of Appeals affirmed the judgment on both the ADEA and ERISA counts, but reversed on the issue of willfulness.

On appeal, the Supreme Court held that an employer's interference with pension benefits, which vest according to years, does not, by itself, support a finding of an ADEA violation. The Court reasoned that, in a disparate treatment case, liability depends on whether the protected trait motivated the employer's decision and that a decision based on years of service is not necessarily age-based.

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[1] *O'Connor* v. *Consolidated Coin Caterers Corp.,* 116 S. Ct. 1307 (1996).

[2] 116 S. Ct. 1307, 1309 (1996).

[3] Justice Scalia, writing for the majority states:

As the very name 'prima facie case' suggests, there must be at least a logical connection between each element of the prima facie case and the illegal discrimination for which it establishes a 'legally mandatory' rebuttable presumption. * * * The element of replacement by someone under 40 fails this requirement. The discrimination prohibited by the ADEA is discrimination 'because of [an] individual's age.'" *Consolidated Coin,* 116 S. Ct. at 1310 (quoting *Texas Dept. of Community Affair* v. *Burdine,* 450 U.S. 248, 254 n.7 (1981)).

Justice O'Connor explained that the ADEA is intended to address the "very essence" of age discrimination, when an older employee is discharged due to the employer's belief in the stereotype that "productivity and competence decline with old age." The ADEA forces employers to focus productivity and competence directly instead of relying on age as proxy for them. But the problems posed by such stereotypes disappear when the employer's decision is actually motivated by factors other than age, even when the motivating factor is correlated with age, as pension status typically is. Further, she explained that the correlative factor remains analytically distinct, however much it is related to age. The vesting of pension plans usually is a function of years of service. However, a decision based on that factor is not necessarily age-based. An older employee may have accumulated more years of service by virtue of his longer length of time in the workforce, but an employee too young to be protected by the ADEA may have accumulated more if he has worked for a particular employer for his entire career while an older worker may have been a new hire. Thus, O'Connor concluded that the discharge of a worker because his pension is about to vest is not the result of a stereotype about age but of an accurate judgment about the employee.

The Court noted, however, that their holding does not preclude a possible finding of liability if an employer uses pension status as a proxy for age, a finding of dual liability under ERISA and ADEA, or a finding of liability if vesting is based on age rather than years of service. The Court also held that the *TransWorld Airlines, Inc.* v. *Thurston,* 469 U.S. 111 (1985), "knowledge or reckless disregard" standard for liquidated damages applies to situations in which the employer has violated the ADEA through an informal decision motivated by an employee's age, as well as through a formal, facially discriminatory policy.

In *St. Mary's Honor Center* v. *Hicks,* 61 U.S.L.W. 4782 (1993) the Supreme Court rejected the burden shifting analysis for resolving Title VII intentional discrimination cases set forth in *Texas Department of Community Affairs* v. *Burdine,* 450 U.S. 248 (1981). *Burdine* had regularly been applied to ADEA cases. See, e.g. *Williams* v. *Valentec Kisco, Inc.,* 964 F.2d 723 (8th Cir.), cert. denied, 113 S.Ct. (1992); *Williams* v. *Edward Apffels Coffee Co.,* 792 F.2d 1492 (9th Cir. (1992)). As a result of the holding in *St. Mary's Honor Center,* an employee who discredits all of an employer's articulated legitimate nondiscriminatory reasons for an employment decision is not automatically entitled to judgment in an action under ADEA.

Twenty years ago, in *McDonnell-Douglas Corp.* v. *Green,* 411 U.S. 792 (1973), the Supreme Court established a three-step framework for resolving Title VII cases involving intentional discrimination. This framework was reaffirmed by the Court in *Texas Department of Community Affairs* v. *Burdine,* 450 U.S. 248 (1981):

> First, the plaintiff must establish a prima facie case of discrimination with evidence strong enough to result in a judgment that the employer discriminated, if the employer offers no evidence of its own;

Second, if the plaintiff establishes a prima facie case, the employer must then come forward with a clear and specific nondiscriminatory reason for the challenged action; and

Third, if the employer offers a nondiscriminatory reason for its conduct, the plaintiff then must establish that the reason the employer offered was a pretext for discrimination. Significantly, the Supreme Court made clear in *Burdine* that the plaintiff can prevail at this third stage "either directly by persuading the court that a discriminatory reason more likely motivated the employer, or indirectly by showing that the employer's proffered explanation is unworthy of credence."

The decision in *Hicks* explaining the various procedural burdens parties face in presenting and defending a Title VII case will make it harder for plaintiffs to prevail. The majority held that an employee who discredited all of an employer's stated reasons for his demotion and subsequent discharge was not automatically entitled to judgment in his case under Title VII. Accordingly, the trial court was entitled to grant judgment to the employer on the basis of a reason the employer did not articulate.

In *Hicks,* an African-American shift commander at a halfway house was demoted to the position of correctional officer and later discharged. He had consistently been rated competent and had not been disciplined for misconduct or dereliction of duty until his supervisor was replaced. The new supervisor, however, viewed him differently. At trial, the plaintiff alleged the employment decisions were racially motivated. The employer claimed the plaintiff had violated work rules. The district court found these reasons to be pretextual. Nevertheless, it ruled for the halfway house. The district court felt the plaintiff had not shown that the effort to terminate him was racially rather than personally motivated. Although, personal animus was never put forward by the employer at trial to explain its conduct, the Eighth Circuit Court of Appeals reversed. It said that once the shift commander proved that all of the employer's proffered reasons were pretextual, the plaintiff was entitled to judgment as a matter of law, because the employer was left in a position of having offered no legitimate reason for its actions.

In a 5–4 decision written by Justice Scalia, the Supreme Court reversed the Eight Circuit's decision and upheld the district court's judgment for the employer. The Court abandoned the 20-year-old *McDonnell-Douglas* framework and held that the plaintiff was not entitled to judgment even though he had proved a prima facie case of discrimination and disproved the employer's only proffered reason for its conduct. Instead, the majority said that plaintiffs may be required not just to prove that the reasons offered by the employer were pretextual, but also to "disprove all other reasons suggested, no matter how vaguely, in the record."

Justice Souter wrote a dissenting opinion, joined by Justices Blackmun, White, and Stevens. Justice Souter charged that the majority's decision "stems from a flat misreading of *Burdine* and ignores the central purpose of the *McDonnell-Douglas* framework." He also accused the majority of rewarding the employer that gives false evidence about the reason for its employment decision, because the falsehood would be sufficient to rebut the prima facie case, and the employer can then hope that the factfinder will con-

clude that the employer acted for a valid reason. "The Court is throwing out the rule," Justice Souter asserted, "for the benefit of employers who have been found to have given false evidence in a court of law."

B. FEDERAL PROGRAMS

The Federal Government provides funds for training disadvantaged and dislocated workers to assist them in becoming more employable. Two important Federal programs designed to promote the employment opportunities of older workers are the Job Training Partnership Act Program and the Senior Community Service Employment Program under Title V of the Older Americans Act.

1. THE JOB TRAINING PARTNERSHIP ACT

The Job Training Partnership Act (JTPA), enacted in 1982, established a nationwide system of job training programs administered jointly by local governments and private sector planning agencies; $4.5 billion was appropriated for the JTPA for fiscal year 1997.

JTPA authorizes several major training programs including the Title II–A program for economically disadvantaged adults, with no upper age limit and the Title III program for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. Under the Title II–A program, funds are allotted among States according to the following three equally weighted factors: (1) Number of unemployed individuals living in areas with jobless rate of at least 6.5 percent for the previous year; (2) number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and (3) the number of economically disadvantaged adults. Training under Title II–A can include on-the-job training, classroom training, and remedial education.

Section 204(d) under Title II–A of JTPA establishes a statewide program of job training and placement for economically disadvantaged workers age 55 or older. Governors are required to set aside 5 percent of their Title II–A allotments for this older worker program. The older workers program under section 204(d) of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the placement of older workers with private business concerns. For the period between July 1, 1994 and June 30, 1995, over 18,000 adults who terminated from the Title II programs were age 55 or older, representing slightly less than 10 percent of total adult terminees. Of this total, over 14,200 were served under the older worker set-aside program.

Title III is for workers who have been or are about to be laid off, workers who are eligible for or have exhausted their entitlement to unemployment compensation, and workers unlikely to return to their previous occupation or industry. The dislocated workers program is administered by the States and provides such services as job search assistance, job development, training in job skills which are in demand, relocation assistance, and activities conducted with employers or labor unions to provide early intervention in cases of plant closings. During the period between July 1, 1994 and June

30, 1995, approximately 17,200 persons age 55 and older were served by the Title III program (about 9 percent of total program participants).

Since 1984, DOL has sponsored biennial surveys (as supplements to the monthly Current Population Survey) to collect information on job displacement. Displaced workers are defined as those who had at least 3 years tenure on their most recent job and lost their job due to a plant shutdown or move, reduced work, or the elimination of their position or shift. Those in jobs with seasonal work fluctuations are excluded.

The February 1996 survey polled workers who lost their jobs between January 1993 and December 1995. In spite of greater seniority, older workers are not protected from displacement. The majority of displaced older workers report job loss following a plant closing, for which seniority is no protection. Older displaced workers were much more likely than younger displaced workers to have left the labor force rather than be reemployed at the time of the survey. Thirty-one percent of the 55- to 64-year-olds, and 64 percent of those 65 years and older were not in the labor force compared to 14 percent of all displaced workers 20 years and older. The reemployment rate for displaced workers 20 year and older was 74 percent, while the rates for workers 55 to 64 years and 65 years and older were 52 percent and 32 percent respectively.

The 104th Congress considered legislation to consolidate and reform Federal employment and training programs that would have eliminated JTPA but final action was not completed before adjournment. H.R. 1617 as passed by the House and Senate would have eliminated the set-aside for older workers. Job training reform is expected to be taken up by the 105th Congress.

2. Title V of the Older Americans Act

The Senior Community Service Employment Program (SCSEP) was given statutory life under Title IX of the Older Americans Comprehensive Services Amendments of 1973. The program's stated purpose is "to promote useful part-time opportunities in community service activities for unemployed low income persons." SCSEP provides opportunities for part-time employment and income, serves as a source of labor for various community service activities, and assists unemployed older persons in their search to find permanent unsubsidized employment. Amendments passed in 1978 redesignated the program as Title V of the Older Americans Act.

The SCSEP is administered by the Department of Labor, which awards funds to national sponsoring organizations and to State agencies. Persons eligible under the program must be 55 years of age and older (with priority given to persons 60 years and older), unemployed, and have income levels of not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services. Enrollees are paid the greater of the Federal or State minimum wage, or the local prevailing rate of pay for similar employment. Federal funds may be used to compensate participants for up to 1,300 hours of work per year, including orientation and training. Participants work an average of 20 to 25 hours per week. In addition to wages, enrollees receive physical examinations, personal and job-related counseling and, under certain cir-

cumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

The SCSEP is one of the few direct job creation programs remaining since the elimination of the Comprehensive Employment and Training Act and the Public Service Employment programs. Nearly 58 percent of enrollees are between the ages of 55 and 64, and about 20 percent are age 70 or older. Over 70 percent are females, and about one-third of all enrolled have not completed high school. About 80 percent have a family income below the poverty line.

The unique aspect of the SCSEP is that it is designed to meet important community needs while at the same time serving as a job training program for older workers. Enrollees are assigned to jobs in community-based, governmental or nonprofit organizations with a demonstrated need for additional assistance. In program year 1995–1996 almost 70 percent of the SCSEP jobs provided services to the general community and 32 percent provided service to the elderly community. Of the jobs serving the general community, the two largest service categories were social services and education, with 18 percent and 16 percent of the slots, respectively. Other categories were health and hospital, housing/home rehabilitation, employment assistance, recreation, parks, and forests, environmental quality, and public works and transportation.

In the elderly service category, 8 percent of the slots are assigned to nutrition programs, 7 percent to recreation/senior centers. Other categories accounting for smaller numbers of job slots are project administration, health and home care, house/home rehabilitation, employment assistance, transportation, and outreach/referral.

The SCSEP has received steady increases in funding and participant enrollment since its inception. In the 1968–69 program year, the first full year of operation in a form similar to the current program, the program's budget was $5.5 million. In program year July 1, 1996 to June 30, 1997, Title V funding is $373 million, which will support an estimated 62,000 job slots. For further information See the Older Americans Act Section.

C. OUR AGING WORK FORCE

1. Age of Retirement Decisions

As mentioned at the beginning of this section, early retirement is becoming an accepted part of American life. The ability to retire early with a comfortable income is a coveted ideal. However, as we have seen, there are many workers in America who continue to work past traditional retirement ages out of necessity or desire. There have also been actions taken by the Federal Government to encourage later retirement.

Among these changes is the phasing in of a later normal retirement age from the current age 65 to 67 beginning in 2000 and concluding in 2022. In addition, the delayed retirement credit for persons working past normal retirement age will be gradually increased from 3 percent a year to 8 percent a year between 1990 and 2008; and the percentage of Social Security benefits available to persons selecting early retirement will be decreased. Legislation

in 1996 substantially increased the amount recipients may earn before having their benefits reduced. This "exempt amount" will rise from $13,500 in 1997 to $30,000 by 2002.

These changes in the Federal legislative framework pertaining to retirement must compete with the retirement incentives and disincentives provided by private employers. Many employers have encouraged early retirement through pension incentives and early retirement incentive programs and hence are working counter to the intent of these Federal policies. A 1989 survey by the American Association of Retired Persons found 35 percent of surveyed employers were considering or had offered early retirement, compared to 21 percent in AARP's 1985 survey. Although these programs are legally required to be voluntary, some argue older workers may feel pressured into accepting these early outs, fearing that they may be forced out anyway and hence they might as well accept the voluntary early out with its positive incentives.

If Congress wants to induce older workers to remain in the workforce longer, policies to encourage more training for older workers and the provision of more flexible work schedules to allow continued employment at pre-retirement jobs would serve as positive inducements for older workers to remain in the workforce.

Chapter 5

SUPPLEMENTAL SECURITY INCOME

OVERVIEW

In 1972, the Supplemental Security Income (SSI) program was established to help the Nation's poor aged, blind, and disabled meet their most basic needs. The program was designed to supplement the income of those who do not qualify for Social Security benefits or those whose Social Security benefits are not adequate for subsistence. The program also provides recipients with opportunities for rehabilitation and incentives to seek employment. In 1994, 6.3 million individuals received assistance under the program.

To those who meet SSI's nationwide eligibility standards, the program provides monthly payments. In most States, SSI eligibility automatically qualifies recipients for Medicaid coverage and food stamp benefits.

Despite the budget cuts that many programs have suffered in the last decade, SSI benefits have not been lowered. This is in part because the Gramm-Rudman-Hollings (GRH) Act exempts SSI benefit payments from across-the-board budget cuts. It is also because of widespread support for the program, recognition of the subsistence-level benefit structure, and concern about the program's role as a safety net for the lowest-income Americans.

Although SSI has escaped the budget axe, the lack of funding for benefit increases has meant that the program continues to fall far short of eliminating poverty among the elderly poor. Despite progress in recent years in alleviating poverty, a substantial number remain poor. When the program was started almost two decades ago, some 14.6 percent of the Nation's elderly lived in poverty. In 1993, the elderly poverty rate was 12.2 percent.

The effectiveness of SSI in reducing poverty is hampered by inadequate benefit levels, stringent financial criteria, and a low participation rate. In most States, program benefits do not provide recipients with an income that meets the poverty threshold. Nor has the program's allowable income and assets level kept pace with inflation. Further, only about half of those elderly persons poor enough to qualify for SSI actually receive program benefits.

In recent years, the gulf between SSI's reality and its potential as an antipoverty weapon has given rise to a desire among advocates and a number of Members of Congress to try and correct the program's inadequacies. Although some proposals have been made to raise the benefit payments to the poverty level and to increase the program's income and assets levels, little progress has been made to enact such changes. Budget constraints, enacted by Con-

gress in the form of the 1993 budget agreement, will continue to limit major reforms.

Among the issues which provoked recent SSI reform legislation was the lack of oversight of representative payees by the Social Security Administration (SSA), the agency charged with administering the SSI program. Representative payees handle benefit checks on behalf of beneficiaries who, due to age or disability, are unable to handle their own finances. Following intense scrutiny by the Senate Aging Committee and other congressional committees, comprehensive legislation was enacted in 1990 to strengthen investigation and monitoring of representative payees for this vulnerable population. In 1994, Congress again turned to this issue and brought about further changes in the operation of the representative payee system.

Also under scrutiny has been the lack of oversight of the SSI program by the SSA, especially with regard to fraud and abuse in obtaining benefits. Of particular concern to Congress has been the payment of cash benefits directly to drug addicts and alcoholics, without enforcing the statutory requirement that these recipients obtain substance abuse treatment as a condition of receiving SSI benefits. A series of legislative actions in the years 1994 to 1996 have brought about major changes to the eligibility of drug addicts and alcoholics.

Other major discussions surrounding reform of the SSI program emerged from the releases of SSA's Disability Redesign proposal. The proposal is the first attempt to address the fundamental changes needed to realistically cope with disability determination workloads.

A. BACKGROUND

The SSI program, authorized in 1972 by Title XVI of the Social Security Act (P.L. 92–603), began providing a nationally uniform guaranteed minimum income for qualifying elderly, disabled, and blind individuals in 1974. Underlying the program were three congressionally mandated goals—to construct a coherent, unified income assistance system; to eliminate large disparities between the States in eligibility standards and benefit levels; and to reduce the stigma of welfare through administration of the program by SSA. It was the hope, if not the assumption, of Congress that a central, national system of administration would be more efficient and eliminate the demeaning rules and procedures that had been part of many State-operated, public-assistance programs. SSI consolidated three State-administered, public-assistance programs—old age assistance; aid to the blind; and aid to the permanently and totally disabled.

Under the SSI program, States play both a required and an optional role. They must maintain the income levels of former public-assistance recipients who were transferred to the SSI program. In addition, States may opt to use State funds to supplement SSI payments for both former public-assistance recipients and subsequent SSI recipients. They have the option of either administering their supplemental payments or transferring the responsibility to SSA.

SSI eligibility rests on definitions of age, blindness, and disability; on residency and citizenship; on levels of income and assets;

and, on living arrangements. The basic eligibility requirements of age, blindness, or disability have not changed since 1974. Aged individuals are defined as those 65 or older. Blindness refers to those with 20/200 vision or less with the use of a corrective lens in the person's better eye or those with tunnel vision of 20 degrees or less. Disabled persons are those unable to engage in any substantial gainful activity because of a medically determined physical or mental impairment that is expected to result in death or that can be expected to last, or has lasted, for a continuous period of 12 months.

As a condition of participation, an SSI recipient must reside in the United States or the Northern Mariana Islands and be a U.S. citizen, an alien lawfully admitted for permanent residence, or an alien residing in the United States under color of law. In addition, eligibility is determined by a means test under which two basic conditions must be satisfied. First, after taking into account certain exclusions, monthly income must fall below the benefit standard—$458 for an individual and $687 for a couple in 1995. Second, the value of assets must not exceed a variety of limits.

Under the program, income is defined as earnings, cash, checks, and items received "in kind," such as food and shelter. Not all income is counted in the SSI calculation. For example, the first $20 of monthly income from virtually any source and the first $65 of monthly earned income plus one-half of remaining earnings, are excluded and labeled as "cash income disregards." Also excluded are the value of social services provided by federally assisted or State or local government programs such as nutrition services, food stamps, or housing, weatherization assistance; payments for medical care and services by a third party; and in-kind assistance provided by a nonprofit organization on the basis of need.

In determining eligibility based on assets, the calculation includes real estate, personal belongings, savings and checking accounts, cash, and stocks. In 1994 and years thereafter, the asset limit is $2,000 for an individual and $3,000 for a married couple. The income of an ineligible spouse who lives with an SSI applicant or recipient is included in determining eligibility and amount of benefits. Assets that are not counted include the individual's home; household goods and personal effects with a limit of $2,000 in equity value; $4,500 of the current market value of a car (if it is used for medical treatment or employment it is completely excluded); burial plots for individuals and immediate family members; a maximum of $1,500 cash value of life insurance policies combined with the value of burial funds for an individual.

The Federal SSI benefit standard also factors in a recipient's living arrangements. If an SSI applicant or recipient is living in another person's household and receiving support and maintenance from that person, the value of such in-kind assistance is presumed to equal one-third of the regular SSI benefit standard. This means that the individual receives two-thirds of the benefit. In 1994, that totaled $297 for a single person and $446 for a couple. In 1995, the SSI benefit standard for individuals living in another person's household will increase to $305 for a single person and $458 for a couple. If the individual owns or rents the living quarters or contributes a pro rata share to the household's expenses, this lower

benefit standard does not apply. In June 1994, 4.9 percent, or 302,700 recipients came under this "one-third reduction" standard. Sixty-seven percent of those recipients were receiving benefits on the basis of disability.

When an SSI beneficiary enters a hospital, or nursing home, or other medical institution in which a major portion of the bill is paid by Medicaid, the SSI benefit amount is reduced to $30. This amount is intended to take care of the individual's personal needs, such as haircuts and toiletries, while the costs of maintenance and medical care are provided through Medicaid.

B. ISSUES

1. Substance Abusers Receiving SSI Benefits

In 1994, Senator William S. Cohen, Ranking Minority Member of the Senate Special Committee on Aging, initiated an investigation of abuses in the payment of SSI benefits to drug addicts and alcoholics. The investigation was begun in response to disturbing reports from many close to the SSI program that there has been widespread abuse of the SSI benefits, and that these benefits are being used directly to fuel drug and alcohol abuse.

Under both the SSI and SSDI programs, drug addiction and alcoholism constituted an impairment qualifying an individual for Social Security benefits. The SSA's listings of mental impairments includes substance abuse disorders. Both the SSA and the courts have established that substance addiction disorder can be considered a medically determinable impairment that can meet the definition of disability.

Special provisions in the original SSI legislation required drug addicts and alcoholics to (1) have a representative payee and (2) participate in a treatment program to facilitate their rehabilitation. However, there was little oversight of the representative payees and SSA was not monitoring whether recipients were complying with the treatment requirement.

Senator Cohen's investigation concluded that these statutory protections that were originally put in place to guard against the abuse of SSI benefits have been ineffective and that the SSA has been extremely lax in enforcing against abuse. Specifically, the investigation concluded that:

> The policy of providing cash assistance to drug abusers and alcoholics invites abuse and rewards addiction. The investigation found that many drug addicts and alcoholics are using SSI benefits to buy more drugs and alcohol, and are failing to comply with treatment requirements;
>
> Large lump sum SSI benefits paid directly to drug addicts and alcoholics are often used immediately to fuel further addiction, at times resulting in life-threatening or even fatal consequences for the recipients;
>
> The current representative payee system is not adequately protecting SSI benefits. In many cases, a friend or relative who acts as the representative payee of the addict or alcoholic is pressured into handing the benefits over to the addict—or is a fellow addict or alcoholic; and

SSA has been lax in enforcing treatment requirements as a condition of receiving SSI benefits on the basis of addiction or alcoholism.

Senator Cohen's investigation found that the SSA had virtually ignored the statutory mandate that drug addicts and alcoholics eligible for SSI must be in treatment and that the treatment be monitored. Despite the statutory requirement that SSA refer and monitor addicts and alcoholics for treatment, as of January 1994, the SSA has approved monitoring agencies for only 18 States.

In order to curb these abuses in the SSI program, Senator Cohen proposed legislation, S. 1863, the Social Security Disability Reform and Rehabilitation Act of 1994. This legislation required that all individuals receiving SSI or SSDI benefits on the basis of substance abuse or alcoholism receive treatment; that all SSI and SSDI benefits, including lump-sum benefits, paid to such individuals be made to institutions or organizations acting as representative payees; and that the SSA must establish a referral and monitoring program for each State for drug addicts and alcoholics receiving SSI within 1 year from the date of enactment. The legislation also specified that proceeds from criminal activity which are used to support substance abuse constitutes "substantial gainful activity," thus making an individual ineligible for SSI benefits.

In addition to these reforms, S. 1863 was the first legislation which placed a time limit on the receipt of benefits in SSI and SSDI. The legislation called for a cumulative limit of 3 years on SSI benefits paid to drug addicts and alcoholics if there is no other basis for disability.

Early in 1994, Senator Cohen introduced the provisions of S. 1863 as an amendment to S. 1560, a bill making the SSA an independent agency. Congress enacted the reforms as part of P.L. 103–296, the Social Security Independence and Program Improvements Act. Under this legislation, Congress required SSA to improve monitoring of drug addicts and alcoholics in the SSI and the SSDI programs and tighten the regulations governing the selection of representative payees. In addition, the legislation created substantially more severe penalties for individuals convicted of fraud and abuse.

SSA began implementing these reforms in the spring of 1995. However, the newly-elected Republican majority returned to the issue during the welfare reform debate. Many elected officials argued that the 1994 reforms did not go far enough to control the receipt of benefits by drug addicts and alcoholics. Provisions to end drug addiction and alcoholism as a basis for disability were included in two separate welfare bills, both of which were vetoed by the President.

Finally, in March 1996, President Clinton signed H.R. 3136 (P.L. 104–121). The primary purpose of the legislation was to increase the amount of earnings Social Security recipients may earn before their benefits are reduced. Included in this legislation was a provision to end drug addiction and alcoholism as a basis for disability. In addition, the mandatory treatment requirements were eliminated. Those affected by the new law started receiving notices in July 1996 to receive a redetermination of their disability. It is estimated that as many as 75 percent of those receiving disability be-

cause of drug abuse or alcohol addiction will requalify for SSI based on another type of disability.

2. Limitations of SSI Payments to Immigrants

The payment of benefits to legal immigrants on SSI has undergone a dramatic change in the last three years.

Until the passage of the 1996 welfare reform legislation, an individual must have been either a citizen of the United States or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law to qualify for SSI. Before passage of the Unemployment Compensation Amendments of 1993 (P.L. 103–152), SSI law required that for purposes of determining SSI eligibility and benefit amount, an immigrant entering the United States with an agreement by a U.S. sponsor to provide financial support was deemed to have part of the sponsor's (and, in most instances, part of the sponsor's spouse's) income and resources available for his or her support during the first 3 years in the United States. Public Law 103–152 temporarily extends the deeming period for SSI benefits from 3 years to 5 years. This provision was effective from January 1, 1994, through September 30, 1996.

The welfare legislation signed in 1996 (P.L. 104-193) has a direct impact on legal immigrants who may be receiving SSI. The bill bars legal immigrants from SSI unless they have worked 10 years or are veterans, certain active duty personnel, or their families. Those who are currently receiving SSI will be screened during a 1-year period after enactment. If the beneficiary is unable to show that he or she has worked for 10 years, is a naturalized citizen, or meets one of the other exemptions, the beneficiary will be terminated from the program. After the ten year period, if the legal immigrant has not naturalized, he or she will likely need to meet the 5 year deeming requirement that was part of the changes in the 1993 legislation.

3. SSA Disability Redesign Project

The disability process redesign proposal, introduced on April 1, 1994, was the first attempt to address major fundamental changes needed to realistically cope with disability determination workloads.

Currently SSA's disability determination process is extremely stressed. Workloads are increasing, and the backlogs are enormous. Until recently, SSA has not sought major business improvements to reverse the mounting problems of long waiting periods and case backlogs at state disability determination service (DDS) offices.

SSA projects that disability beneficiaries will more than double, from 4.2 million in 1990 to 817 million in 2005. The workload for initial disability claims has risen from 1.7 million cases in 1990 to an estimated 2.9 million cases in 1994, and SSA estimates that case backlogs could reach a million cases by 1995. SSA's reported administrative budget for processing disability and appeals determinations was about $2.5 billion in fiscal year 1993—over half of its reported administrative costs.

In response to concerns raised the General Accounting Office (GAO), Congress, and disability advocates, SSA is in the process of finalizing its redesign plan. The solution presented by SSA focuses on streamlining the determination process and improving service to the public. The proposed process is intended to reduce the number of days for a claimant's first contact with SSA to an initial decision, from an average of 40 days to less than 15 days. To accomplish this goal, the team proposed that SSA establish a disability claims manager as the focal point for a claimant's contact and that the number of steps needed to produce decisions by substantially reduced. The proposal also suggested providing applicants with a better understanding of how the disability determination process is working and the current status of their claims.

GAO has commented on the plan and has stated that the proposal is a good first step. However, there will be more work in the form of testing and planning the transition to the streamlined process.

4. Benefits

Ever since the program's start-up in 1974, benefit levels have fallen below the poverty level. As a result, the program has relieved, but not eliminated, poverty rates among elderly and disabled individuals. The poverty rate among the elderly has declined only marginally from 14.6 percent in 1974 to 12.2 percent in 1993. For black elderly, the poverty rate is even greater, at 28 percent. The poverty rate is highest for black elderly women, at 31 percent. The 1994 benefit of $446 left an elderly individual 27 percent below the 1994 poverty level of $7,360. For elderly couples, the maximum benefit level of $669 was 18 percent below the poverty level of $9,840 in 1994. In 1993, out of a total population of 30.8 million elderly age 65 and over, 3.8 million elderly had incomes below the poverty level.

A 1988 study by the National Council of Senior Citizens found that the average low-income elderly household had an annual income of $5,306. Of that amount, housing costs totaled more than 38 percent, food totaled 34 percent, and home energy totaled 17 percent. This left about $493, or $9.38 a week, for discretionary spending.

Under SSI, States also may voluntarily supplement the Federal SSI benefit. Approximately 49 percent of SSI recipients receive such supplementation. Seven States provide no supplement. The median State supplement in 1994 was only $31 for an individual per month. In 1994, only one State, Alaska, supplemented SSI enough to bring benefits up to the poverty level.

In 1992, in an effort to extend the effectiveness of SSI, the majority of experts on the SSI Modernization Project recommended raising the SSI benefit standard to 120 percent of the poverty level. These experts believe that those who are aged, blind, and disabled should no longer have to live in poverty. The proposed benefit increase would be extremely costly, and would bump up against serious budget constraints in 1994. Unless creative sources of financing can be identified, large increases in SSI will be difficult to achieve in the near future.

5. Income and Assets Limits

Concern has stemmed from the fact that the level of cash income disregarded in determining SSI program eligibility has not been changed since the inception of the program in 1974. If the 1974 values of these disregards had been indexed to reflect price inflation they would have increased from $20 of monthly income from any source and $65 monthly earned income to $61 and $197, respectively. The $20 disregard affects almost 85 percent of elderly beneficiaries. The experts on the SSI Modernization Project recommended increasing the $20 monthly income exclusion to $30, applied only to unearned income.

Compounding this problem is the absence of regular indexing for the asset limits individuals must meet to receive SSI benefits. Through the program's first 10 years, the allowable asset limits remained constant at $1,500 for individuals and $2,250 for couples. In 1984, however, the Deficit Reduction Act (P.L. 98–369) raised these limits annually through 1989 by $100 for individuals and by $150 a year for couples to its current level of $2,000 and $3,000, respectively. Even so, anti-poverty advocates remain concerned that the asset test is still too stringent and disqualifies otherwise eligible persons.

The results of a 1988 study conducted by the Policy Center on Aging of Brandeis University for the American Association of Retired Persons (AARP), support this contention. The study found that 34 percent of the income eligible 65–69 age group and 45 percent of the 85 and over age group were ineligible because of assets. The study also reported that a significant number of individuals possessed assets close to the cutoff. For example, about 60,000 elderly persons had countable assets that fell within $750 of the 1984 asset test threshold. The assets held by a majority of the asset ineligible population were interest earning accounts, homes, and automobiles. About half of income eligible/asset ineligible elderly households had modest life insurance policies that contributed to ineligibility.

In addressing these concerns, the SSI Modernization Project issued a number of recommendations. Regarding the resource limits, the experts supported raising the limits to $7,000 for an individual and $10,500 for a couple, while eliminating most of the resource exclusions. The home, an essential car, business property essential for self-support, and household goods and personal effects would continue to be excluded. The experts view these changes as making the program simpler and more equitable. They believe that the increased limits, with fewer exclusions, would more effectively and efficiently identify the truly needy among persons who are aged, blind, or disabled.

6. Representative Payees

Under SSA's representative payee program, an individual other than the beneficiary is appointed to handle checks from the Social Security and SSI programs when the beneficiaries are deemed unable to manage their own finances. The monthly payments to approximately 1 million SSI beneficiaries are handled by representa-

tive payees. By definition, beneficiaries in need of a payee are vulnerable.

The Special Committee on Aging has held hearings to ensure that safeguards are in place to protect beneficiaries. Senator Pryor chaired a hearing to investigate the lack of safeguards to protect beneficiaries from abuse by representative payees and lapses by SSA. As a result, legislation was enacted in 1990, to intensify oversight of the program by strengthening SSA's procedures. In 1993, SSA also moved to address some of the weaknesses that had been identified in its representative payee program. Finally, in 1994, reform of the representative payee provisions continued with the passage of the Social Security Independence and Program Improvements Act of 1994 (P.L. 103–296). As discussed in Section B, Congress placed additional safeguards on the use of representative payees.

7. Employment and Rehabilitation for SSI Recipients

Section 1619 and related provisions of SSI law provide that SSI recipients who are able to work in spite of their impairments can continue to be eligible for reduced SSI benefits and Medicaid. The number of SSI disabled and blind beneficiaries with earnings has increased from 87,000 in 1980 to 241,000 in 1994. In addition, 27,000 aged SSI recipients had earnings in 1994.

Before 1980, a disabled SSI recipient who found employment faced a substantial risk of losing both SSI and Medicaid benefits. The result was a disincentive for disabled individuals to attempt to work. The Social Security Disability Amendments of 1980 (P.L. 96–265) established a temporary demonstration program aimed at removing work disincentives for a 3-year period beginning in January 1981. This program, which became Section 1619 of the Social Security Act, was meant to encourage SSI recipients to seek and engage in employment. Disabled individuals who lost their eligibility status for SSI because they worked were provided with special SSI cash benefits and assured Medicaid eligibility.

The Social Security Disability Benefits Reform Act of 1984 (P.L. 98–460), which extended the Section 1619 program through June 30, 1987, represented a major push by Congress to make work incentives more effective. The original Section 1619 program preserved SSI and Medicaid eligibility for disabled persons who worked even though two provisions that set limits on earnings were still in effect. These provisions required that after a trial work period, work at the "substantial gainful activity level" (then counted as over $300 a month earnings, which has since been raised to $500) led to the loss of disability status and eventually benefits even if the individual's total income and resources were within the SSI criteria for benefits.

Moreover, when an individual completed 9 months of trial work and was determined to be performing work constituting substantial gainful activity, he or she lost eligibility for regular SSI benefits 3 months after the 9-month period. At this point, the person went into Section 1619 status. After the close of the trial work period, there was, however, an additional one-time 15-month period during which an individual who had not been receiving a regular SSI payment because of work activities above the substantial gainful ac-

tivities level could be reinstated to regular SSI benefit status without having his or her medical condition reevaluated.

The Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99–643) eliminated the trial work period and the 15-month extension period provisions. Because a determination of substantial gainful activity was no longer a factor in retaining SSI eligibility status, the trial work period was recognized as serving no purpose. The law replaced these provisions with a new one that allowed use of a "suspended eligibility status" that resulted in protection of the disability status of disabled persons who attempt to work.

The 1986 law also made Section 1619 permanent. The result has been a program that is much more useful to disabled SSI recipients. The congressional intent was to ensure ongoing assistance to the severely disabled who are able to do some work but who often have fluctuating levels of income and whose ability to work changes for health reasons or the availability of special support services.

While Congress has been active in building a rehabilitation component into the disability programs administered by SSA over the last decade, the number of people who leave the rolls through rehabilitation is very small. Because of concerns about the growth in the SSI program, policymakers have begun to question the effectiveness of the work incentive provisions. The General Accounting Office (GAO) undertook two studies which were completed in 1996 which analyzed the weaknesses of the work incentive provisions and SSA's administration of these provisions.

The Aging Committee convened a hearing to review GAO's findings in June 1996. The hearing focused on the conclusion that the work incentives are not effective in encouraging recipients with work potential to return to employment or pursue rehabilitation options. In addition, the report concluded that SSA has not done enough to promote the work incentives to their field employees, who in turn do not promote the incentives to beneficiaries.

C. PROGNOSIS

Over the last two years, SSI has been the target of a number of changes in eligibility and benefits—prompted in part because of concern over the growing burden of entitlement programs. In the future, Congress is more likely to continue looking to SSI as a source of savings. With considerable public pressure in favor of reining in entitlements, no major benefit expansions are likely in 1997.

Congressional oversight of SSA is likely to ensure that administrative problems do not undermine the SSI program. Oversight will focus on backlogs in the disability determination and adjudication programs as well as requiring continuing disability reviews on a widespread basis for SSI, and ensuring that SSI recipients and others can get accurate and timely answers to questions over the Agency's telephone systems. One of the greatest challenges for the mid-1990's will be ensuring proper use of resources provided in appropriations for SSA's administrative expenses. Even more importantly, Congress and the public are becoming increasingly aware that the philosophy of the SSI program must be evaluated to en-

sure that the program is keeping pace with strides in medical technology and the emphasis to equal access to work for those with disabilities.

Chapter 6

FOOD STAMPS

OVERVIEW

The 104th Congress and the year of 1994 was a period which brought extensive changes to the Food Stamp Program. In 1996, the passage of the Personal Responsibility and Work Opportunity Act led to decreases in food stamp spending and changes in eligibility and work requirements. The changes in the Food Stamps program follow the trend of the welfare reform legislation which calls for increased state control over income security programs. The 1996 changes also reflect the growing sentiment that spending in entitlement programs must be curtailed.

This activity builds on other changes in the first half of the decade. In 1994, Congress took only a few, limited actions with regard to food stamps. It approved the Food Stamp Program Improvements Act (P.L. 103–225), which (1) changed rules governing what types of Food concerns may be authorized to accept food stamps, (2) allowed sharing of information provided by participating food stores with law enforcement agencies, (3) authorized a pilot project testing ways to combat street trafficking in food stamps, and (4) revised some of the rules governing food stamp program operations on Indian reservations. As part of the fiscal year 1995 food stamp appropriation measure (P.L. 103–330), the number of pilot projects in which food stamp benefits are "cashed out" (i.e. issued in cash rather than food stamp coupons) was limited to 25 projects with total enrollment of no more than 3 percent of the national caseload. P.L. 103–354 prevented a scheduled October 1994 benefit reduction of 1.6 percent in Alaska.

The recently enacted welfare reform legislation nullified some of the more substantial changes to the Food Stamp Act. In 1993, the Food Stamp Act was amended as part of the 1993 Omnibus Budget Reconciliation Act (OBRA 93) (P.L. 103–66). The food stamp revisions, titled The Mickey Leland Childhood Hunger Relief Act, increased benefits and eased eligibility by increasing and then removing the limit on special benefit adjustments for households with very high shelter costs; ending a practice of reducing benefits when there are short "procedural" breaks in enrollment; disregarding child support payments as income to the payor; increased the degree to which vehicles are disregarded as assets in judging eligibility; and boosting Puerto Rico's nutrition assistance block grant. The Mickey Leland Act also lowered the Federal share of some State administrative costs, reduced "quality control" fiscal penalties on States with high rates of erroneous benefit and eligibility decisions, and liberalized the appeals process for these penalties. Fi-

nally, it expanded support for method of collecting claims against recipients, and increased penalties for trafficking in food stamps.

A. BACKGROUND

The Food Stamp Program works to alleviate malnutrition and hunger among low-income persons by increasing their food purchasing power. State welfare agencies, following Federal regulations established by the U.S. Department of Agriculture (USDA), issue food coupons that eligible households may use in combination with other income to purchase a more nutritious diet than would otherwise be possible.

In 1995, an average of 26.6 million low-income persons participated in the program, with an average monthly benefit of $69 per person. In addition, about 1.4 million people a month were enrolled in Puerto Rico under its Nutrition Assistance Program (NAP), a block grant authorized under the Food Stamp Act that has replaced the Food Stamp Program in the Commonwealth. Food stamps are available to households meeting certain federally established income and asset tests, or who already receive Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or State/local general assistance. It is estimated that a minimum of 40 million persons in the United States may actually be eligible to receive food stamps. Over the past decade, average monthly participation has ranged from a low of 18.6 million people in fiscal year 1988 to an all-time high in 1994 of 28 million people.

The origins of the Food Stamp Program can be traced to an eight-county, experimental antihunger project established by Executive Order in 1961. A national expansion of the project concept followed passage of the Food Stamp Act of 1964. After 1964, all States were given the option to offer a coupon distribution program in lieu of their existing commodity donation projects. By 1975, the program was available nationwide. In 1977, Congress enacted the Food Stamp Act of 1977, fundamentally revising the program's benefit structure, eligibility criteria, and administrative scheme. Since then, Congress has enacted amendments intended to improve the Food Stamp Program and strengthen its integrity.

Eligible applicants receive monthly food stamp allotments to buy food through standard market channels, usually authorized grocery stores. These stores then forward them to the commercial banks for cash or credit. The stamps flow through the banking system to the Federal Reserve Bank where they are redeemed out of a special account maintained by the U.S. Treasury Department. In a few pilot projects, benefits are issued in cash rather than coupons. The Food Stamp Program serves as an income security program by supplementing family income. It also contributes to farm and retail food sales and helps reduce surplus commodity stocks by encouraging increased food purchases.

Recent studies confirm the correlation between nutritional status and health, especially for the young and the old, underscoring the true significance of the Food Stamp Program. The program recognizes that elderly people with high medical bills may have total incomes higher than the poverty level, but less money actually available for food than others with lower incomes and no medical bills. To address these and other unique circumstances of the elderly, the

program provides for more liberal treatment of shelter costs, medical expenses, and assets. For the 13 percent of elders who take the medical deduction for the elderly, the average deduction is nearly $100 per month, providing an increase in benefits of about $30 per month.

Although 15 percent of food stamp households have at least one elderly member (age 60 or older), they make up only 9 percent of food stamp recipients and receive 6 percent of food stamp benefits because elderly households are typically smaller (an average of 1.4 persons) and have relatively higher incomes than recipient households of the same size. Most (75 percent) of food stamp households with elderly members are single-person households, and 60 percent are single elderly women. But, almost 10 percent of households with elderly recipients also include children (2 percent include preschool children). Older food stamp recipients (overage 60) tend to depend on Social Security and Supplemental Security Income (SSI) benefits; over two-thirds get SSI or Social Security payments as their primary source of income.

The Federal Government pays 100 percent of all food stamp benefits and 50 percent of most State and local administrative costs. The Food and Nutrition Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At State and local levels, the Food Stamp Program is administered by State welfare departments.

Elderly persons who are applicants for or recipients of SSI benefits frequently qualify for special assistance with food stamp applications. Under the terms of the 1977 Food Stamp Act as amended, Social Security offices are required by law to provide this type of assistance to SSI applicants and recipients. It has been alleged, by some advocates for the elderly, that SSA has not consistently met this legal mandate. A GAO study requested by Chairman Pryor and released in 1992 confirmed that SSA has not met the responsibilities assigned to the agency under the Food Stamp Act, and further recommended the development of a plan for the coordinated delivery of food stamp application assistance by Department of Health and Human Services (HHS) and the Department of Agriculture.

State and local welfare offices are also required to establish and implement special procedures for those who have difficulty applying for food stamps at the welfare offices and for those with extremely low incomes who need food stamps quickly, e.g., out-of-office application procedures, permission to use "authorized representatives" to apply for and use food stamps, and "expedited service" for those in extreme need. Benefits must be provided to eligible households within 30 days of application, or within 5 days for those in extreme need.

Uniform national household eligibility standards for program participation are established by the Secretary of Agriculture. All households must meet a liquid assets test and, except for those with an elderly or disabled member, a two-tiered income test to be eligible for benefits. Recipients of two primary Federal-State categorical cash welfare programs—AFDC and SSI—are automatically eligible for food stamps, although in California increased SSI bene-

fits replace food stamp assistance. An eligible household's monthly gross income must not exceed 130 percent of the income poverty levels set annually by the Office of Management and Budget (OMB), and its monthly income (after deducting amounts for such things as medical and dependent care, shelter, utilities, and work-related expenses) must be equal to or less than 100 percent of the OMB poverty level. Only the second test, monthly income after deductions, is applied to households with elderly or disabled members.

To be eligible, a household cannot have liquid assets exceeding $2,000, or $3,000, if the household has an elderly member. The value of a residence, personal property and household belongings, business assets, burial plots, a portion of the value of a vehicle, and certain other resources are excluded from the liquid assets limit.

Certain able-bodied household members (older than 16–18 years of age, depending upon their school and family status, and younger than 60 years) who are not working must register for employment and accept a suitable job, if offered one, to maintain eligibility. States are required to operate Employment and Training (E&T) programs under which adults who are registered for work and not subject to certain exemptions must fulfill work requirements. These work requirements were tightened by the welfare reform legislation which will be described later.

Applicant households certified as eligible are entitled to a monthly benefit amount calculated from their income and size. A food stamp household is expected to contribute 30 percent of its monthly cash income after expense deductions (or about 15–20 percent of its gross income) for food purchases. Food Stamp benefits then make up the difference between that expected contribution and the amount needed to buy a low-cost, adequate diet; this amount is the maximum monthly benefit and is equal to the cost of USDA's "Thrifty Food Plan," adjusted for household size and inflation. The welfare reform legislation eliminates the special 3-percent "add on." In fiscal year 1995, the maximum food stamp benefit is $115 a month for a one-person household and $212 for a two-person household. Average monthly benefits in 1994 were $69 per person and about $50 among elderly recipients. However, about one-quarter of elderly households receive only the minimum $10 a month benefit.

B. LEGISLATIVE DEVELOPMENTS

During 1994 and during the 104th Congress, three pieces of legislation were enacted which affect the Food Stamp program.

Three laws directly affecting food stamps were enacted in 1994. First, P.L. 103–225 changed rules to limit the types of food concerns that can be approved to accept food stamps, allowed sharing of information provided by food stores with appropriate law enforcement agencies in order to help control illegal practices, authorized a pilot project to help control street trafficking in food stamps, and made some changes in food stamp program rules for Indians on reservations. A second piece of legislation, P.L. 103–330 limited the number of pilot projects than can cash out food stamp benefits; and finally, P.L. 103–354 prevented a reduction in food stamp benefits in Alaska.

During the 104th Congress, leaders turned to consideration of welfare reform and reauthorization of the Food Stamp Act—activities which resulted in substantial reforms to the Food Stamp program.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) contained a number of provisions which impact this program. The changes to the program were consistent with the new Republican leadership's philosophy of increased state control and flexibility. The legislation expands the states' role in administering the program, increases the work requirements on recipients of food stamps, restricts future increases in benefits, and denies legal resident alien eligibility. This legislation also emphasized changes in administrative controls and penalties by encouraging the delivery of benefits through electronic benefit transfer (EBT) and increasing the penalties on people who traffic in food stamps.

The signed legislation differed from previous reform attempts in the 104th Congress which had been strongly criticized by the Administration and advocacy groups. One of the principle objections to earlier legislation was a move to permit states to convert to a food stamp block grant. This change in policy was viewed as risky because of the move toward a time-limited, non-entitlement benefit for families on the Aid to Families with Dependent Children (AFDC) program. Those who opposed the Food Stamp block grant successfully argued that the program should maintain its Federal identity as the final "safety net" against hunger.

1. State Control

Under the new legislation, States will be permitted to operate a simplified Food Stamp program under which they can incorporate the rules established for the Temporary Assistance for Needy Families (TANF) welfare block grant when determining food stamp benefits. States will also exert more control over regular program rules. In addition, Federal administrative controls will be relaxed. For example, states will have more latitude in running food stamp offices and conducting hearings.

2. Work Requirements

The Act tightens work requirements for able-bodied adult recipients of food stamps. Under the new law, adults between 18 and 50 without dependents, will be ineligible for food stamp benefits if, during the prior 36 month period, they received food stamps for 3 months while not working at least 20 hours a week or participate in job training. Those adults who are declared ineligible can requalify for benefits if during a 30-day period, they work 80 hours or participate in a work/training activity.

The states will also have a greater ability to disqualify recipients for failure to meet work requirements. In addition, a mandatory minimum disqualification period is established.

3. Benefit Reductions

The new Act implements a reduction in the basic food benefit, the "Thrifty Food Plan." Under current law, benefits are paid equal

to 103 percent of the Plan. Benefits will now be lowered to 100 percent of the cost of the TFP, indexed for inflation. Benefits will also be cut back by a freeze on the standard deduction at its current level of $134 a month. Another deduction available to beneficiaries—a capped shelter expense deduction—which was scheduled to increase by eliminating the cap—will be replaced. Under the new law, the shelter expense cap will rise from the current $247 a month to $300 beginning in fiscal year 2001. The Act also eliminates the scheduled increase in the value of a vehicle. Prior to the passage of the legislation, the law indexed the existing threshold above which the fair market value of a vehicle is counted as a household asset ($4,600) beginning in October 1996; the threshold will be raised slightly to $4,650 but no further increases are provided by statute.

The second legislative action was passage of the Federal Agriculture Improvement and Reform Act (P.L. 104–127). This legislation reauthorized the operation of the Food Stamp program through FY 1997. In addition, the farm legislation included provisions to continue funding grants to Puerto Rico and American Samoa, state-run employment and training programs through FY 2002, and authority for several pilot projects. The farm legislation made other changes to the penalties for food stamp trafficking cases.

C. HUNGER IN AMERICA

1. Studies Documenting Prevalence of Hunger in America

Hunger in America captured congressional attention soon after a visit to the rural South in April 1967 by members of the Senate Subcommittee on Employment, Manpower and Poverty. The subcommittee held hearings on the effectiveness of the so-called "War on Poverty" and was told of widespread hunger and poverty. Later that year, a team of physicians found severe nutritional problems in various areas of the country. These and other reports of hunger and malnutrition in America led to an expansion of Federal food assistance programs. In 1977, physicians returned to evaluate progress made in combating hunger in these same communities and found dramatic improvements in the nutritional status of their residents. These gains were attributed to the expansion of Federal food programs in the 1970's.

Throughout the 1980's, considerable attention was focused on the re-emergence of widespread hunger in the United States. Since 1981, at least 32 national and 43 States and local studies on hunger have been published by a variety of government agencies, universities, and religious and policy organizations. They suggested that hunger in America is widespread and entrenched, despite national economic growth.

In 1983, the Conference issued a report which detailed a significant increase in requests for emergency food assistance, citing unemployment as a primary cause.

Later that year, President Reagan appointed a commission to investigate allegations of rampant hunger in the United States. At the end of 1984, the President's Task Force of Food Assistance concluded that there was little evidence of widespread hunger in the

United States and that reductions in Federal spending for food assistance had not injured the poor. The Commission did formulate several modest recommendations to make the Food Stamp Program more accessible to the hungry, including:

(1) Raising asset limits;

(2) Increasing the food stamp benefit to 100 percent of the Thrifty Food Plan;

(3) Categorical eligibility for AFDC and SSI households;

(4) Targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled); and

(5) Modification of the permanent residence requirement so benefits would be made available to the homeless.

These liberalizations, however, were offset by cost-reduction measures which included increasing the State responsibility for erroneous payments and an optional State block grant for food assistance.

During the period the Reagan commission operated, other groups were continuing to study the prevalence of hunger and malnutrition in this country. These studies, in comparison to the report of the Reagan commission, painted a grimmer picture.

The Harvard School of Public Health, after 15 months of research into the problem of hunger in New England, concluded in 1984 that:

(1) Substantial hunger exists in every State in the region;

(2) Hunger is far more widespread than generally has been realized; and

(3) Hunger in the region had been growing at a steady pace for at least 3 years and was not diminishing.

The researchers found that greater numbers of elderly persons were using emergency food programs and that many were suffering quietly in the privacy of their homes. The staff also expressed concern over what had been noted in medical clinical practice: Increasing numbers of malnourished children and greater hunger among their patients, including the elderly. The staff also cited the impact of malnutrition on health and stated that children and elderly people are likely to suffer the greatest harm when food is inadequate.

Studies and research papers have continued to be released over the last 10 years, charging that there is a hunger crisis. Indeed, the U.S. Conference of Mayors released another study 10 years after their first report. In December 1994, the Conference reported that requests for emergency shelter have increased an average of 13 percent in 30 different cities over the last year. Over the same period, requests for emergency food increased by 12 percent.

One of the most widely cited reports, sponsored by the Center on Hunger, Poverty, and Nutrition Policy at Tufts University, announced in September 1992 that 30 million Americans fail to get enough food. The report found that hunger affects nearly one-eighth of the U.S. population.

This study was used by hunger advocacy groups as evidence of the need to increase spending on food-related programs, particularly during debate over the Mickey Leland Act. However, opponents of increased spending have attacked this study and other similar studies as relying on shaky statistics and using unproven

measurements to calculate the numbers of people who experience hunger.

The debate over research methods seems to have made an impact on new congressional leaders. With the trend toward less Federal Government involvement in poverty programs, conservative officials have started asking why Federal funds do not seem to be solving the hunger problem.

Still, no one seems to argue that the health benefits of a proper diet are not real and that the country does not need to address the problems of malnutrition. This problem, generally thought to be an issue for children, continues to be a serious threat to the health of the elderly.

(A) STUDIES FOCUSING SPECIFICALLY ON HUNGER AMONG THE ELDERLY

According to medical experts on aging, malnutrition may account for substantially more illness among elderly Americans than has been assumed. The concern about malnutrition is rising fast as the numbers of elderly grow and as surveys reveal how poorly millions of them eat. The New York Times reported in 1985 that scientists estimate that from 15 to 50 percent of Americans over the age of 65 consume fewer calories, proteins, essential vitamins, and minerals than are required for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in resistance to disease seen in elderly patients—a weakening in immunological defenses that commonly has been blamed on the aging process. Experts say that many elderly fall into a spiral of undereating, illness, physical inactivity, and depression. Recent findings suggest that much illness among the elderly could be prevented through more aggressive nutritional aid. In the view of some physicians, immunological studies hold promise that many individuals may lighten the disease burden of old age by eating better. Being poor also greatly exacerbates the effect of nutrition problems. Low participation in the Food Stamp Program leaves large numbers of Americans without enough to eat and the problems exist largely because many people who are eligible for food stamps are not receiving them.

A 1985 report by the GAO, based on research conducted by private organizations, USDA, and the President's Task Force on Food Assistance concluded that nonparticipation in the Food Stamp Program by many low-income households was attributed to several factors including:

(1) Lack of awareness regarding household eligibility for the program;

(2) Relatively low benefit payments may provide little incentive for eligible elderly to apply;

(3) Administrative requirements such as complex application forms and required documentation;

(4) Physical access problems such as transportation or the physical condition of the applicant; and

(5) Attitudinal factors, including sensitivity to the social stigma associated with receiving food assistance.

More recent studies suggest that the battle against malnutrition is not being won. The April 1993 issue of the Journal of the American Dietetic Association reported a study that found that over a third of the elderly who were admitted from their homes into a nursing facility were malnourished at the time of admission.

The Urban Institute published a study in 1994 which found that about 5 million people over the age of 60 are either hunger of malnourished. With the increases in the elderly population, policy makers may need to focus some resources on improving the nutritional health of older Americans.

(B) FOOD STAMP PARTICIPATION STUDIES

An issue which has received less attention more recently is the number of eligible people, particularly elderly, who do not apply for food stamp benefits. In November 1988, a study by the Congressional Budget Office highlighted the low rates of participation in the Food Stamp Program by those eligible for food stamp assistance. According to then current census data, only 41 percent of eligible households and 51 percent of eligible individuals received food stamps in 1984. Eligibility conditions were, however, more strict at that time. Participation levels were the highest for very-low income households and individuals. Participation rates ranged from 67 to 90 percent for those who were eligible to receive over $100 in benefits per month. Eligible families with children also had higher participation rates, as many also participated in AFDC. Households with elderly members had lower participation rates of 34 to 44 percent. The lowest participation rates were for households without children or elderly members.

In 1989, USDA's Food and Nutrition Service released two studies examining Food Stamp Program participation rates. USDA found that participation rates were not as low as some earlier studies had suggested. Nevertheless, it concluded that some vulnerable populations, including the elderly, experience very low participation rates. USDA findings included the following: (1) 66 percent of eligible individuals and 60 percent of eligible households participated in the Food Stamp Program in 1984; (2) participating households received 80 percent of all benefits that would have been paid if all eligible households had participated; (3) 74–82 percent of eligible persons who had income at or below the poverty line were participating in the Food Stamp Program; and (4) only 33 percent of eligible elderly individuals participated in the Food Stamp Program.

Recent studies suggest that food stamp participation rates have increased over the period of 1988 to 1993. The number of participants increased by about 12 percentage points. For separate demographic groups, the rate is higher. For example, children of preschool age and younger have high participation rates. In 1992, almost 95 percent of children under the age of 5 who were eligible for the program participated. However, participation among the elderly continues to be low. Only one-third of eligible elderly persons participated in the Food Stamp program in 1992.

D. REGULATORY AND JUDICIAL ACTION

The only recent major regulatory action, which took place in 1994, was the issuance of final regulations affecting electronic benefit transfer (EBT) systems, by the Federal Reserve. Electronic benefit transfer systems are in place in several pilot projects, and one State (Maryland), and a number of States are preparing to implement them. These systems provide benefits through the use of ATM-like cards that are issued to recipients' food purchases are automatically deducted from their food stamp "account" by using a special machine at the check-out counter. The Federal Reserve's regulations extend, as of March 1997, certain protections to recipients using EBT cards, most importantly the rule that limits cardholder liability, in cases of lost or stolen cards, to the first $50 (if a timely report is made).

E. PROGNOSIS

With the successful passage of welfare reform in 1996, much of the work to rein in spending on food stamp benefits and to emphasize work has been done. However, President Clinton indicated that he signed the welfare legislation with some reservations. The Administration stated specifically that it would pursue changes to the legislation to correct some flaws in the Food Stamp provisions. For example, the Administration would like to revisit the issue of maintaining the shelter expense deduction cap. In addition, the Administration has opposed the new work requirement for adults without dependents. It is likely that changes will be sought which would continue food stamp eligibility for people unable to work or participate in training if slots were not available.

A more difficult debate will center on the denial of food stamps to legal resident aliens. The Administration will likely seek changes to permit legal resident aliens to receive food stamps as a means of minimal support.

Given the extent of the spending decreases enacted in 1996, it is unlikely that further reductions will be sought. These decreases amount to about $23.3 billion through 2002. The program paid out about $24.5 billion in benefits in FY 1995.

Chapter 7

HEALTH CARE

A. NATIONAL HEALTH CARE EXPENDITURES

1. Introduction

In 1960, national health care expenditures amounted to $26.9 billion, or 5.1 percent of the Gross Domestic Product (GDP), the commonly used indicator of the size of the overall economy. The enactment of Medicare and Medicaid and the expansion of private health insurance covered services contributed to a health spending trend that, over much of the last 35 years, grew much more quickly than the overall economy. By 1990, spending on health care was at $697.5 billion, or 12.1 percent of the GDP. Increases in health care spending during the late 1980s and early 1990s focused attention on the problems of rising costs and led to unsuccessful health care reform efforts in the 103rd Congress to expand access to health insurance and control spending.

In the mid-1990s, however, changes in financing and delivery of health care such as the emerging use of managed care by public and private insurers, impacted on U.S. health care spending patterns. Growth in spending between 1993 and 1995 was the slowest in more than three decades. Spending as a percent of the economy remained relatively constant at around 13.5 percent; for the first time this could be attributed to a slowdown in the rate of growth of health care spending, rather than growth in the overall economy.

National health expenditures include public and private spending on health care, services and supplies related to such care, funds spent on the construction of health care facilities, as well as public and private noncommercial research spending. The amount of such expenditures is influenced by a number of factors, including the size and composition of the population, general price inflation, changes in health care policy, and changes in the behavior of both health care providers and consumers. The aging of the population contributes significantly to the increase in health care expenditures.

In 1995, spending for health care in the United States totaled $988.5 billion, with 88.9 percent of all health care expenditures used for personal health care or services used to prevent or treat diseases in the individual. The remaining 11.1 percent was spent on program administration, including administrative costs and profits earned by private insurers, noncommercial health research, new construction of health facilities, and government public health activities.

Ultimately, every individual pays for each dollar spent on health through health insurance premiums, out-of-pocket, taxes, philan-

thropic contributions, or other means. There has, however, been a substantial shift over the past four decades in the relative role of various payers of health services. While the private sector continues to finance most health care spending in the United States ($532 billion or 54 percent), payments made by private health insurance have decreased from 33.3 percent of health spending in 1990 to 31.4 percent in 1995. Out-of-pocket spending by individuals has also decreased. In 1960, almost half of all health expenditures were paid out-of-pocket. The growth of private health insurance and public health programs has resulted in out-of-pocket spending accounting for only about 20 percent of all health spending in 1995.

When combined, all private sources make up the largest share of health spending, but it is Federal spending (primarily through the Medicare and Medicaid programs) that is the largest single contributor—financing 33 percent of all spending. The Federal Government assumed an increasingly significant role in funding national health expenditures in the 1960s with the enactment of the Medicare and Medicaid programs. In 1964, before their enactment, the Federal Government contribution represented about 12 percent of all health expenditures. By 1970, the Federal Government's share increased to 25 percent. Federal spending continued to rise as a percent of all expenditures until 1976, when it represented about 28 cents of each health dollar. Between 1976 and 1990, the share of health spending paid by the Federal Government hovered around 28 percent. Since 1990, Federal spending on health has grown from this plateau to represent 1/3 of all health spending in 1995. The Federal Government is projected to have spent $349 billion, 33.9 percent of total national health expenditures, in 1995. The Federal Government is expected to spend $469 billion for health care in the year 2000, amounting to 36.2 percent of health care expenditures.

CBO projects that total health spending will resume growing faster than the rest of the economy, rising gradually from about 13.6 percent of GDP in 1996 to 14.3 percent by the year 2000 and to over 16 percent in 2007. This assumes that the economy continues at about full employment, and that workers and their employers who purchase health insurance will concentrate less on low costs and more on high quality. Long-term demographic trends may also affect the growth in health spending due to increased costs associated with the needs of an aging baby boom population. All health projections are subject to a great amount of uncertainty, however, as Federal and State Governments take new actions to change the health spending of government programs, and new legislation affects the private health insurance system.

2. Medicare and Medicaid Expenditures

The Medicare and Medicaid programs are an important source of health care financing for the aged. Medicare provides health insurance protection to most individuals age 65 and older, to persons who are entitled to Social Security or Railroad Retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. It consists of two parts. Part A (Hos-

pital Insurance) covers medical care delivered by hospitals, skilled nursing facilities, hospices and home health agencies. Part B (Supplementary Medical Insurance) covers physicians' services, laboratory services, durable medical equipment, outpatient hospital services and other medical services. Most outpatient prescription drugs are not covered under Medicare, and some services are limited. Medicare is financed by Federal payroll and self-employment taxes, government contributions, and premiums from beneficiaries.

Medicaid is a joint Federal-State entitlement program that pays for medical services on behalf of certain groups of low-income persons. Medicaid is administered by States within broad Federal requirements and guidelines. The Federal Government finances between 50 and 83 percent of the care provided under the Medicaid program in any given State. For more information on the background and mechanics of the Medicare and Medicaid programs see Chapters 8 and 9.

During 1967, the first full year of the program, total Medicare outlays amounted to $3.4 billion. In 1995, Medicare expenditures ($187.0 billion) accounted for 56.9 percent of all Federal health spending and 18.9 percent of national health spending. While total Medicare spending has increased significantly since the program began, the average annual rate of growth has slowed somewhat in recent years. Over the fiscal year 1980–1990 period, total outlays grew from $35.0 billion to $109.7 billion, for an average annual rate of growth of 12.1 percent. For the fiscal year 1990–1996 period, total outlays grew from $109.7 billion to $194.3 billion, for an average annual growth rate of 10.0 percent. Different trends are recorded for spending on Part A and Part B. The average annual rate of growth in Part A spending increased from 10.6 percent over the fiscal year 1980–1990 period to 11.1 percent over the fiscal year 1990–1996 period. Conversely, the average annual rate of growth for Part B declined from 14.9 percent in the fiscal year 1980–1990 period to 8.2 percent over the fiscal year 1990–1996 period.

CBO projects that with no changes in funding gross Medicare outlays will grow from $194.3 billion in fiscal year 1996 to $468.7 billion in fiscal year 2007. This represents an average annual overall rate of growth of 8.3 percent. CBO projects that total Part A outlays will increase at an average annual rate of growth of 7.9 percent, while Part B will increase at an average annual rate of growth of 9.1 percent.

Medicaid expenditures have historically been one of the fastest growing components of both Federal and State budgets. From 1975 to 1984, Medicaid spending almost tripled, increasing from $12.6 billion to 37.6 billion. Spending rose even more dramatically in the late 1980s and early 1990s, increasing an average of 21 percent per year from fiscal year 1989 through fiscal year 1992. This was attributed to increased enrollment, medical care inflation, and state initiatives to maximize collection of Federal funds.

Growth slowed down, however, to an average of about 10 percent from 1993 to 1995. Total Federal and State outlays for Medicaid in 1995 were $141.0 billion. The Federal Government pays about 57 percent of total Medicaid costs, and according to CBO, Federal outlays for Medicaid were $92 billion in 1996, an increase of only 3.3 percent from 1995, the slowest rate of growth since 1982. CBO

projects that Federal outlays for Medicaid will grow from $92 billion in 1996 to $216 billion in 2007—an average growth rate of 8 percent.

Medicare covers about 45 percent of the total personal health care expenses of the elderly. About 22 percent of total costs are paid by the elderly out-of-pocket, and 10 percent by private insurance coverage. The remaining costs are paid by other governments, especially through Medicaid, or other private sources such as charity.

The particular mix of funding sources for health care used by the elderly depends on whether the elderly person is in an institution (generally a nursing home) or not. Among the elderly in institutions, Medicare pays about 26 percent of total personal health costs, and Medicaid, funded by both the Federal and State Governments, pays an additional 29 percent of costs. In contrast, Medicare pays about 55 percent of the costs of personal care for the non-institutionalized elderly; Medicaid funds an additional 10 percent. Institutionalized elderly pay about 35 percent of the costs of care out-of-pocket, compared to 15 percent among the non-institutionalized elderly. Private health insurance pays for a greater proportion of costs among the non-institutionalized elderly (12 percent) than among the institutionalized elderly (5 percent) since relatively few elderly have private insurance coverage for long-term care.

3. Hospitals

Hospital care costs continue to be the largest component of the Nation's health care bill. In 1995, an estimated 35.4 percent, or $350.1 billion, of national health care expenditures was paid to hospitals. The annual growth rate of hospital spending was lower than in the past, however. In 1980, the growth rate of spending for hospital services was 14.3 percent. The growth rate for 1994 and 1995 has been less than 5 percent.

In 1995, public (Federal, State, and local) sources accounted for over 61 percent of hospital service expenditures. The single largest hospital services payer is the Federal Government, contributing half of the total spending for this service category. Private health insurance represents the next largest payer paying about one-third of all hospital spending.

Between 1960 and 1995, Federal payments grew from 17 percent to 50 percent of hospital spending. Medicare and Medicaid's enactment coincide with a reduction in out-of-pocket spending between 1960 and 1980. Over the most recent years, the increased role of Federal dollar in this service category may partially be the result of an increased use of managed care options by private insurers.

From 1978 through 1983, hospital inpatient admissions for persons 65 and over increased an average of 4.8 percent per year, compared to an annual rate of 1.0 percent for total inpatient admissions. In 1983, Medicare's prospective payment system was introduced which pays hospitals a pre-determined rate for each patient based on their diagnosis. With this incentive to provide care more efficiently, total admissions decreased until 1992, though the increase each year among the older population averaged 1.6 from 1987 to 1992. In 1993, overall admissions increased for the first

time in 12 years due to a continuing increase in hospital utilization of those 65 and over.

Older persons tend to stay in the hospital more than two days longer than those under 65. According to the American Hospital Association National Hospital Panel Survey, however, the average length of stay for elderly patients has declined from 10.6 days in 1978 to an estimated 7.1 days in 1995. The average hospital stay for persons age 65–74 was about 7.03 days in 1994 compared with 7.9 days for the age 85 and older group.

4. Physicians' Services

Utilization of physicians' services increases with age. Largely as a result of an increase in the number of visits by the aged, the number of physician contacts per person has increased from 5.4 contacts per person per annum in 1987 to 6.0 contacts per annum per year in 1994. Placing these numbers in context, each percentage point increase represents approximately 250,000 contacts with a physician in person or by phone for the purpose of examination, diagnosis, treatment or advice. For the elderly, the number of physician contacts increased from 8.9 contacts per year in 1989 to 11.3 contacts per person in 1994.

Nearly 9 out of 10 persons over the age of 65 visited a physician in 1994. According to the National Health Interview Survey, an increasing number of the elderly are visiting physicians. This has grown from 69.7 percent in 1964 to 89.3 in 1994. This may in part reflect the need for care among those advanced ages combined with the increased average age of persons over 65 years old and may also reflect an increase in regular preventive care.

Approximately 53 percent of physician visits by the elderly in 1994 were made to a doctor's office. The remaining visits were to hospital outpatient departments, by telephone, in the home, or at clinics and other places outside a hospital.

Spending for physician services to the elderly grew an average of 16 percent per year from 1977 to 1987, reaching a level of $33.5 billion in 1987. In 1994, spending for physician services by persons aged 65 and over amounted to $58.44 or 31 percent of total personal health expenditures for physicians services ($185.87 billion). (CBO national health expenditures estimates; age breakdowns estimated by private actuaries for CRS).

Total spending for physician services in 1995 amounted to $201.6 billion, or 22.9 percent of personal health care. About $1 in $5 spent on physician services in the United States is paid directly by individuals either in the form of copayments, deductibles, or in-full for services that are not covered by their health insurance. Like hospital services, the probability of individuals paying for physicians services has declined sharply since the 1960s. However, the single largest payer for physician services is not Federal Government, but rather private health insurance companies. In 1985, private health insurers contributed to about 40 percent of the total; in 1995 private health insurers paid for 48 percent of all physician services.

Medicare spending for physician services was $40 billion in 1995, or 19.8 percent of total funding for care by physicians. In comparison, Medicare paid for only 12.2 percent or $1.7 billion of total phy-

sician service expenditures in 1970. According to HCFA, the average annual rate of growth change (AARC) for Medicare physician personal health care expenditures (PHCE) from 1970–1994 was 13.9 percent. Based on the relative growth index, Medicare physician expenditures grew approximately 71 percent faster than national physician PHCE during this time. Because of changes in the Medicare physician payment system, the growth of Medicare spending for physician services has decelerated substantially. The AARC in Medicare physician and national physician PHCE during the period 1990–1994 were both 6.8 percent.

5. Nursing Home and Home Health Costs

Long-term care refers to a broad range of medical, social, and personal care, and supportive services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. The need for long-term care is often measured by assessing limitations in a person's capacity to manage certain functions. These are referred to as limitations in ADLs, "activities of daily living", which include self-care basics such as dressing, toileting, moving from one place to another, and eating. Another set of limitations, "instrumental activities of daily living," or IADLs, describe difficulties in performing household chores and social tasks.

In its estimate of total national heath expenditures, HCFA includes spending for nursing home and home health care. The total for these two categories of services amounted to $106.4 billion in 1995, and is for all age groups needing long-term care.

In 1995, almost three-quarters of long-term care spending, or $77.9 billion, was for nursing home care. Nursing home care represented 7.9 percent and home care services represented 2.9 percent of national health care expenditures. The cost of long-term care can be catastrophic, with average charges per day of $127 for care in freestanding nursing facilities according to the nursing home expenditure estimate. At that rate, a 1-year stay would cost more than $46,000. Senior citizens who must enter a nursing home encounter significant uncovered liability for this care with out-of-pocket payments by the elderly and their families comprising 37 percent of nursing home spending. Private insurance coverage of nursing home services is currently very limited, and covered only 3.2 percent of spending in 1995. The elderly can qualify for Medicaid assistance with nursing homes expenses, but only after they have depleted their income and resources on the cost of care.

Federal and State Medicaid funds finance a growing portion of the share of nursing home care—46.5 percent in the 1995. Medicare's role as a payer for nursing home care has also increased in the last several years to 9.4 percent. This accounts for much of the increase in the Federal Government's share of nursing home spending from 31 percent in 1990 to 38 percent in 1995.

About 1.5 million Americans were receiving nursing home care in 1995. This represented only 4.2 percent of the aged, however; most elderly prefer to use long-term care services in the home and community.

Comparatively little long-term care spending is for these alternative sources of care, with home health care spending at $28.6 billion in 1995. In 1995, Medicare paid 40.5 percent and Medicaid

paid 14.3 percent of home care costs. It should be noted that this total for home health excludes spending for nonmedical home care services needed by many chronically ill and impaired persons. Sources of funding for these services include the Older Americans Act, the Social Services Block Grant, and State programs as well as out-of-pocket payments.

Also, while Americans are not entering nursing homes at the same rate as they have in previous years, pubic policy experts are concerned about the large future commitment of public funding to long term care. The elderly (65 years and over) population is the fastest growing age group in the U.S. In 1995, there were 34 million people ages 65 and over representing 13 percent of the population. The middle-series projection for 2050 indicates that there will be 79 million people ages 65 and over, representing 20 percent of the population.

Although chronic conditions occur in individuals of all ages, their incidence, especially as they result in disability, increases with age. The population ages 85 and over is growing especially fast and is the age group most likely to need nursing home care. This group is projected to more than double from nearly 4 million (1.4 percent of the population) in 1995 to over 8 million (2.4 percent) in 2030, then to more than double again in size from 2030 to 2050 to 18 million (4.6 percent).

6. Prescription Drugs

In 1995, prescription drug expenditures in the United States constituted about 5.6 percent of total health care spending—about $55.4 billion. This figure measures spending for prescription drugs, over-the counter medicines, and sundries purchased in retail outlets. It would represent an even larger portion of the total health care pie, but the value of drugs and other products provided by hospitals, nursing homes, or health professionals is included instead with estimates of spending for these provider's services. Prescription drug spending growth was slower than that of personal health care in 1993 and 1994, but jumped 8.1 percent in 1995, 2 percentage points faster than personal health care.

Both outpatient (retail) and the inpatient (hospital and institutional) spending constitutes a large component of the total health care expenditures in the United States. Because expenditures for drugs used in a hospital stay are often calculated as part of hospital expenditures rather than prescription drug expenditures, spending on prescription drugs in the United States is usually reported only in terms of outpatient prescription drug expenditures. This makes prescription drug expenditures seem a smaller part of total health care spending than they really are. Obviously, while the outpatient sector is the larger component of total prescription drug spending, spending on drugs in the institutional sector is substantial, and should not be overlooked when calculating total drug spending.

(A) PRESCRIPTION DRUG SPENDING BY OLDER AMERICANS

Older Americans take more prescription drugs on average than the under age 65 population. For example, while the average

younger person takes about four prescription medications in any year, the average older American takes about 15 prescriptions medications each year. Older Americans represent about 13 percent of the population—about 34 million individuals—but account for almost one-third of all prescriptions dispensed in the United States.

In 1994, spending for prescription drugs by persons aged 65 and over amounted to more than $19 billion or 36.8 percent of total personal health expenditures for prescription drugs ($51.84 billion) (CBO national health expenditures estimates; age breakdowns estimated by private actuaries for CRS). Elderly Medicare beneficiaries spent an average of $455 a year on outpatient prescription drugs in 1993. Despite high levels of supplemental health insurance coverage, beneficiaries paid 58 percent of these costs out of pocket. Beneficiaries earning less than $5,000 a year spent significantly less per capita on prescription drugs than other beneficiaries; $389 a year, or about 15 percent less than the average. Out of pocket expenses as a percentage of total spending on prescription drugs is relatively stable across different incomes. Beneficiaries earning less than $5,000 a year paid 57 percent of their prescription drug costs out of pocket, only slightly less than the 60.6 percent paid by beneficiaries earning more than $50,000 a year.

The group of older Americans at most risk of high out-of-pocket prescription drug costs continues to be those Medicare beneficiaries that have no public or private prescription drug coverage of any type. These are individuals who are not poor enough to have Medicaid, do not have employer-based retiree prescription drug coverage, and cannot afford any other private prescription drug insurance plans.

(B) PRESCRIPTION DRUG COVERAGE AMONG OLDER AMERICANS

Most outpatient drugs used by elderly patients are not paid for by the Medicare program. Medicare Part B does fund some drugs such as flu vaccines and injections that are given as part of a physician's or hospital outpatient center's services but these costs amounted to only $1.4 billion in 1994. Part A of Medicare covers prescription drugs given to hospital and skilled nursing facility patients.

The group of older Americans most at risk of high out-of-pocket prescription drug costs was and continues to be those Medicare beneficiaries that have no public or private prescription drug coverage of any type. Almost one-half of current Medicare enrollees have no third party insurance for prescription drug coverage. Data from the 1992 Medicare Current Beneficiary Survey (MCBS) show that 37 percent of non-institutionalized enrollees had drug coverage through private insurance, and another 14 percent were covered through public programs such as Medicaid.

(C) PRESCRIPTION DRUG INFLATION

In general, prescription drug prices are determined by the forces of supply and demand in the market. The pricing of prescription drugs is of concern to society as a whole. On the one hand is the ideal goal of insuring quality and affordable health care services to all persons. On the other hand is the need to provide adequate professional and financial incentives to all providers of health care

services to ensure their near- and long-term supply. Society's concerns with respect to prescription drug pricing are reflected in legislative hearings and legislative proposals to achieve balance between the interests of research-based drug companies and the consumers' interest in having a wide range of lower-priced generic equivalents as soon as possible.

The rate of prescription drug inflation is measured by the Consumer Price Index (CPI) and the Producer Price Index (PPI). Consumer prices—as measured by the CPI—rose by about 75.4 percent from December 1980 through December 1994, or at an annual rate of 4.1 percent. Among the expenditures that contributed to this increase are prescription drugs. Tables 1 and 2 compare percent increase in the CPI and the PPI, respectively, to the percent increase in prescription drug prices.

TABLE 1.—CONSUMER PRICE INDEX (CPI) FOR ALL ITEMS AND FOR PRESCRIPTION DRUGS, 1992–1996. (1982–1984 = 100.0)

Year	CPI–All Items		CPI-Prescription Drugs	
	Index	% Change Previous Year	Index	% Change Previous Year
1992	140.3	n/a	214.7	n/a
1993	144.5	3.0	223.0	3.9
1994	148.2	2.6	230.6	3.4
1995	152.4	2.8	235.0	1.9
1996	156.9	3.0	242.9	3.4

n/a: not applicable
Source: U.S. Department of Labor. Bureau of Labor Statistics. The data were obtained from the Bureau's web page on the Internet.

TABLE 2.—PRODUCER PRICE INDEX (PPI) FOR ALL COMMODITIES AND FOR PRESCRIPTION DRUGS, 1992–1996. (1982 = 100.0)

Year	PPI–All Items		PPI-Prescription Drugs	
	Index	% Change Previous Year	Index	% Change Previous Year
1992	117.2	n/a	231.7	n/a
1993	118.9	1.5	242.0	4.4
1994	120.4	1.3	250.0	3.3
1995	124.7	3.6	257.0	2.8
1996	127.6	2.3	265.4	3.3

n/a: not applicable
Source: U.S. Department of Labor. Bureau of Labor Statistics. The data were obtained from the Bureau's web page on the Internet.

The data on consumer prices does not indicate clearly that the rise in prescription drug prices may have contributed to the rise in the all items index. For example, in 1995, prescription drug prices rose by less than 2 percent, while the CPI for all items rose by nearly 3 percent. One reason that prescription drug prices might not have had a greater effect on the overall CPI is the competition among sellers in the retail market. The kinds of retail outlets are several: the so-called traditional stand along pharmacy, the chain pharmacies, general merchandise stores (e.g. K–Mart), and food stores. The competition among these kinds of stores could suppress increases in prices over time. In addition, price competition between name brand and generic drug substitutes was credited with holding down medical care prices in 1994.

Data also indicates that in the overall market, most of the five leading products—as measured by 1996 sales volume—had inflation rates below or close to the CPI rate. Prices for the top drug,

Glaxo Wellcome's Zantac, remained flat, while Astra Merck's Prilosec actually decreased 0.9 percent. Prozac (Lilly) increased at 3.7 percent, Epogen (Amgen) was down 1.8 percent and Zoloft (Pfizer) was up to 3.3 percent. Thus, the blockbuster drugs, which manufacturers look to for profit, are mostly experiencing only modest price increases.

PRICE CHANGES FOR LEADING DRUGS—1996

Product	Fourth Quarter Sales (Dollars) (000s)	Percent Increase Over 1995 Sales	Retail Price, Percent Increase Fourth Quarter 1996
Zantac	1,760,726	−18	+0.3
Prilosec	1,741,898	+46	−0.9
Prozac	1,685,345	+14	+3.7
Zoloft	1,097,819	+23	+3.1
Epogen	1,183,595	+23	−1.8

Source: Retail Provider

Of the 2.47 billion outpatient prescriptions dispensed in 1996, nearly 90 percent were filled by community retail pharmacies. The elderly, on average, consume 12–15 prescription medications annually, compared to 4–6 for the general population. Of the 38 million eligible to participate in Medicare, which does not cover out-patient prescription drugs, 17.5 million lack any form of prescription coverage. The remainder have drug benefit coverage through private insurance, Medicap policies, or through Medicaid.

(D) VOLUNTARY PHARMACEUTICAL MANUFACTURER PRICE RESTRAINTS

Evidence suggests that moderation of prescription drug prices is not as pronounced in the retail sector as it is in the managed care sector. These retail price increases occurred in spite of the fact that several drug manufacturers had pledged to "voluntarily" restrain their price increases to the rate of inflation as measured by the CPI.

By the end of 1993, 18 drug manufacturers made some type of "voluntary" price restraint pledge. However, evidence suggests that these pledges may not have translated into meaningful price restraint at the retail level, where most older Americans buy their drugs. The basic approach advocated by most of the manufacturers was to limit their "weighted average price" increase to the rate of inflation. In calculating this weighted average price, the manufacturer would take into account all prices and price increases to all of the manufacturer's customers; hospitals, HMOs, nursing homes, mail order houses, and community pharmacies.

However, manufacturers traditionally negotiate much lower prices and price increases with the institutional health care sector, such as hospitals and HMOs. The lower prices in the institutional side can, in many cases, more than offset the higher prices and higher price increases in the outpatient sector. Therefore, drug prices could still increase significantly on the outpatient side, but these increases would not be evident when calculating the manufacturer's weighted average price because they would be diluted by the lower prices on the institutional side.

Therefore, weighted average price limits by themselves are not as effective as holding individual retail product package size price

increases to the rate of inflation. This fact is evident after examining price increases on those prescription drugs commonly taken by older Americans. Table 2 illustrates the price increases from 1992 to 1997 for top prescription products sold to elderly patients.

PRICE INCREASES, 1/1/92–1/1/97, FOR TOP PRESCRIPTION PRODUCTS SOLD TO ELDERLY PATIENTS SORTED BY PRICE INCREASE PERCENT

Produce Name	Form	Manufacturer
46.5% K–DUR	TAB 20MEQ CR	KEY
45.0% AZMACORT	AER 100MCG	RHONE POULENC RORER
39.9% TRENTAL	TAB 400MG CR	HOECHST MARION ROUSSELL
34.0% CARAFATE	TAB 1GM	HOECHST MARION ROUSSELL
30.4% BIAXIN	TAB 500MG	ABBOTT
30.0% AXID	CAP 150MG	LILLY
28.4% ATROVENT INH	AER 18MCG/AC	BOEHRINGER INGELHEIM
27.7% PROZAC	CAP 20MG	DISTA
26.3% CIPRO	TAB 500MG	BAYER
23.2% PEPCID	TAB 20MG	MERCK HUMAN HEALTH
23.1% VASOTEC	TAB 20MG	MERCK HUMAN HEALTH
23.1% VASOTEC	TAB 5MG	MERCK HUMAN HEALTH
23.1% VASOTEC	TAB 2.5MG	MERCK HUMAN HEALTH
23.1% VASOTEC	TAB 10MG	MERCK HUMAN HEALTH
21.1% PROCARDIA XL	TAB 30MG CR	PFIZER U.S.
20.4% HUMULIN N	INJU–100	LILLY
19.7% NITRO–DUR	DIS 0.2MG/HR	KEY
19.7% NITRO–DUR	DIS 0.4MG/HR	KEY
17.5% MEVACOR	TAB 20MG	MERCK HUMAN HEALTH
17.5% MEVACOR	TAB 40MG	MERCK HUMAN HEALTH
16.4% PROCARDIA XL	TAB 60MG CR	PFIZER U.S.
15.3% TICLID	TAB 250MG	ROCHE
12.2% ZANTAC	TAB 150MG	GLAXO WELLCOME
11.9% PROCARDIA XL	TAB 90MG CR	PFIZER U.S.
11.4% PRAVACHOL	TAB 20MG	B–M SQUIBB U.S. (PRIMARY CARE)
9.3% PRILOSEC	CAP 20MG CR	ASTRA/MERCK
6.4% CARDIZEM CD	CAP 240MG/24	HOECHST MARION ROUSSEL
6.0% CARDIZEM CD	CAP 300MG/24	HOECHST MARION ROUSSEL
5.0% CARDIZEM CD	CAP 180MG/24	HOECHST MARION ROUSSEL

(E) CONGRESSIONAL RESPONSE

Society's concerns with respect to prescription drug pricing are reflected in legislative efforts to achieve balance between the interests of research-based drug companies and the consumers' interest in having a wide range of lower-priced generic equivalents as soon as possible. In his opening statement to a hearing of the Senate Judiciary Committee on March 5, 1996 to assess the effectiveness of (P.L. 98-417), the Drug Price Competition and Patent Term Restoration Act of 1984 (that is often referred to as the Hatch-Waxman Act), Senator Orrin Hatch commented that the Act continues to provide incentives for drug companies to undertake research on new drugs while enabling low cost, generic equivalents that are relied upon by consumers to come quickly to the market. The Hatch-Waxman Act provided a statutory mechanism which enabled generic drug producers to bring their equivalent products to market immediately upon expiration of the patent.

(F) THE ROLE OF LARGE PAYERS FOR PRESCRIPTION DRUGS

In recent years insurance companies, hospitals, HMOs and other managed care organizations and government have become major countervailing forces against the presumed high prices of research-

based pharmaceutical manufacturers. Hospitals and HMOs and other managed care organizations exert influence on drug prices through the establishment of formularies. In essence, formularies are lists of drugs that these organizations rely upon for dispensing and to achieve financial objectives. Managed care organizations and insurance companies attempt to shift patients to drugs listed on the formulary by monitoring the extent to which doctors prescribe them. Those doctors who do not meet the insures' criteria are reportedly subject to pressure from so-called pharmacy benefit managers. Insurers also provide incentives to policy holders to use mail order pharmacies which at least offer administrative cost savings to the insurance companies. Mail order pharmacies, which also have formularies, are large enough to bargain for lower wholesale prices. Given the captive patient base of the large payers, the use of formularies enables these organizations to bargain intensively with the drug companies on the basis of price.

In 1994, a Los Angeles Times report presented data showing that hospitals could buy various drugs at prices as much as and perhaps more than 90 percent below the wholesale price charged to retail druggists. Similarly, HMOs and other managed care facilities are reported to be increasingly aggressive in dealing with pharmaceutical manufacturers with respect to price. These organizations are able to exert influence on price by establishing highly restrictive formularies.

Government exerts its influence on prices by requiring drug manufacturers to provide rebates to States for Medicaid and Veterans Administration drug purchases. The Boston Consulting Group (BCG) indicates that Medicaid rebates are at least 15.7 percent of the manufacturer's weighted average price for all products. BCG also states that a minimum 24 percent discount in price is required to be given to the Veterans Administration.

7. Health Care for an Aging U.S. Population

Advances in medical care, medical research, and public health have led to a significant improvement in the health status of Americans during the twentieth century. Between 1900 and 1995, the average life expectancy at birth increased from 46 years to 73.4 years for men, and from 48 to 79.6 years for women. The American population is aging at an accelerating rate, due to increasing longevity and the number of "baby boomers" who will begin to reach age 65 in the year 2011. Until about 2050, when the latest born of this group turn 85, there will likely be increasing numbers of chronically ill and disabled elderly people requiring greater amounts of of health care and other services..

Also, while life expectancy is considered a key indicator of health status, increased longevity among the elderly raises questions about the quality of these extended years and whether they can be spent as healthy, active members of the community.

Self-assessed health is a common method used to measure health status, with responses ranging from "excellent" to "poor." Poor health is not as prevalent as many assume, especially among the young old. Among noninstitutionalized persons in 1992, three in four aged 65 to 74 consider their health to be good, very good, or excellent, as do about 2 in 3 aged 75 and over.

Family income is directly related to the elderly person's perception of their health. Income level is also strongly correlated with morbidity and mortality, lending credibility to the use of this measure as an assessment tool. In 1994, about 49 percent of older people with incomes over $35,000 described their health as excellent or very good, compared to others their age, while only 29 percent of those with low incomes (less than $10,000) reported excellent or very good health.

As chronological age increases, however, so does the probability of having multiple chronic illnesses. Over 80 percent of the elderly report having at least once chronic condition. The chronic condition most highly reported by Americans 65 years and older is arthritis. Over three of five noninstitutionalized 75-and-older women and more than one in three of the men reported they had arthritis. For men 75 and over, the second most frequently reported chronic condition, after hearing impairment, was heart conditions (40 percent). For women in this age group, the second ranked chronic condition, following arthritis, was hypertension. With age, rates of hearing and visual impairments also increase rapidly. Alzheimer's disease is expected to become a significant source of illness and mortality in coming years, as the numbers of the oldest old grow. According to the National Institute on Aging, as many as 4 million people in the United States and about half the persons 85 years and older have symptoms.

The extent of need for personal assistance with everyday activities also increases with age and is an indicator of need for health and social services. Non-institutionalized elderly persons reporting the need for personal assistance with everyday activities in 1990–91 increased with age, from only 9 percent of persons aged 65 to 69 up to 50 percent of the oldest old.

Demographic trends have important implications for Medicare and Medicaid, the two open-ended entitlement programs which fund health and long term care services for the elderly. As of 1995, Medicare and Medicaid provided health insurance for 96 percent of people age 65 and over.

The U.S. population is aging rapidly, creating significant growth in the numbers of individuals eligible for Medicare. The elderly Medicare population grew from 19.1 million in 1966 to an estimated 33.3 million persons in 1996. Medicare spending has increased significantly over the last 30 years. In fiscal year 1967, Medicare spent $3.7 billion on health care for approximately 19 million elderly Americans. Elderly beneficiaries will account for 87 percent of Medicare spending in 1996 ($194.3 billion).

Medicare began with the goal of helping beneficiaries pay for acute care—the most expensive of these being inpatient hospital and physician services. In fiscal year 1967, Medicare payments for inpatient hospital services were $2.6 billion; by fiscal year 1995, that had increased to $87.7 billion. However, the inpatient hospital share of Medicare spending is shrinking as medical care is shifting more towards the outpatient setting.

The average annual benefit payment per Medicare elderly enrollee increases by age, reflecting the need for more health care as this population ages. In 1994, the average Part A payment was $1,494 for the 65 to 69 year old population, rising to $4,214 for

those 85 and older. Similarly, Part B payments increased from $1,087 for the youngest age group to $1,762 for the oldest group.

Although the economic status of the elderly as a group has improved over the past 30 years, many elderly continue to live on very modest incomes. In 1993, 72 percent of elderly beneficiaries reported incomes of less than $25,000. Thirty percent had incomes less than $10,000. Medicare coverage is an integral part of retirement planning for the majority of the elderly; however, there are a number of particularly vulnerable subgroups within the Medicare's population who depend greatly on the security Medicare provides to meet some basic health needs, including the disabled, the "oldest" old, particularly women over the age of 85, and the poor elderly. The majority of Medicare spending is for beneficiaries with modest incomes: 38 percent of program spending is on behalf of those with incomes of less than $10,000; 76 percent of program spending is on behalf of those with incomes of less than $25,000.

Most persons spend a portion of their incomes out-of-pocket for health care. This spending includes payments for health insurance, medical services, prescription drugs and medical supplies. The percentage of after-tax income that the elderly spend on health care has risen from 11 percent in the early 1960s to 18 percent in 1994. In contrast, the percentage spent by nonelderly households has remained relatively constant—declining from 6 percent in the early 1960s to 5 percent in 1994. The higher percentage spent by the elderly reflects several factors, including payments by this population for long-term care services and the premiums paid by those elderly persons who purchase supplemental insurance (i.e., "Medigap") policies.

Because per capita, the elderly consume four times the level of health spending as the under 65 population, the demands of an aging population for health services will continue to be a major public policy issue. It is difficult however to predict the numbers of people that will need long-term care. Much depends on whether medical technology can increase active life expectancy among the oldest old as well as increase the length of life. If symptoms of diseases which disproportionately afflict the aged could be delayed by 5 or 10 years, more of the end of life could be lived independently with fewer expensive medical services.

Chapter 8

MEDICARE

A. BACKGROUND

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Over the past two decades, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In fiscal year 1996, Medicare insured approximately 38 million aged and disabled individuals at an estimated cost of $194.3 billion ($212 billion in gross outlays offset by $20.0 billion in beneficiary premium payments). Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

Medicare (authorized under title XVIII of the Social Security Act) provides health insurance protection to most individuals age 65 and older, to persons who have been entitled to Social Security or Railroad Retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of the Hospital Insurance (HI) program (Part A) and the Supplementary Medical Insurance (SMI) program (Part B).

An insurance for short-term acute illness, Medicare covers most of the costs of hospitalization and a substantial share of the costs for physician services. However, Medicare does not cover all of the hospital costs of extended acute illnesses and does not insure beneficiaries for potentially large copayments. In 1994, approximately 81.7 percent of aged Medicare beneficiaries had supplemental coverage, including employer based coverage, individually—purchased protection (known as Medigap), and Medicaid. Another 8.7 percent were enrolled in managed care organizations which are required to provide the same coverage to beneficiaries as traditional fee-for-service Medicare.

One of the greatest challenges in the area of Medicare policy in the 1990's is the need to rein in program costs while assuring that elderly and disabled Americans have access to affordable, high quality health care.

Among recent achievements are physician payment reform, major rural health care initiatives (including the elimination of the urban-rural hospital payment differential), expansion of preventive care coverage to include screening pap smears and mammograms, and hospitalization services in a community mental health center.

There was also a successful effort to keep increases in beneficiary out-of-pocket costs to a minimum.

The 104th Congress passed H.R. 2491, the Balanced Budget Act (BBA) of 1995, which included a $270 billion savings target for Medicare over the fiscal year 1996–2002 period (The savings were later estimated at $226 billion). The bill provided for reductions in Medicare's rate of growth, largely through reductions in update factors for provider payments, and expanded the options available to beneficiaries for obtaining covered services. The conference agreement also established total spending targets for Medicare for each of the years 1998–2002. If spending targets were exceeded, a failsafe mechanism would be triggered and payments to providers would be reduced by additional specified amounts. The bill was ultimately vetoed by President Clinton.

1. Hospital Insurance Program (Part A)

Most Americans age 65 and older are automatically entitled to benefits under Part A. For those who are not automatically entitled (that is, not eligible for monthly Social Security or Railroad Retirement cash benefits), they may obtain Part A coverage providing they pay the full actuarial cost of such coverage. The monthly premium for those persons is $311 for 1997. Also eligible for Part A coverage are those persons receiving monthly Social Security benefits on the basis of disability and disabled Railroad Retirement system annuitants who received such benefits for 2 years.

Part A is financed principally through a special hospital insurance (HI) payroll tax levied on employees, employers, and the self-employed. Each worker and employer pays a tax of 1.45 percent on covered earnings. The self-employed pay both the employer and employee shares. In fiscal year 1996, payroll taxes for the HI Trust Fund amounted to an estimated $104.4 billion, accounting for 88.2 percent of all total HI financing. Taxes on a portion of social security benefits accounted for an estimated $4.0 billion (3.3 percent of the total). Interest payments, transfers from the Railroad Retirement Account and the general fund, along with premiums paid by voluntary enrollees equal the remaining 8.5 percent. An estimated $125.2 billion in Part A benefit payments were made in fiscal year 1996.

Benefits included under Part A, in addition to inpatient hospital care, are skilled nursing facility care, home health care and hospice care. For inpatient hospital care, the beneficiary is subject to a deductible ($760 in 1997) for the first 60 days of care in each benefit period. For days 61–90, a coinsurance of $190 is required. For hospital stays longer than 90 days, beneficiary may elect to draw upon a 60-day "lifetime reserve." A coinsurance of $380 is required for each lifetime reserve day.

Hospitals are reimbursed for their Medicare patients on a prospective basis. The Medicare prospective payment system (PPS) pays hospitals fixed amounts that correspond to the average costs for a specific diagnosis. PPS uses a set of approximately 490 diagnosis-related groups (DRGs) to categorize patients for reimbursement. The amount a hospital receives from Medicare no longer depends on the amount or type of services delivered to the patient, so there are no longer incentives to overuse services. If a hospital

can treat a patient for less than the DRG amount, it can keep the savings. If treatment for the patient costs more, the hospital must absorb the loss. Hospitals are not allowed to charge beneficiaries any difference between hospital costs and the Medicare DRG payment.

After Medicare changed to the PPS system in 1983, Medicare patients have been sent home from the hospital after shorter stays and, in some cases, greater need of follow-up health care which may be provided under the Medicare home health care benefit.

The home health benefit is the fastest growing part of the Medicare program. The number of persons served per 1000 enrollees increased from 50 in 1989 to 97 in 1995, a 94 percent increase for the period. In the same period, the average number of visits per person served increased 159 percent, from 27 in 1989 to 70 in 1995.

2. Supplementary Medical Insurance (Part B)

Part B of Medicare, also called supplementary medical insurance, is a voluntary, non-means-tested program. Anyone eligible for part A and anyone over age 65 can obtain Part B coverage by paying a monthly premium ($43.80 in 1997). Beneficiary premiums finance 25 percent of program costs with Federal general revenues covering the remaining 75 percent. Part B covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, durable medical equipment, and certain other services. Beneficiaries using covered services are generally subject to a $100 deductible and 20 percent coinsurance charges.

The Omnibus Budget Reconciliation Act of 1989 made substantial changes in the way Medicare pays physicians. The new law provides for the establishment of a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. The RVS is coupled with annual volume performance standards which are target rates of increase in physician expenditures. Also included in the reform were limits on actual charges to provide protection to beneficiaries from large extra-billing amounts.

3. Professional Review Organizations

Professional Review Organizations (PROs), established by the Tax Equity and Fiscal Responsibility Act of 1982, were charged with reviewing services furnished to Medicare beneficiaries to determine if the services met professionally recognized standards of care and were medically necessary and delivered in the most appropriate setting. Most PRO review is focused on inpatient hospital care; however, there is limited PRO review of ambulatory surgery, postacute care, and services received from Medicare HMOs. There are currently 53 PRO areas, incorporating the 50 States, Puerto Rico, and the territories. Organizations competitively bid for contracts include physician-sponsored organizations (composed of a substantial number of licensed physicians practicing in the PRO review field, such as a medical society) and physician-access organizations (including a sufficient number of licensed physicians to assure adequate review of medical services).

In general, each PRO has a medical director and a staff of nurse reviewers (usually registered nurses), data technicians, and other support staff. In addition, each PRO has a board of directors which includes physicians, representatives from the State Medical Associations, and a consumer representative.

PROs are paid by Medicare on a cost basis for their review work with funds apportioned each year from the Medicare HI and SMI trust funds. Spending for PROs in fiscal year 1997 was projected to be $270 million.

The PRO review process combines both utilization and quality review. Although some utilization review is done on a prospective basis, the bulk of the reviews are done retrospectively. When a PRO determines that the services provided were unnecessary or inappropriate (or both), it issues a payment denial notice. The providers, physicians and the patient are given an opportunity to request reconsideration of the determination. The PRO also checks for indications of poor quality of care as it is conducting utilization review. If a PRO reviewer detects a possible problem, further action must be taken which could result in sanctions if the PRO determines that the care was grossly substandard or if a pattern of substandard care exists.

HHS and the PROs enter into three-year contracts which must contain certain similar elements outlined in a document known as the Scope of Work. PROs are currently operating under the fifth scope of work. It was designed to encourage a continual improvement in the entire spectrum of care given to Medicare beneficiaries by emphasizing a constructive relationship with providers rather than a random examination of individual medical records. PRO medical and data experts in conjunction with communications staff, meet with providers to establish quality goals, analyze performance, and improve patient outcomes. PROs are required to use explicit, nationally uniform criteria to examine patterns of care and outcomes. Using detailed clinical information on providers and patients, PROs focus on persistent differences between *actual* indications of care and outcomes and those which are considered *achievable.* The fifth scope of work requires PROs to work on collaborative "improvement projects" in 3 specific areas of health care delivery: heart attack, diabetes, and preventive care. Each PRO is required to conduct 4–18 quality improvement projects each year, depending on the size of their beneficiary population.

4. Supplemental Health Coverage

At its inception, Medicare was not designed to cover its beneficiaries' total health care expenditures. Several types of services, such as long-term care for chronic illnesses and most outpatient prescription drugs, are not covered at all, while others are partially covered and require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare covers approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Remaining health care expenses are paid for out-of-pocket or by private supplemental health insurance, such as Medigap, by employer-based coverage, by Medicaid, or other sources. The term "Medigap" is commonly used to describe an individually-purchased

private health insurance policy that is designed to supplement Medicare's coverage.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) provided for a standardization of Medigap policies. The intent was to enable consumers to better understand policy choices and to prevent marketing abuses. OBRA 90 was amended by the Social Security Amendments of 1994 (P.L. 103–432), and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104–191). The following outlines the current requirements.

Simplification of Policies.—Benefit options were simplified to provide for a core group of benefits, and up to a maximum of nine other groups of defined Medigap packages. The defined core group of benefits is common to all defined Medigap benefit packages, and all Medigap insurers are required to offer the core group of benefits. Noncompliance with simplification standards is subject to a civil monetary penalty not to exceed $25,000.

Uniform Policy Description.—Using uniform language and format, insurers are required to provide an outline of coverage to facilitate comparisons among Medigap policies and comparisons with Medicare benefits.

Prevention of Duplicate Medigap Coverage.—It is unlawful to sell or issue the following policies for Medicare beneficiaries: (i) a health insurance policy with knowledge that it duplicates Medicare or Medicaid benefits to which a beneficiary is otherwise entitled; (ii) a Medigap policy, with knowledge that the beneficiary already has a Medigap policy; or (iii) a health insurance policy (other than Medigap) with knowledge that it duplicates private health benefits to which the beneficiary is already entitled. A number of exceptions to these prohibitions are established. A policy which pays benefits without regard to other coverage is not considered duplicative. Further, a policy offering only long-term care coverage is permitted to coordinate its benefits with Medicare.

The sale of a Medigap policy is not in violation of the provisions relating to duplication of Medicaid coverage if: (i) the State Medicaid program pays the premiums for the policy; (ii) in the case of qualified Medicare beneficiaries (QMBs), the policy includes prescription drug coverage; or (iii) the only Medicaid assistance the individual is entitled to is payment of Medicare Part B premiums.

It is unlawful for a Medigap policy to be issued unless the seller obtains from the applicant a written, signed statement stating what type of health insurance the applicant has, the source of the health insurance, and whether the applicant is entitled to Medicaid. Also, it is unlawful to sell or issue a Medigap policy, or health insurance that duplicates a Medigap policy to an individual who has a Medigap policy, unless the individual indicates in writing that the policy replaces an existing policy which will be terminated.

Loss Ratios.—Minimum loss ratios were increased to 65 percent for individually sold Medigap policies and are 75 percent for group policies. NAIC has developed a methodology for uniform calculation of actual and projected loss ratios as well as uniform reporting requirements. Policy issuers are required to provide a refund or a credit against future premiums to assure that loss ratios comply with requirements. Noncompliance with these requirements is subject to civil monetary penalties.

Renewability, Replacement, and Coverage Continuation, Preexisting Condition and Medical Underwriting Limitations.—Medigap policies are required to be guaranteed renewable. The issuer is permitted to cancel or non-renew the policy solely on the grounds of the health status of the policyholder. If the Medigap policy is terminated by the group policyholder and is not replaced, the issuer is required to offer an individual Medigap policy which provides for the continuation of benefits contained in the group policy.

Medigap insurers are required to offer coverage to individuals, regardless of medical history, for the 6-month period after an applicant turns 65; and, for the working aged, for a 6-month period when they first enroll in Medicare Part B. Also, insurers are prohibited from discriminating in the price of the policy, based upon the medical or health status of the policyholder. Violations of medical underwriting provisions are subject to civil monetary penalties.

Premium Increases.—States must have a process for approving or disapproving proposed premium increases, and establish a policy for holding public hearings prior to approval of premium increases.

Enforcement of Standards.—No policy may be sold or issued unless the policy is sold or issued in a State with an approved regulatory program, or is certified by the Secretary. States are required to report to the Secretary on the implementation and enforcement of standards.

State Approval of Policies Sold in the State.—All policies sold in a State, including policies sold through the mail, must be approved by the State in which the policy is issued.

Medicare Select.—OBRA 1990 established a demonstration project under which insurers could market a Medigap product known as Medicare SELECT. SELECT policies are the same as other Medigap policies except that they will only pay in full for supplemental benefits if covered services are provided through designated health professionals and facilities known as preferred providers. OBRA 1990 limited the demonstration project to 3 years (1992–1994 and to 15 States. The Social Security Amendments of 1994 (P.L. 103–432) extended SELECT for 6 months.

P.L. 104–18, signed into law July 7, 1995, extended the program for 3 years (to June 30, 1998) and to all States. A permanent extension beyond the 3-year period is authorized unless the Secretary of the Department of Health and Human Services (HHS) determines, based on a study, that the SELECT program significantly increases Medicare expenditures, significantly diminishes access to and quality of care, or that it does not result in lower Medigap premiums for beneficiaries.

B. ISSUES

1. Medicare Solvency and Cost Containment

Controlling expenditures within the Medicare program and looking for ways to assure the program's solvency continue to be among the highest priority issues for both the Congress and the Administration. A driving force for Medicare cost containment is the need to assure solvency of the Medicare Hospital Insurance (HI) trust fund and to control the rate of growth in expenditures in the Supplementary Medicare Insurance (SMI) trust fund. Both funds are

maintained by the Treasury and evaluated each year by a board of trustees.

Trustees projections show financial problems ahead for the HI fund. Since 1970, the trustees have been projecting the impending insolvency of the Part A trust fund. However, 1995 was the first year that the insolvency of the trust fund became a major part of the budget debate. Both the 1996 trustees report and the January 1997 estimates by the CBO project that the fund will become insolvent in 2001. In that year revenues coming into the trust fund (primarily payroll taxes), together with any balances carried over from prior years will be insufficient to cover the payment for Part A benefits in that year. Unlike Part A, Medicare Part B does not face insolvency because of the way it is financed (namely through a combination of beneficiary premiums and Federal general revenues. However, both the rapid rate of growth and the impact of this growth on general revenue spending and the Federal deficit continue to be of concern.

The CBO has estimated that, under current law, Part A outlays would grow from $137.4 billion in fiscal year 1997 to $289.7 billion in fiscal year 2007, for an average annual rate of growth of 7.74 percent. Over the same period, Part B outlays would grow from $74.6 billion to $178.9 billion, for an average annual growth rate of 9.14 percent. Net Medicare spending (after deduction of beneficiary premiums) would grow at an average of 8.57 percent per year, from $191.8 billion in fiscal year 1997 to $436.4 billion in fiscal year 2007.

These estimates do no reflect major demographic changes which are slated to affect the Medicare program. First, beginning in 2011, the babyboom generation (persons born between 1946 and 1964) begin to turn age 65. Second, there is a shift in the number of workers supporting persons receiving benefits under Part A. In 1995, there were 3.9 workers per beneficiary. The ratio is expected to decline to 3.1 by 2015 and about 2:1 by 2030.

Because of its rapid growth, both in terms of aggregate dollars, and as a share of the Federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by the Congress since 1980. With few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers. Of particular importance were the implementation of the prospective payment system for hospitals beginning in 1984 and the fee schedule for physicians services beginning in 1992. These reductions stemmed, but did not eliminate the year-to-year increases in Medicare outlays.

The 104th Congress also considered, but did not enact legislation which would have achieved significant Medicare savings through reductions in the rate of growth in payments to providers and a cap on spending. During the debate, considerable attention was also given to expanding the options available to beneficiaries for obtaining covered services and restructuring the program to make it work more like the private insurance market.

The 105th Congress is likely to revisit the proposals to achieve Medicare savings by reducing the rate of growth in payments to providers. It is also likely to reconsider proposals to increase the managed care options available to beneficiaries and to change the

payment methodology used for HMOs to take greater advantage of the forces of market competition. This perspective is, in part, encouraged by the experiences of the private sector, where the rapid movement of large group health plans from fee-for-service into managed care has helped to slow the rate of medical care inflation. (In 1987, only 27 percent of participants in employer plans were enrolled in managed care plans. By 1996, 74 percent of participants in such plans were enrolled in managed care plans.) Many also see lessons for Medicare in some of the Nation's more competitive medical marketplaces, such as California, where the growing penetration of managed care plans has stimulated substantial price competition. While these changes are not regarded by everyone as positive (concerns exist, for example, that the growth of managed care has reduced access to services for lower-income populations), substantial support exists for trying to restructure Medicare to make it work more like the large group private insurance market.

2. President's Fiscal Year 1998 Budget Proposal

The President transmitted the fiscal year 1998 budget to Congress on February 6, 1997. The budget includes proposed savings in Medicare which, based on the Administration's estimates, would save $106.1 billion over the five-year period, fiscal years 1998–2002. The CBO reestimated the savings at $82.6 billion over the same period. These proposed savings would be achieved by slowing the rate of growth in payments to hospitals, physicians, and other providers; establishing new payment methodologies for skilled nursing facilities and home health agencies; and providing flexibility to Medicare to enable it to be a more prudent purchaser of certain services and supplies. The budget also provides coverage for additional preventive benefits.

Significant savings are also achieved by making changes in Medicare's payments to health maintenance organizations (HMOs). Approximately 13 percent of Medicare beneficiaries are enrolled in HMOs. Most of these entities are paid a fixed monthly capitation payment to provide covered services to beneficiaries. The President's budget proposes to modify payments made to HMOs. It would reduce the geographic variations in payments, and carve out graduate medical education and disproportionate share hospital payments from the amounts paid to HMOs. It also would reduce payments to plans from 95 percent to 90 percent of fee-for-service expenditures. Additional savings in Medicare payments to HMOs would be indirectly achieved through the Administration's proposals to reduce the rates of increase in payments made to providers, such as to physicians and hospitals. In addition, the budget would also expand managed care options available to Medicare beneficiaries to include preferred provider organizations and provider-sponsored organizations.

3. Medicare Managed Care

In 1983, Congress authorized payment to qualified "risk-contract" HMOs or similar entities that enrolled Medicare beneficiaries. In 1996, approximately 13 percent of Medicare beneficiaries were enrolled in HMOs, most of whom were in risk HMOs.

Under the risk contract program, a beneficiary in an area served by a qualified HMO may voluntarily choose to enroll in the organization. Medicare HMOs agree to provide beneficiaries with the full range of Medicare services through an organized system of affiliated physicians, hospitals, and other providers. No more than 50 percent of the HMO's enrollees can be Medicare or Medicaid beneficiaries (the 50/50 rule). Medicare makes a single monthly capitation payment for each of the organization's Medicare enrollees, known as the adjusted average per capita cost (AAPCC). The AAPCC is Medicare's estimate of 95 percent of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who was not enrolled in an HMO and who obtained services on the usual fee-for-service (FFS) basis. Although the original intent of setting the AAPCC at 95 percent of the FFS cost was to save Medicare money, some studies have found that Medicare actually loses money because HMOs tend to enroll the relatively younger, healthier Medicare beneficiaries, leaving the FFS program with a sicker risk pool.

Medicare traditionally did not offer beneficiaries the option of participating in other types of managed care arrangements such as preferred provider organizations (PPOs) and point-of-service (POS) plans. In 1995, HCFA issued guidelines to Medicare HMOs for operating, on an optional basis, a POS option. By mid-1996, HCFA had approved POS options for 11 plans. In an attempt to test additional types of managed care delivery and financing arrangements (such as PPOs), HCFA selected managed care plans to participate in the Medicare Choice demonstration program which began enrolling beneficiaries in January 1997.

The President's fiscal year 1998 budget proposal includes a number of modifications to the Medicare managed care program. These modifications include:

- changes would be made in the method of calculating the AAPCCs;
- PPOs and PSOs that meet certain standards would be allowed to participate in the Medicare program;
- limits would be placed on charges for out-of-network services;
- the 50/50 rule would be eliminated once a new quality measurement program was in place.

4. Issues Affecting Part A Medicare Payments

(A) MEDICARE'S HOSPITAL PAYMENT UPDATE

Under Medicare's prospective payment system (PPS) for inpatient hospital care, fixed hospital payment amounts are established in advance of the provision of services on the basis of a patient's diagnosis. The base payment rate is updated annually for increases in hospital operating costs. Since hospital payments represent a significant part of total Medicare spending, and 67 percent of total Part A payments, reductions in the growth of Medicare payments to hospitals provides significant budgetary savings. During the 105th Congress, legislation reducing the growth in hospital payments is expected to be considered.

The Prospective Payment Assessment Commission (ProPAC) is mandated by the Congress to analyze the effects of PPS on hospital financial performance, including looking at hospital PPS margins and total margins. PPS margins compare Medicare capital and operating payments to costs, while total margins reflect gains and losses from all payers. The rapid drop in hospital cost growth has enabled hospitals to begin making a profit on Medicare patients despite payment updates that have been as low as at any time since PPS began. According to ProPAC these profits are the highest in the past 10 years, and higher than at any time prior to the implementation of PPS. Based on the high PPS inpatient profit margins and other factors, ProPAC recommends that the Congress enact a PPS hospital payment update for fiscal year 1998 of zero, freezing Medicare hospital payments at current levels.

The President's fiscal year 1998 budget proposal, includes reductions in Medicare's payments to hospitals of about $33 billion over 5 years and about $45 billion in 6 years, as well as other provisions affecting hospital payments. The proposal would reduce the annual PPS hospital payment update by 1.0 percent for each year from fiscal year 1998–2002. PPS-exempt hospital and distinct-part unit updates would be reduced by 1.5 percent for each year from 1998–2002.

(B) SKILLED NURSING FACILITIES (SNFS)

Currently Medicare reimburses the great bulk of SNF care on a retrospective cost-based basis. This means that SNFs are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide. For Medicare reimbursement purposes, the costs SNFs incur for providing services to beneficiaries can be divided into three major categories: (1) routine services costs that include nursing, room and board, administration, and other overhead; (2) ancillary services, such as physical and occupational therapy and speech language pathology, laboratory services, drugs, supplies and other equipment; and (3) capital-related costs.

Routine costs are subject to national average per diem limits. Separate per diem routine cost limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding SNF routine limits are set as 112 percent of the average per diem labor-related and nonlabor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limits and 112 percent of the average per diem routine services costs of hospital-based SNFs. Routine cost limits for SNF care are required to be updated every 2 years. In the interim the Secretary applies a SNF market basket developed by HCFA to reflect changes in the price of goods and services purchased by SNFs. OBRA 93 eliminated updates in SNF routine cost limits for cost reporting periods beginning in fiscal year 1994–1995.

Ancillary service and capital costs are both paid on the basis of reasonable costs and neither are subject to limits.

Cost-based reimbursement has been cited as one of the reasons for significant growth in SNF spending since 1989. Spending has increased from $3.5 billion in 1989 to $11.7 billion in 1996, for an

average annual rate of growth of 19 percent. Growth in SNF spending can be explained largely by the increasing number of persons qualifying for the benefit and increases in reimbursements per day of care. Numbers of persons served has nearly doubled since 1989, reaching 1.15 million persons in 1996. Average payments for care have grown from $117 per day in 1989 to $292 per day in 1996. Increases in ancillary service reimbursements explain much this per diem payment growth.

The President's fiscal year 1998 budget would implement a SNF prospective payment system beginning in fiscal year 1998. Payments would cover routine, ancillary, and capital-related SNF costs and would be case-mix adjusted to reflect patients' varying service needs. Rates would be set to capture permanently the savings from the OBRA 93 freeze on SNF cost limits.

(C) HOME HEALTH

Both Parts A and B of Medicare cover home health. Neither Part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d) of Medicare law prohibits payments to be made under Part B for covered services to the extent that individuals are also covered under Part A for the same services. As a result, the comparatively few persons with Part B coverage only are the only beneficiaries for whom payments are made under Part B.

Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to limits.

Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide). Cost limits, however, are applied to aggregate agency payments; that is, an aggregate cost limit is set for each agency that equals the agency's limit for each type of service multiplied by the number of visits of each type provided by the agency. Limits for the individual services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies (i.e. agencies not affiliated with hospitals). To reflect differences in wage levels from area to area, the labor-related portion of a service limit is adjusted by the current hospital wage index. Cost limits are updated annually by applying a market basket index to base year data derived from home health agency cost reports.

Cost-based reimbursement for home health has been criticized as providing few incentives for maximizing efficiency, minimizing costs, or controlling volume of services. It is cited as one of the reasons for the significant growth in home health spending since 1989. Spending has increased from $2.6 billion in 1989 to $18.1 billion in 1996, for an average annual rate of growth of 32 percent. Most of the growth in spending has been the result of an increasing volume of services being covered under the program, both in terms of increases in the numbers of users as well as the number of covered visits per user.

The President's fiscal year 1988 budget would implement a home health prospective payment system (PPS) beginning October 1, 1999 (fiscal year 2000). Payments would be based on an episode of care for a time period as yet undefined. Budget neutral rates under the new PPS would be calculated after reducing expenditures that exist on the last day prior to implementation by 15 percent.

In the interim, home health agencies would be paid the lesser of: (1) the actual costs (i.e. allowable reasonable costs); (2) the per visit cost limits, reduced to 105 percent of the national median; or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs. In addition, beginning January 1, 1998, payments would be based on the location where services are rendered, rather than where they are billed.

The President's budget would also divide financing of the home health benefit between Parts A and B. Effective in fiscal year 1998, the first 100 visits following a 3-day hospital stay would be reimbursed under Part A. All other visits would be reimbursed under Part B. These would include visits for persons needing more than 100 visits following a hospitalization, visits for persons who have not had a 3-day prior hospitalization, and visits for those persons with Part B coverage only. For up to 18 months after enactment Part A would pay what would otherwise be Part B costs for Part A only individuals; subsequently, Part A only individuals would only have payments made for the newly defined Part A benefits.

The proposal has the effect of extending the solvency of the Part A trust fund by shifting some Part A costs to Part B. While Part B premiums generally equal 25 percent of total Part B costs, the premium would not be increased to reflect the cost of the additional Part B benefits.

5. Issues Affecting Part B

(A) PART B PREMIUM

When Medicare was established in 1965, the Part B monthly premium was intended to equal 50 percent of program costs. The remainder was to be financed by Federal general revenues, i.e., tax dollars. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which social security benefits were adjusted for the cost-of-living (i.e., cost-of-living or COLA adjustments). As a result, revenues dropped to below 25 percent of program costs in the early 1980s. Since the early 1980s, Congress has regularly voted to set the premium equal to 25 percent of costs. Under current law, the 25 percent provision is extended through 1998.

Under current law, the COLA limitation would again apply in 1999. If this were to occur, beneficiaries' contributions to Part B would decline below 25 percent. The President's proposal would permanently set the Part B premium at 25 percent of program costs.

Some persons have proposed income-relating the Part B premium. They argue that it is inappropriate for taxpayers to be paying three-fourths of Part B costs for high income Medicare beneficiaries. In particular, they point out that low and middle income working persons may be subsidizing higher income elderly persons.

Many persons share the concern that taxpayers are subsidizing the high income elderly. However, many persons oppose turning Medicare into a means tested program. Of particular concern is the possibility that the income thresholds might be lowered at a future date in order to achieve additional budget savings. Many also claim that the requirement would be costly to administer because of the need to obtain and verify information on income.

(B) PAYMENTS TO PHYSICIANS

Medicare pays for physicians services on the basis of a fee schedule. The fee schedule assigns relative values to services. Relative values reflect three factors: physician work (time, skill, and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically adjusted relative values are converted into a dollar payment amount by a dollar figure known as the conversion factor. There are three conversion factors—one for surgical services, one for primary care services, and one for other services. The conversion factors in 1997 are $40.96 for surgical services, $35.77 for primary care services, and $33.85 for other services.

The conversion factors are updated each year by a formula specified in the law. The update equals inflation plus or minus actual spending growth in a prior period compared to a target known as the Medicare volume performance standard (MVPS). (For example, fiscal year 1995 data were used in calculating the calendar 1997 update.) However, regardless of actual performance during a base period, there is a 5 percentage point limit on the amount of the reduction. There is no limit on the amount of the increase.

Conversion Factor.—The President's fiscal year 1998 budget proposal would set a single conversion factor beginning in 1998, based on the 1997 primary care conversion factor, updated to 1998 by a single average fee update. The proposal would replace the MVPS with a cumulative "sustainable growth rate" based on real gross domestic product (GDP) growth. This new target would begin affecting updates in 1999. The proposal would also place an upper limit on allowable fee increases—three percentage points above inflation. The lower limit on decreases would change from inflation minus 5 percentage points to inflation minus 8.25 percentage points.

The Physician Payment Review Commission (PPRC), a congressional advisory body, has recommended use of a single conversion factor and replacing the MVPS with a sustainable growth rate; however there are a number of technical differences between the PPRC and Administration proposals.

Practice Expenses.—While the calculation of the physician work portion of the fee schedule is based on resource costs, the practice expense and malpractice expense components continue to be based on historical charges. The Social Security Amendments of 1994 (P.L. 103–432) required the Secretary of HHS to implement a resource-based methodology for practice expenses in January 1998. In response, HHS established mechanisms for determining both direct and indirect costs; however, a low response to a survey made collection of some of the necessary data difficult. In early 1997, HCFA outlined the potential impact of four possible options for de-

termining resource-based practice expense relative values that it had under consideration; however, it emphasized that another option might be selected before publication of the proposed regulation, slated for May 1997. Under the potential scenarios, some physician specialties, primarily surgeons, would see major reductions in Medicare practice expense payments, while other specialties would see increases. In some cases, a given specialty could see either an increase or a decrease depending on the option selected.

Many physicians question the accuracy of the current data, and argue that HCFA needs more time to obtain better data and validate its methodology. They have therefore recommended that implementation of the resource-based methodology be delayed for one year. However, the PPRC and some physician groups argue that the current charge-based system needs to be replaced and suggest that the date will not be better in one year.

(C) MEDICARE PAYMENTS FOR HOSPITAL OUTPATIENT DEPARTMENTS

Medicare beneficiaries receive services in a variety of ambulatory facilities, including hospital outpatient facilities. Under Medicare, the aggregate payment to hospital OPDs and hospital-operated ambulatory surgical centers (ASCs) for covered ASC procedures is equal to the lesser of the following two amounts: (1) the lower of the hospital's reasonable costs or customary charges less beneficiary deductibles and coinsurance, or (2) the amount determined based on a blend of the lower of the hospital's reasonable costs or customary charges, less beneficiary deductibles and coinsurance, and the amount that would be paid to a free-standing ASC in the same area for the same procedures. For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42 and 58 percent, respectively.

Unlike most other Part B services where beneficiary cost sharing is 20 percent of the total Medicare payment, for hospital outpatient department services beneficiary coinsurance is set in law at 20 percent of charges. Because charges are much higher than payments, beneficiaries using hospital outpatient services are responsible for significantly more than 20 percent of the total payment. ProPAC reports that for certain surgical, radiological, and diagnostic procedures, Medicare beneficiaries, on average, are liable for more than half of the total amount paid. Moreover, beneficiary liability for services provided in hospital outpatient departments is considerably higher than if the same service were provided in a different ambulatory setting.

ProPAC recommends that the Congress change beneficiary liability for hospital outpatient services from 20 percent of charges to 20 percent of the allowable Medicare payment, despite the fact that this change would increase Medicare expenditures. The President's fiscal year 1998 Medicare budget proposal includes this change in beneficiary liability for hospital outpatient services.

(D) DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETICS AND ORTHOTICS (PO)

Medicare covers a wide variety of DME and PO. As defined, DME must be equipment that can withstand repeated use, is used primarily to serve a medical purpose, generally would not be useful

in the absence of illness or injury, and is appropriate for use in the home. A home can include an institution such as an old age home, but not a hospital or skilled nursing facility. DME includes such items as iron lungs, hospital beds, wheelchairs, and such supplies that are necessary for their effective use, such as drugs and biologicals necessary for the equipment's proper functioning. Prosthetics and orthotics are items which replace all or part of an internal organ (such as colostomy bags and intraocular lenses), other devices such as cardiac pacemakers, prostheses, back braces, and artificial limbs.

DME and PO are reimbursed on the basis of a fee schedule established by the Omnibus Budget Reconciliation Act of 1987. Payment is the lesser of 80 percent of the actual charge or the fee schedule amount. If it is determined that the standard rules for calculating payment result in an amount which is "grossly excessive or grossly deficient and not inherently reasonable," the Secretary of HHS is permitted to increase or decrease this amount accordingly. The authority to make these adjustments is referred to as the inherent reasonableness authority. A lengthy process, involving public notices and input from all interested parties, must be followed before a change in the reimbursement level can be made. This process or congressional legislation are the only methods through which HCFA can address inappropriate reimbursement levels. The reimbursement program is administered through four regional carriers. Suppliers of DME and PO (who must meet a number of standards in order to participate in the program) submit their claims to the carrier in their region.

Investigations have shown that Medicare payments for DME and PO are higher than those made by other health care insurers and other government agencies, including the Department of Veterans Affairs (VA). Some interested parties, including HCFA, have suggested granting HCFA the authority to bid competitively for selected items of DME and PO, a practice currently used by the VA. The VA acquisitions process includes developing specifications for equipment and requirements for services in a geographic area, and soliciting bids from suppliers. HCFA feels that, given certain considerations, competitive bidding arrangements could be appropriate for certain items of DME and PO under the Medicare program.

The President's fiscal year 1998 budget proposal contains a provision which would allow the Secretary of HHS to bid competitively for DME and PO (as well as certain laboratory services and other medical items and supplies). The items included in a bidding process and the geographic areas selected for bidding would be determined by the Secretary, based on the availability of suppliers and the potential for savings. The Secretary would be permitted to exclude suppliers whose bids were determined to be too high. An automatic reduction in rates would be triggered if a 20 percent reduction had not been achieved by 2001.

(E) MEDICARE'S COVERAGE OF PREVENTIVE SERVICES

Medicare covers health services which are reasonable and necessary for the diagnosis and treatment of illness of injury. In general the program does not cover preventive services. In recent years, Congress has responded to concerns about the lack of this

coverage by amending and expanding Medicare law. As a result of this legislation, the program covers the following preventive services (unless otherwise noted, beneficiaries are liable for regular Part B cost-sharing charges: $100 annual deductible and 20 percent coinsurance):

Pneumococcal Pneumonia Vaccination.—Effective July 1980, Medicare began covering the costs for vaccinations against pneumococcal pneumonia, a condition to which the elderly are especially susceptible. The benefit covers 100 percent of the reasonable costs of the vaccine and its administration when prescribed by a doctor (i.e., not subject to deductible or coinsurance).

Hepatitis B Vaccination.—On September 1, 1984, Medicare began coverage of hepatitis B vaccinations for high- or intermediate-risk beneficiaries when prescribed by a doctor. High-risk individuals include patients with end-stage renal disease (ESRD), certain hemophiliacs, certain individuals who have been exposed to hepatitis B, homosexual men, certain drug users, and people residing in institutions for the mentally retarded. Intermediate-risk individuals include staff in institutions for the mentally retarded and certain health care workers. The benefit includes the vaccine and its administration.

Screening Pap Smears.—On July 1, 1990, Medicare began covering pap smears screening for early detection of cervical cancer. The benefit includes the test, which must be prescribed by a physician in order to be covered, and its interpretation by a doctor. The test is covered once every three years The Secretary of the Department of Health and Human Services (HHS) may specify a shorter interval in the case of women at "high risk of developing cervical cancer." No beneficiary cost-sharing is imposed.

Screening Mammography.—This benefit, for early detection of breast cancer, became effective January 1, 1991. It provides coverage for the test and interpretation by a doctor. There is an established limit on payment ($63.34 for 1997). Frequency of coverage is dependent on the age and risk factors of the woman:

- for women over 34 but under 40, a limit of one test during that period
- for women over 39 but under 50
  - at high risk, one test annually
  - not at high risk, one test every two years
- for women over 49 but under 65, one test annually
- for women over 64, one test every two years

A prescription or referral by a doctor is not necessary for coverage.

Influenza Vaccination.—Another disease that widely affects the elderly is influenza. Medicare began 100 percent of the cost of influenza virus vaccine and its administration on May 1, 1993, for all Medicare beneficiaries. Coverage does not require a physician's prescription or supervision, and is not subject to coinsurance or deductible.

The President's fiscal year 1998 budget proposes expanding these benefits to include:

- coverage for annual screening mammograms for all women aged 40 and over, waiving coinsurance requirements

• coverage for four common screening procedures for colorectal cancer. These are barium enemas, colonoscopy, sigmoidoscopy, and fecal-occult blood tests. Cost sharing would apply.

• an increase in the payment levels for preventive injections and waiver of the cost-sharing requirements for hepatitis B vaccines.

6. Prescription Drugs

(A) BACKGROUND

Medicare provides coverage for prescription drugs used as part of a hospital stay, but in general does not cover outpatient prescription drugs. There are some exceptions, which include prescription drugs used:

In conjunction with dialysis treatment under the Medicare End State Renal Disease (ESRD) program. Items covered under this program include (EPO) erythropoietin, used in the treatment of anemia which often is a complication of chronic renal failure;

Incidental to a physician's service if provided in the physician's office, such as an injectable product;

In immunosuppressive therapy, such as cyclosporin, for the first 30 months (first 36 months beginning in 1998) after an individual receives a Medicare-approved transplant, such as a kidney or liver transplant; and

Oral cancer drugs, in certain cases.

As an option to the current fee-for-service program, Medicare beneficiaries can choose to obtain all the health care services from a managed care plan that has a risk contract with the Medicare program. Some of these managed care plans offer outpatient prescription drugs as part of their standard benefits package. As of March 1997, 69.5 percent of plans that had risk contracts with Medicare offered prescription drugs as part of their standard benefits package.

Beneficiaries may also obtain drug coverage, under some employer-based policies: They may also purchase one of the Medigap policies that offers partial prescription drug coverage. Beneficiaries who are "dual eligible," (i.e., also have Medicaid) have prescription drug coverage.

(B) CURRENT POLICY ISSUES/RECENT LEGISLATIVE CHANGES

(1) Coverage of Oral Cancer Drugs

In 1994, Medicare began covering oral cancer drugs if the active ingredient in the oral form of the drug is the same as the active ingredient in the intravenously administered form of the anti-cancer drug already covered by Medicare. Under this provision, Medicare covers the FDA-approved indications (commonly known as "off-label" use) for the oral cancer drug which appears in any one of the three authoritative medical compendia. Covered drugs are cyclophosphamide, etoposide, mephalan, and methotrexate. Also included, as of January 1996, are self-administered antiemetic drugs when needed for the administration and absorption of the primary Medicare covered oral anti-cancer drug.

Chapter 9

MEDICAID AND LONG-TERM CARE

OVERVIEW

Long-term care, which encompasses a range of health, social, and residential services, is provided to compensate for disabilities caused by physical, cognitive, or mental impairments. For years long-term care has been considered a step-child in the health care arena. However, the health care reform debate over the last few years combined with the stark reality of a growing elderly and disabled population have advanced this issue to the forefront of public policy. There is unprecedented consensus that long-term care needs to be a part of any discussion about government, private sector, and personal responsibility for health care.

Among older people, who still use the majority of long-term care services, there is a drive for change. Perhaps the most compelling argument for change is the fact that the expense of long-term care, especially nursing home care, can bankrupt a family. Many Americans are under the false impression that Medicare or their traditional health insurance will cover long-term care costs. Too often it is only when a family member becomes disabled that they learn that these expenses will have to be paid for out-of-pocket. Furthermore, individuals whose long-term care needs arise as a result of a sudden onset of a stroke or other illness do not have adequate time to plan for the set of services that best meets their needs. With the cost of institutionalized care ranging from $35,000–$60,000 a year and home care costs between $35–$100 a day, long-term care expenses are unaffordable to even middle and upper-middle class families. Another argument for change is the preference of many older people and their families to receive services in home and community-based settings. Our current long-term care system relies predominately on institutionalized care and there is very little coverage, either through private or public programs, for home and community-based services.

Despite often heroic efforts by family members to care for their loved-ones at home and help pay for uncovered expenses, many older and disabled Americans most eventually rely on Medicaid to pay for their long-term care. Medicaid, a joint Federal/State matching entitlement program that pays for medical assistance for low-income persons, has increasingly become the primary payor of long-term care costs in this country. In fact, in 1993 Federal and State spending for nursing home care—mostly through the Medicaid program—was in excess of $30 billion; and an additional $15 billion was spent for home care. For many states long-term care has become the fastest growing part of state budgets. With the reality

that long-term care costs will only worsen as the population grows older in the next few decades, both the Federal and State governments recognize the urgency in controlling the ever-growing costs of Medicaid long-term care.

Long-term care describes the set of services provided to individuals with disabilities or chronic health conditions that dictate a need for ongoing assistance. It differs from other types of health care in that the goal of long-term care is not to cure an illness, but to allow an individual to attain and maintain an optimal level of functioning. Long-term care also differs from other types of health care in that it includes services that are social, as opposed to purely medical, in orientation. Indeed, for many persons needing long-term care, a mixture of social services can best meet their needs. Because an individual's needs can change, long-term care is most effective when it encompasses a true continuum of services.

Despite the advances in our thinking about long-term care, neither the private nor public sector have found adequate ways to finance long-term care. With the trend toward reducing the growth of entitlement programs and the fact that long-term care costs are simply too high for most American families, it seems likely that both sectors will be critical in financing the long-term care needs of our nation's elderly and disabled population. In recent years, there has been a growth in the private long-term care insurance market, but still, less than 2 percent of the population is covered for long-term care expenses. How long-term care should be organized and delivered, how broadly it should be defined, who should be eligible for publicly funded services—all of these are policy issues being hotly debated in Congress and State legislators throughout the country.

Chairman William S. Cohen and other Senate colleagues introduced legislation in the 104th Congress to provide incentives, through the tax code, for persons and employers to purchase private long-term care insurance. These provisions were contained in the conference agreement on H.R. 2491, the Balance Budget Act of 1995. The Balanced Budget Act also included provisions to restructure Medicaid into a block grant program. While significant cost savings would have been realized by this approach to Medicaid reform, significant disputes over the impact this kind of restructuring would have had on health care services to low-income Americans made it highly controversial. Due to disputes over this and other program changes, the President vetoed the legislation.

Negotiations on the budget have continued to take center stage throughout the early part of 1996 and Medicaid restructuring has remained at the center of this debate. While aggregate savings proposed by both sides for Medicaid came closer together, significant differences in policy and numbers still exist and have left closure on a balanced budget agreement in jeopardy.

This chapter will describe the various types of long-term care, the population served, the settings in which services are provided, and the providers and payors of long-term care services. The Federal programs which finance part of the long-term care system will be discussed, and special issues pertinent to health care reform will be presented. Some of the special issues to be addressed in this chapter include inconsistency in the long-term care system, the role

of care management, long-term care insurance, acute and long-term care integration, and ethical issues. Finally, the prognosis for long-term care in the United States will be discussed.

A. BACKGROUND

1. What Is Long-Term Care?

Long-term care today encompasses a wide array of medical, social, personal, and supportive and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Long-term care services range from skilled medical and therapeutic services for the treatment and management of these conditions to assistance with basic activities and routines of daily living, such as bathing, dressing, eating, and housekeeping. Any discussion about long-term care should include a discussion about its scope and definition. For the purposes of this section, long-term care includes a continuum of services of differing intensity. Although vocabulary can differ by funding program, region, and provider, the following is a description of the services most commonly included in the long-term care continuum. An effort is made to organize this section in order of increasing service intensity, but that is not always possible due to the varying nature of some of the services.

(A) ADULT DAY CARE

According to the National Council on the Aging's National Institute of Adult Day Care, adult day care is a community-based group program designed to meet the needs of adults with functional impairments through an individual plan of care. It is a structured, comprehensive program that provides a variety of health, social, and related support services in a protective setting during any part of a day, but less than 24-hour care. Individuals who participate in adult day care attend on a planned basis during specified hours. Adult day care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with an impairment."

There are currently no Federal regulations governing the provision of adult day care, but some States have their own requirements. Adult day care is sometimes separated into medical model and social model programs. The difference between the two varies by State, but essentially the distinction arises from staff qualifications required under each model, as well as what services can be provided to participants in the adult day care setting. Not every State makes such a distinction.

(B) HOME CARE

Several subcategories of care are provided in the in-home setting, including home health care, various types of rehabilitative therapy, personal assistance, personal care, and homemaker/chore services. It is important to note that not all of the above services are provided exclusively in the home. For example, personal assistance is a service that can be provided in any setting, including a workplace, to a person with a disability.

Patients requiring home care may or may not require medical care, but almost always require assistance in essential every day tasks called activities of daily living, or ADLs. The six ADLs are bathing, eating, dressing, toileting, transferring, and continence. To provide patients with appropriate services an assessment can be conducted by an eligibility determination agency, a case manager, or the home care provider to measure an individual's functional impairments. After the assessment is conducted, a plan of care is developed to provide assistance in the affected areas.

According to the National Association for Home Care, there were a total of 15,027 home care agencies in the United States as of 1994. Of those agencies, 7,521 are Medicare-certified home health agencies, 1,459 are Medicare-certified hospices, and 6,047 are home health agencies, home care aide organizations, and hospices that do not participate in Medicare.

In the past few years, both the Medicare and Medicaid programs have begun to cover home care more frequently as an alternative to institutionalization. In these programs, another way to gauge the need for home care services is by determining whether the individual would otherwise require hospital or skilled nursing care.

(C) RESPITE CARE

Respite care is intermittent care provided to a disabled person to provide relief to the regular caregiver. Care can be provided for a range of time periods, from a few hours to a few days. Care can also be provided in the individual's home, in a congregate setting such as a senior center or drop-in center, or in a residential setting such as a nursing home or other facility. Unlike other forms of long-term care, which is aimed at benefiting the frail individual, respite care is a service to the caregiver—usually a family member—as well. Because respite care is not universally available, and has few sources of public funding, many innovative options for the delivery of respite care have taken shape across the country, including family caregivers of Alzheimer's Disease patients pooling their time and resources to provide voluntary services.

(D) SUPPORTIVE HOUSING

There is a lack of uniformity in defining the different types of housing-with-services options in the long-term care continuum. This is partly because there are many funding sources and partly because housing options have developed without due consideration being given to the linkages between housing and services. Some of the names given to the different types of supportive housing are congregate living, retirement community, sheltered housing, foster group housing, protective housing, residential care, and assisted living. Assisted living is being given a great deal of attention as a relatively new option with the potential to meet the needs of many older people. In large part, it has developed because service providers are recognizing that the medical model of providing long-term care does not meet the needs of many disabled individuals needing assistance. Advocates are hopeful that there will be an increase in availability of assisted living options for persons with moderate incomes.

The various supportive housing options, including assisted living, are characterized by the availability of services to frail residents on an as-needed basis. Many such facilities have certain congregate services such as meals and other activities. Residents normally live in separate quarters. Laundry and housekeeping services are generally provided, and other services that can be provided on an as-needed basis are personal care, medication management, and other home care-type services.

(E) CONTINUING CARE RETIREMENT COMMUNITY

The continuing care retirement community (CCRC) is a special type of housing option which covers the entire spectrum of long-term care. Older people enter a CCRC by paying an entrance fee. A monthly fee is also required. In exchange for this payment, residents, who are typically able to live independently at the time of admission, are guaranteed that the CCRC will provide services needed from an agreed-upon menu of services specified in the entrance agreement. The menu of services can include skilled nursing care. When additional services are needed, there may be additional charges, depending upon the specific arrangement made by the community. CCRCs are an option only for those older people who can afford the fees, which are beyond the reach of older people with low and moderate incomes.

(F) NURSING HOMES

Nursing homes typically represent the high end of the long-term care spectrum in both cost and intensity of services provided. Nursing home residents are typically very frail individuals who require nursing care and round-the-clock supervision or are technology-dependent. Nursing homes can have special units to manage certain illnesses like Alzheimer's-type dementia. Many States have instituted measures to limit nursing home construction, and are using gatekeeping measures to limit nursing home placement to individuals who need round-the-clock skilled care. In the coming years, nursing homes are expected to concentrate more on post-acute care patients and to work aggressively to transition residents into other forms of care.

(G) ACCESS SERVICES

A host of other services are considered to be part of the long-term care continuum because they offer access to other services. Examples of these services are transportation, information and referral, and case management. These services deserve mention in this section because as Federal, State, and local policymakers work to fashion long-term care systems, they are increasingly taking these other services into account. In rural areas, transportation is an essential link to community-based long-term care services. Transportation is also an issue in the suburbs, where many of today's and tomorrow's older population resides. Suburbs, with their strip zoning and separation of residential, commercial, and service areas, were built with the automobile in mind. Older people who do not drive can find the suburbs to be an extremely isolating place.

Information and referral is also a key linkage service. This service is essential because the sometimes conflicting funding streams and lack of consistent long-term care policy have facilitated the development of a confusing array of services with multiple entry points and differing eligibility requirements. Both information and referral and case management are keys to sorting out this complex system for older people and their families. The role of case management will be discussed in greater detail later in this chapter.

(H) NUTRITION SERVICES

Nutrition services, including both congregate and home-delivered meals (also called "meals on wheels"), are also considered to be a part of the long-term care continuum because they support older people living in the community by providing one to three nutritious meals per day. Home-delivered meals ensure that frail older people, particularly those living alone, have an adequate supply of calories and important nutrients. Meals can be delivered up to 7 days per week. Meals are commonly delivered hot, but can also be delivered cold or frozen to be heated and consumed later. In a small number of hard-to-reach rural areas, meal providers are experimenting with intermittent deliveries of frozen meals which can be heated in pre-programmed microwave ovens, which are also supplied by the meal provider.

Congregate meals, provided at dining sites open 3 to 7 days per week, add a social component to the standard nutrition service. In addition to providing a hot nutritious meal, the dining site also offers socialization. Dining sites in the congregate nutrition program are also important access points for other services, e.g., health promotion activities, insurance and financial counseling, and recreation activities.

2. Who Receives Long-Term Care?

Of all persons receiving long-term care services in the United States, most are elderly—a total of about 7.3 million. Overall, approximately three-fifths of the long-term care population are elderly. However, a significant proportion of people needing long-term care are under age 65—about 5.1 million working age adults and 400,000 children. Despite public perception the majority of 12.8 million Americans who need long-term care do not live in institutions and do not receive assistance through government programs. The majority of long-term care is provided in home and community-based settings—predominantly from family members and friends. In fact, only 2.4 million live in institutions, such as nursing homes, chronic care hospitals, or other facilities. The remaining 10 million individuals live at home or in small community residential settings, such as group homes or supervised apartments.

Another way to look at the question of who receives long-term care in the United States is to examine the prevalence of need for long-term care among the elderly. The need for long-term care is often measured by assessing limitations in a person's capacity to manage certain functions or activities. For example, a chronic condition may result in dependence in certain functions that are basic for self-care, such as bathing, dressing, toileting, getting in or out

of a bed or chair, or eating. These are referred to as limitations in "activities of daily living," or ADLs. Assistance with these ADLs may require hands-on assistance or direction, instruction, or supervision from another individual.

Another set of limitations that reflect lower levels of disability are used to describe difficulties in performing household chores and social tasks. These are referred to as limitations in "instrumental activities of daily living," or IADLs, and include such functions as meal preparation, cleaning, grocery shopping, managing money, and taking medications.

Limitations in ADLs and IADLs, can vary in severity and prevalence. Persons can have limitations in any number of ADLs or IADLs, or both. An estimated 7.3 million elderly persons need long-term care because of limitations in ADLs or IADLs. This is nearly one-quarter of the Nation's elderly population. Of the total, 3.7 million elderly persons are estimated to be severely disabled, requiring assistance with at least three ADLs or substantial supervision due to cognitive impairment or other behavioral problems. The remaining 3.6 million are less severely disabled. Of all disabled elderly persons, only 22 percent live in nursing homes.[1]

The level of disability in the elderly population, and the use of higher-end institutional long-term care services, increases with age. According to the 1985 National Nursing Home Survey, 5 percent of persons age 65 and older reside in nursing homes on any given day. However, only 1 percent of older people age 65–74 reside in nursing homes, compared with 22 percent of those age 85 and over.

These snapshot estimates are one way of looking at the prevalence of nursing home use among the elderly. Another way to look at this issue is to predict future nursing home use for a given cohort of elderly people. From the standpoint of public policy and personal planning, this provides a more important look into the need for nursing home care. According to an article printed in the New England Journal of Medicine, of those persons who turned age 65 in 1990, 43 percent will enter a nursing home sometime before they die.[2] And because the elderly population, particularly those age 85 and older, is growing, nursing homes will be increasingly burdened in the years ahead. Estimates show that the number of elderly needing help with ADLs and/or IADLs may grow from 7.3 million to 10 to 14 million by the year 2020, and 14 to 24 million by the year 2060. Not only will utilization increase, but those in nursing homes will be older and therefore more severely disabled. Researchers at the Brookings Institution estimate that in the years 2016–20, 51 percent of nursing home residents will be age 85 and older, compared to 42 percent in 1986–90.[3]

Analysis of nursing home utilization has found a high degree of variance in length-of-stay patterns among nursing home residents. The majority (75 percent) of persons entering a nursing home stay less than 1 year, and one-third to one-half stay for less than 3 months. Although only 5 percent of all older Americans are likely

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[1] Based on information from the U.S. Department of Health and Human Services, and the Institute for Health Policy Studies at the University of California, San Francisco.

[2] Kemper, Peter, Ph.D., and Christopher M. Murtaugh, Ph.D., "Lifetime Use of Nursing Home Care," *New England Journal of Medicine,* February 18, 1991, Volume 324, No. 9, p. 595.

[3] Rivlin and Wiener, p. 11.

to be in a nursing home at any given time, those residents are more likely to be very old, female, and white. Residents age 85 and older comprise 45 percent of the nursing home population; 75 percent of elderly residents are female, and 93 percent are white.[4] For women age 85 years and older, their rate of nursing home use per 1,000 population is 248.9, compared to 13.8 per 1,000 for women age 65 to 74, and 66.5 per 1,000 for women age 75 to 84. A similar pattern exists for men, although their utilization rates are much lower. The greater likelihood of elderly white people to live in nursing homes is particularly true in the oldest age group. Of those age 85 and older, 23 percent of white people, compared to 14 percent of black people, reside in nursing homes.[5]

Of course, the nursing home population is only a portion of all older people receiving long-term care. For every person age 65 and older residing in a nursing home, there are nearly four times as many living in the community requiring some form of long-term care. According to a recent General Accounting Office report, there were approximately 5.7 million noninstitutionalized elderly residing in the community, or 22 percent of the over age 65 population, that had limitations in ADLs and IADLs.[6]

3. Where Is Long-Term Care Delivered?

Long-term care services are often differentiated by the settings in which they are provided. In general, services are provided either in nursing homes or in home and community-based settings. Most settings are community settings, since the great majority of elderly persons needing long-term care reside in the community. An estimated 5.7 million elderly, or almost 80 percent of the total 7.3 million elderly needing assistance with ADLs or IADLs, live in their own homes or other community-based settings.

Because of the growth in demand for services all along the long-term care continuum, services are now offered in a vast array of settings. Outside of the nursing home, there are many options in service settings. Nutrition services can be delivered in the home, as in the case of home-delivered meals, or in congregate dining sites. Sites can be located in senior centers and other community focal points, senior housing facilities, churches, schools, and government buildings. Adult day care centers can be located in nursing homes, hospitals, or in community-based settings such as senior centers, churches, senior housing facilities, and other focal points. Home health services are delivered in the recipient's home, whether it is a free-standing dwelling, apartment, board and care home, assisted living facility, or other type of group housing option. Respite care can be delivered in the client's home, or in a congregate setting such as a senior center or drop-in center, or in a residential setting such as a nursing home or other facility.

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[4] National Center for Health Statistics, E. Hing: Use of Nursing Homes by the Elderly: Preliminary Data from Vital and Health Statistics, No. 135, HHS, Public Health Service, Washington, D.C., May 14, 1987.

[5] National Center for Health Statistics, E. Hing, p. 3.

[6] United States General Accounting Office, "Long-term Care: Diverse, Growing Populations Includes Millions of Americans of All Ages.", November 1994., p. 5–6.

4. Who Provides Long-Term Care?

Because of the wide assortment of long-term care services available to disabled individuals, it is difficult to present a comprehensive breakdown of all personnel delivering these services across the entire long-term care continuum. There is information available, however, about personnel working in some aspects of the long-term care field.

Any discussion of individuals who deliver long-term care services would be incomplete without a discussion of informal caregivers. This is because most long-term care is provided by these caregivers. About 65 percent of the noninstitutionalized disabled elderly relied exclusively on unpaid sources of home and community health care. Twenty-six percent received at least some paid care and only 9 percent used paid care only. In 1993, $21 billion spent on home care, $5.2 billion was from out-of-pocket payments, $3.8 billion was from Medicaid, $9.4 billion was from Medicare, and only $100 million was from private insurance.[7]

These figures illustrate the extent to which informal caregiving provides for the long-term care needs of the disabled elderly population. One study estimates that more than 27 million unpaid days of informal care are provided each week.[8] The majority of unpaid caregivers are women, usually wives, daughters, or daughters-in-law. Caring for a frail friend or family member places severe emotional, and physical strain-and to a lesser degree, financial strain-on the caregiver. For example, according to the 1982 Long-Term Care Survey, 27 percent of caregivers surveyed reported that they were unable to leave their elderly disabled relatives at home alone, and 54 percent reported that their social life or free time had been limited by caregiving. However, only 15 percent said that their parents' care cost more than they could afford. Although most studies have found that worsening health is the primary factor precipitating institutionalization, the stresses associated with caregiving are often cited as a factor contributing to that decision.

Formal caregivers in community-based settings include those professionals and paraprofessionals who provide in-home health care and personal care services. Little information is available on the total number of formal caregivers. Neither the Bureau of Labor Statistics nor the major organizations that collect information on health care providers gather information specific to the home care industry. What is known about home care workers comes from the information provided by Medicare-certified home health agencies in the Health Care Financing Administration. According to a National Association for Home Care compilation of this information, there were 657,622 personnel delivering home care in Medicare-certified agencies in 1993. Of those, 245,143 or 39 percent were registered nurses, 34,757 or 5 percent were licensed practical nurses, 48,460 or 7 percent were physical therapists, 171,346 or 26 percent were home care aides, with 148,916 or 23 percent falling in other categories. According to a NAHC survey of home health agency com-

[7] The U.S. Department of Health and Human Services.

[8] Liu, Korbin and Kenneth Manton, "Disability and Long-Term Care," paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Workshop, Bethesda, MD, June 1985, p. 14. As cited in *Caring for the Disabled Elderly* by Alice Rivlin and Joshua Wiener, Washington, D.C.: The Brookings Institution, 1988, p. 5.

pensation conducted in 1993, the highest average annual salary for a physical therapists was $50,495, and the lowest average annual for home care aides was $18,721.

Analysis of personnel delivering care in the nursing home setting reveals a preponderance of individuals at the aide level. The number of full-time equivalent positions engaged in patient care duties in nursing homes, according to the 1985 National Nursing Home Survey, was physicians, 2,500; dietitians, 7,000; other health personnel, 18,200; registered physical therapists, 2,900; activities directors, 19,200; social workers, 10,300; other therapeutic staff, 2,200; registered nurses, 83,300; licensed practical nurses, 120,000; and nurses aides and orderlies, 501,000. Because of the traditionally low salaries and high rate of turnover of aide-level staff in both the home care and nursing home arena, recruitment, retention, and quality are key issues.

5. Who Pays for Long-Term Care?

The question of how long-term care is financed is at the heart of much of the discussion about reform. As we have witnesses in the current debate over Medicaid reform, long-term care financing is complicated by the stakeholders: older people and their families; States; and provider agencies of all types; watching to see how their interests and pocketbooks are affected by reform proposals. But it is also difficult because the fragmented and complex system we have in place to pay for long-term care has created some of the other policy challenges we see in long-term care. At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly, through cash assistance, in-kind transfers, or the provision of goods and services. Examples of issues which have arisen as a result of the payment structure are access problems and the bias toward a high-cost medical model for delivering long-term care services.

While the attention to long-term care financing has grown in the past few years, policymakers have been struggling with various aspects of the issue for the past 20 years. Creation of Federal task forces on long-term care issues, as well as Federal investment in research and demonstration efforts to identify cost-effective "alternatives to institutional care," date back to the late 1960's and early 1970's when payments for nursing home care began consuming a growing proportion of Medicaid expenditures. The awareness that public programs provided only limited support for community-based care, as well as concern about the fragmentation and lack of coordination in Federal support for long-term care, led to the development of a number of legislative proposals in the mid–1970's.

Today, the issue of financing long-term care costs has been heightened by the desire of Congress to slow the growth of entitlement programs such as Medicaid and Medicare and to balance the Federal budget. In 1993, the Nation spent nearly $80 billion on long-term care for the elderly. Federal and State governments account for the bulk of this spending, $46 billion or 58 percent of the total.

Nearly three-quarters of long-term care spending for the elderly is for nursing home care; approximately $58.6 billion. Two sources of payment, the Medicaid program and out-of-pocket payments, ac-

count for nearly 90 percent of this total. In 1993 Medicaid spent $23.5 billion on nursing home care for the elderly; individual out-of-pocket were $28.2 billion, Medicare $5.5 billion, other Federal and State programs $1.3 billion and private long-term care insurance only $1 million.[9]

By far the most important figure, in terms of its impact on older people and their families, is the portion of all nursing home costs paid by residents and their families out-of-pocket. Unfortunately, older people and their families often do not learn until it is too late that Medicare is generally not a viable option for financing nursing home care. Medicaid program data show that spending for the elderly is driven largely by its coverage of people who have become poor as the result of depleting assets and income on the cost of nursing home care. With nursing home costs in excess of $35,000 a year, this process of "spend-down" is not difficult for an elderly person in need of institutionalized care. It is the impoverishing consequences of needing nursing home care that has led policymakers over the years to try and look for alternative ways of financing long-term care.

While the market for long-term care insurance is growing rapidly, coverage for long-term care expenses is still extremely limited. In 1993, for example, only 0.2 percent of total nursing home care was paid with private insurance payments.

What type of long-term care is covered is also a key public policy issue. By far the greatest portion of public long-term care spending is for nursing home care. Very little coverage, either through public programs or private insurance, exists for the alternative home and community-based services that the elderly and their families often prefer. In 1993, elderly spending for home care amounted to $21 billion, or about one-quarter of the total long-term care spending for elderly in that year. This spending, however, does not take into account the substantial support provided to the elderly by family and friends. Studies have found that as much as 65 percent of functionally impaired elderly living in the community rely exclusively on unpaid sources for their care. Surveys have found that eight out of ten caregivers provide unpaid assistance averaging 4 hours a day, 7 days a week. Caregivers, often elderly wives and daughters, are frequently financially disadvantaged and one in three is in relatively poor health. Caregiving often competes with the demands of employment and requires caregivers to reduce work hours, take time off without pay, or quit their jobs.

Comparatively little of Medicaid's funding is devoted to home care, approximately $3.8 billion in 1993. This amount, however, has been growing in recent years as States have used a variety of options authorized by Congress to allow Medicaid coverage for a broad range of community-based services, including social services, to a disabled long-term care population.

While Medicare is the largest single payor for home care services, it's coverage is quite limited. To qualify for home care services the person must be in need of skilled nursing care on an intermittent basis, or physical or speech therapy. Most chronically impaired people do not need skilled care to remain in their homes, but rather

[9] Office of the Assistant Secretary for Planning and Evaluation, DHHS.

nonmedical supportive care and assistance with basic self care functions and daily routines that do not require skilled personnel. Yet despite these coverage limitations, growth in Medicare home care payments has been substantial in recent years. According to estimates by the Office of the Assistant Secretary for Planning and Evaluation, DHHS, in 1993 Medicare paid 46 percent of home care costs, followed by 25 percent paid out-of-pocket. Other sources of payment for home care are Medicaid, 18 percent, private insurance, .05 percent, and other 10 percent.

Three other Federal programs—the Social Services Block Grant (SSBG), the Older Americans Act, and the Supplemental Security Income (SSI) program-provide support for community-based long-term care services for impaired elderly people. The SSBG provides block grants to States for a variety of home-based services for the elderly, as well as the disabled and children. The Older Americans Act also funds a broad range of in-home services for the elderly. Under the SSI program, the federally administered income assistance program for aged, blind, and disabled people, many States provide supplemental payments to the basic SSI payment to support selected community-based long-term care services for certain eligible people, including the frail elderly. However, since funding available for these three programs is limited, their ability to address the financing of long-term care is also limited. In addition to these Federal programs, a number of States devote significant State funds to home and community-based long-term care services.

When we look at other parts of the long-term care continuum besides nursing homes and home health care, we see even more confusion and fragmentation in the way services are financed. Services such as transportation, case management, respite care, and adult day care are paid for by combinations of Federal, State, and private funds based on conditions and circumstances unique to each community. There is no single national data base on payment sources for all services in the long-term care continuum.

B. FEDERAL PROGRAMS

Although a substantial share of long-term care costs are paid out-of-pocket, as we have seen above, the Federal programs that pay for long-term care are important in that they have provided the framework for how long-term care is provided in the United States. The following is a discussion of the primary public sources of long-term care financing: Medicaid, Medicare, the Older Americans Act, and Social Services Block Grants. No one of these programs can provide a comprehensive range of long-term care services. Some provide primarily medical care, others focus on supportive or social services. The Medicaid program, for example, has certain income and asset requirements, while the Medicare program does not. Many advocates for the elderly contend that these differences contribute to the fragmented and uncoordinated nature of the long-term care system in this country.

1. Medicaid

(A) INTRODUCTION

Medicaid is a Federal-State entitlement program which provides medical assistance for certain low-income persons. Each State designs and administers its own Medicaid program, setting eligibility and coverage standards within broad Federal guidelines. Although originally intended to provide basic medical services to the poor and disabled, Medicaid has also become the primary source of public funds for nursing home care. Approximately 78 percent of all public expenditures for nursing home care are paid by Medicaid and 50 percent of all nursing home residents use Medicaid as their primary source of payment. Because of the enormous role of the Medicaid program in financing nursing home care for the elderly, a section of this chapter provides an in-depth discussion of Medicaid.

Although Medicaid pays primarily for nursing home care, there is some coverage of home and community-based care, mostly through the Section 2176 waiver program, also called the Section 1915(c) waiver program. Congress established these waivers in 1981, giving HHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a nursing home. Services covered under the Section 1915(c) waivers include case management; homemaker, home health aide, and personal care services; adult day care; rehabilitation; respite; and others. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203) established an additional home and community-based services waiver program similar to the Section 2176 program, but the new program is available only to persons over age 65.

Medicaid expenditures for nursing home care in 1993 were approximately $23.5 billion. This represents almost 40 percent of total national spending for nursing homes and 78 percent of public spending for nursing home care.

Due to the rise in long-term care expenses, many States have imposed cost containment measures to control their Medicaid expenditures. For example, most States use a form of prospective reimbursement for nursing home care. At least 30 States have instituted formal pre-admission screening programs for all Medicaid eligible persons wishing to enter a nursing home. Other states have toughened eligibility standards or adjusted their Medicaid assessment tools to require individuals to be more disabled than previously required to receive nursing home care. The OBRA 87 nursing home reforms require all States to screen current and prospective residents for mental illness or mental retardation, based on the premise that nursing homes are inappropriate for such persons. These screening programs are intended to identify those mentally disabled people who could be cared for in their own homes or in the community if appropriate services are available, and to assure that nursing home beds are available for those who have medical needs. The certificate of need process, in which a provider must apply to the State in order to expand or construct new beds or risk

becoming ineligible for Medicare or Medicaid reimbursement, is seen as a Medicaid cost-containment measure in some States.

(B) MEDICAID AVAILABILITY AND ELIGIBILITY

Medicaid was established in 1965 as its authority is contained in Title XIX of the Social Security Act. It is a means-tested entitlement program; it covers, certain groups of persons (e.g., the aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children) qualify for coverage if their incomes and resources are sufficiently low. Medicaid recipients are entitled to have payment made by the State for covered services. States then receive matching funds from the Federal Government to pay for covered services. There is no Federal limit on payments; allowable claims are matched according to a formula which varies inversely with a State's per capita income. Therefore, States with a higher per capita income will receive a lower percentage of Federal matching funds and vice versa. The established minimum matching rate is 50 percent. For fiscal year 1994, 14 States and the District of Columbia had matching rates of 50 percent. Ten States had matching rates between 50 percent and 60 percent. Fifteen States had matching rates between 60 percent and 70 percent, and 14 States had matching rates over 70 percent. Mississippi received the highest rate in effect, 78.85 percent.

State Medicaid programs are required by Federal law to cover the categorically needy; that is, all persons receiving cash assistance under a welfare program—Aid to Families with Dependent Children (AFDC)—and most people receiving assistance under the Supplemental Security Income (SSI) program. Eligible persons must meet the cash assistance program's definition of age, blindness, disability, or membership in a family with dependent children. Therefore, if a person does not fall into one of these categories, he or she is ineligible for Medicaid, regardless of income. Furthermore, people who fall into one of these categories must also meet specific income and resource standards, which vary from State to State.

In addition, States may, at their discretion, cover the optional categorically needy and the medically needy. Optional categorically needy programs extend Medicaid eligibility to those persons who are not receiving cash welfare assistance but who meet certain other criteria. Insofar as the elderly are concerned, optional categorically needy coverage enables persons living in institutions (e.g., nursing homes) to be covered by Medicaid if their incomes are low enough. Medically needy persons are defined as those whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for their medical care. These State-by-State variations in eligibility can mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another. State officials have made the case that some individuals are likely to choose their State of residence according to how generous the Medicaid benefits are.

A State may also, within Federal guidelines, define its own benefit package. Mandatory services include physicians' and hospital services, and care in a nursing facility (NF). Optional services in-

clude prescription drugs, eyeglasses, and services in an intermediate care facility for the mentally retarded (ICF/MR). States may also limit the coverage of all services; e.g., a limit on the number of hospital days. Reimbursement levels vary from State to State as well, so States vary widely in both the breadth and depth of their covered services.

Overall, Medicaid covers less than one-half of the population with incomes below the Federal poverty line. Approximately 47 percent of the noninstitutionalized poor were covered by Medicaid in 1991; the percentage varied by age with coverage extended to 66 percent of poor children under age 18, 38 percent of poor adults age 18–44, 30 percent of poor adults age 45–64, and 32 percent of the poor children under age 18, 38 percent of poor adults age 18–44, 30 percent of poor adults age 45–64, and 32 percent of the poor elderly. However, although the elderly constituted only 14 percent of beneficiaries in fiscal year 1991, they accounted for 33 percent of total Medicaid spending. Conversely, while 68 percent of Medicaid recipients in fiscal year 1990 qualified because they were a member of an AFDC family, these recipients accounted for only 24 percent of program benefits.

The elderly covered by Medicaid can be divided into three groups. The first group, representing nearly half of all elderly Medicaid beneficiaries, are those elderly who have incomes low enough to qualify for cash assistance; in other words, the categorically needy. The Supplemental Security Income (SSI) program is one of the cash welfare programs linked to Medicaid eligibility. It provides cash welfare assistance to needy aged, disabled, and blind individuals who have little or no income and resources. Medicaid law generally requires that States cover persons receiving SSI. However, Medicaid is above all a program of exception and variation, and therefore the law does give States the option of using an alterative set of eligibility standards that may be more restrictive. Currently, fewer than 12 States use these alternative eligibility standards.

The second and third groups are composed of persons who do not receive cash welfare assistance. The second group, the optional categorically needy, comprises close to one-quarter of the elderly beneficiaries. These persons have incomes too high to qualify for Medicaid, but (1) Require care provided by a nursing home or other medical institution, (2) meet the State's resource standard, and (3) have incomes that does not exceed a specified level. Medicaid law requires that income for there persons be no more three times the basic SSI payment. This provision in Medicaid law is often referred to as the 300 percent rule. In order to qualify for coverage under this rule, the applicant's gross income, with no disregards or deductions permitted, must be below the prescribed level. In 1992, 35 states used the 300 percent rule or some lower special income level for making persons eligible for institutionalized care.

The third group also representing roughly one-quarter of elderly Medicaid beneficiaries are referred to as medically needy. These persons are not poor by SSI standards, but require assistance due to medical expenses. Generally, they become medically needy by "spending-down" or depleting their income and resources on the cost of care. In order to qualify for medically needy coverage, a person must first live in a State that exercises the medically needy op-

tion. Approximately three-fourths of all States have programs designed to cover medical expenses for elderly persons who had too much income to qualify for cash assistance. Persons seeking medically needy coverage for their medical expenses must also deplete their income and resources to the specified level before they can qualify. In practice, persons qualifying for medically needy coverage generally first deplete their resources to the State's eligibility standard, and then continue to incur medical expenses that reduce their income to the level required by the State.

States also have an option of covering needy persons needing home and community-based services, if these persons would otherwise require institutionalized care that would be paid for by Medicaid.

(C) QUALIFIED MEDICARE BENEFICIARY PROGRAM

The Qualified Medicare Beneficiary (QMB) Program, which was originally part of the Medicare Catastrophic Care Act, requires States to "buy-in" the Medicare premiums, copayments, and deductible for low-income Medicare beneficiaries with incomes below the Federal poverty level and assets below twice the Supplemental Security Income (SSI) level ($4,000 in liquid assets). This provision was to be phased-in over 3 years, beginning in 1989 for those beneficiaries with income at or below 85 percent of poverty, and increasing in 5 percent increments up to 100 percent of poverty by 1992.

A provision in OBRA 90 accelerated the implementation of the QMB program by 1 year; that is, up to 100 percent of poverty by January 1, 1991. OBRA 90 also requires States to buy-in the Part B premiums (but not other copayments and deductibles) for Medicare beneficiaries with assets below twice the SSI level and incomes below 110 percent of poverty beginning on January 1, 1993, going up to 120 percent of poverty by January 1, 1995.

Unfortunately, participation rates in the QMB program have been lower than anticipated. Although HHS does not have any national data, participation is estimated to be between 20 percent and 30 percent. According to a 1993 report by Families USA, an estimated 1.8 million—roughly 42 percent—of poor seniors are eligible for the QMB benefit but are not receiving it.[10] This is largely because many low-income elderly and disabled are unaware of the program. While some States have been more aggressive than others in informing the public about the QMB program, many aging advocates, believe that a more active role on part of HHS in promoting the QMB program, as well as a simplified application process, could serve to increase participation rates across the country.

In July 1991, the Senate Aging Committee held a hearing to examine the implementation of the QMB program, and to explore ways the Federal and State governments, as well as the private sector, could strengthen their outreach efforts to inform the public about the program and to increase participation rates. Options that were discussed at the hearing included accepting applications for the QMB program at local Social Security Administration offices and including information about the program in the monthly Social

[10] Liu, Korbin, and Kenneth G. Manton, "The Effect of Nursing Home Use on Medicaid Eligibility." *The Gerontologist,* Volume 29, No. 1, 1989, p. 63.

Security checks of recipients whose checks are under a certain amount.

Senators Cohen and Pryor subsequently joined Senator Riegle and others in introducing legislation, the Medicare Improvement and Enrollment Protection Act (S. 649) to require the Secretary of Health and Human Services to initiate more effective enrollment procedures, to improve outreach and notification efforts, and to make outreach grants available for community organizations.

(D) SPOUSAL IMPOVERISHMENT

A particularly important concern over the past few years has been the issue of Medicaid spend-down for nursing home care. To become eligible for Medicaid coverage, persons must either be poor or "spend down" their income to the level set by their State Medicaid program. While there is a great deal of variability among State's Medicaid programs and income eligibility levels, nursing home residents—and often their spouses—frequently face impoverishment before they become eligible for Medicaid coverage.

A study on the effects of nursing home use on Medicaid eligibility status found that the likelihood of being Medicaid eligible was 31 percent if a person spent time in a nursing home, as opposed to 7 percent for those who had not.[11] Medicaid eligibility is also closely related to the length of stay in a nursing home. Although temporary or short stays in a nursing home do not increase one's risk of spending down to Medicaid eligibility, 41 percent of those persons studied who had long-term stays (i.e., at least 2 years) in nursing homes spent down to Medicaid eligibility.

A provision in the Medicaid Catastrophic Care Act (MCCA) that was retained addresses this issue of Medicaid spend-down. The so-called "spousal impoverishment" provisions are intended to protect some of the income and assets of the spouse who remains at home when the institutionalized spouse is in the process of spending down to become Medicaid eligible.

Generally when determining Medicaid eligibility, income (such as Social Security checks, pensions, and interest from investments) is attributed to the person whose name is on the instrument conveying the funds. In the case of Social Security, the amount attributed to each spouse is the individual's share of the couple's benefit. Therefore, if the couple's pension check is made out to the husband, all of that income would be considered his for the purpose of determining Medicaid eligibility. The attribution of resources such as certificates of deposit and savings accounts is done similarly. Because the current generation of women whose husbands are at risk of needing nursing home care typically did not work outside the home, they likely have very little income or assets other than those in their husband's name.

Prior to the passage of MCCA, once an institutionalized spouse was determined Medicaid-eligible, some of that individual's monthly income was reserved for the use of the spouse. When combined with the community spouse's income (if any existed) it allowed a maintenance needs level, which could not exceed the highest of the

[11] Pharmaceutical Benefits Under State Medical Assistance Programs, National Pharmaceutical Council, Reston, VA, Sept. 1991.

SSI, State supplementation, or "medically needy" standards in the State. According to a survey taken by the AARP in March 1987, maintenance needs levels varied widely from State to State—from a high of $632 in Alaska to zero in Oklahoma. Thus, in a State with a maintenance needs level of $350, if the community spouse's monthly income was equal to $150, the contribution from the institutionalized spouse would have been $200.

Beginning in September 1989, the spousal impoverishment provisions allowed the community-based spouse to keep a monthly income equal to 122 percent of poverty, which was increased to 133 percent on July 1, 1991, and increased again to 150 percent on July 1, 1992. However, the maximum allowance will not exceed $1,718 per month. This provision also provides for a one-time determination of liquid assets, with half attributable to each spouse. The institutionalized person may transfer an amount equal to one-half, or $14,532 (in 1994), whichever is higher, to the spouse, up to $72,660 (the amount of protected assets increases each July 1, based on the increase in the Consumer Price Index). For example, if the couple has assets worth $20,000, the institutionalized person may transfer $14,532 to the spouse. If they have assets worth $150,000, the institutionalized person may transfer $72,660 to the spouse, keeping the remainder for him or herself. In other words, if the spouse's share of assets exceeds $72,660, the excess is attributed to the institutionalized person. States have the option to increase the minimum level of protected income to any amount above the required minimum of $1,179 per month, up to the maximum of $1,817 per month.

(E) PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Nursing home residents who are Medicaid-eligible depend on their personal needs allowance (PNA) each month to cover a wide range of expenses not paid for by Medicaid. On July 1, 1988, the PNA was increased from $25 to $30 per month. States have the option to supplement this payment, which 26 States do. Prior to this, the PNA had not been increased—or adjusted for inflation—since Congress first authorized payment in 1972. As a result, the $25 PNA was worth less than $10 in 1972 dollars. There is no provision for a cost-of-living adjustment (COLA) in the PNA, even though noninstitutionalized recipients of Social Security and SSI benefits have received annual COLAs to their benefits since 1974.

For impoverished nursing home residents, the PNA represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, eye glasses, clothing, laundry, newspapers, and phone calls. In addition to personal needs, many nursing home residents have substantial medical needs that are not covered by State Medicaid programs. Although the PNA is not intended to cover medical items, these residents may have to save their PNA's over many months to pay for these costs, such as hearing aids and dentures.

If a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve his bed there. Even though a resident who cannot pay this fee is likely to lose his place in the nursing home, 40 percent of State Medicaid plans will not cover the

cost nor guarantee the nursing home resident a bed to come back to. As a result of the various expenses not covered by many Medicaid programs, many advocates of the Nation's nursing home residents believe the $30 PNA is inadequate to meet the needs of most residents.

(F) MEDICAID SECTION 1915 WAIVER PROGRAMS

Prior to 1981, Federal regulations limited Medicaid home care services to the traditional acute care model. To counter the institutional bias of Federal long-term care spending, Congress in 1981 enacted new authority to waive certain Medicaid requirements to allow States to broaden coverage for a range of community-based services and to receive Federal reimbursement for these services. Specifically, Section 2176 of the Omnibus Budget Reconciliation Act of 1981 authorized the Secretary of the Department of Health and Human Services to approve "Section 2176 waivers" for home and community-based services for a targeted group of individuals who, without such services, would require the level of care provided in a hospital, nursing facility, or intermediate care facility, or who are already in such a facility and need assistance returning to the community. These waivers are also called 1915(c) waivers. The target population may include the aged, the disabled, the mentally retarded, the chronically mentally ill, persons with AIDS, or any other population defined by the State as likely to need extended institutional care. Community-based services under the waiver include case management, homemaker/home health aide services, personal care services, adult day care services, habilitation services, respite care, and other community-based services. As of 1994, almost all states (with the exception of Arizona and DC.) had approved waiver programs; and most had waivers for the elderly and disabled. In 1991, waivers for the elderly and disabled served 135,000 people.

HCFA has expressed concern that the home and community-based waiver program may actually increase Federal expenditures for long-term care. While home and community-based care may be less costly on an individual recipient basis, aggregate Medicaid costs may increase if the program results in the provision of a new range of services to persons who would not otherwise use nursing homes or other institutional care funded by Medicaid. Previous research and demonstration efforts in home and community-based care suggest that achieving program savings depends on how effectively waiver services are targeted. HCFA has argued that targeting the services to the population most at risk of entering an institution is quite difficult, if not impossible.

Spending for 1915(c) waiver services has grown dramatically since the enactment of the authority in 1981. Federal and State spending increased from $3.8 million in fiscal year 1982 to $1.7 billion in fiscal year 1991. However, waiver spending represents a small proportion of total long-term care spending. For these purposes, long-term care is defined as including the following Medicaid services: nursing facility care, ICF/MR care, home health, inpatient mental health, personal care, and waiver services (both 1915(c) and 1915(d)). Waiver spending amounted to less than 10 percent of total long-term care spending in 35 States. For all the States, waiv-

er spending represented 4.7 percent of total long-term care spending. These relatively small percentages reflect the large sums States have traditionally spent, and continue to spend, on nursing facility services and ICF/MR care.

The 1915(c) waivers have proven to be very popular with States, and Congress has taken action to ensure their continued availability. OBRA 87 included provisions aimed at expanding the program. It created a new waiver authority (Section 1915(d) waivers) under which States can provide home and community-based services for the elderly alone. Under the 1915(d) waiver program, the requirements that the program be statewide and comparable for all eligibility groups may be waived. In addition, income and resource rules applicable to persons residing in the community may be waived. Expenditures for skilled nursing facility services, intermediate care facility services, and home and community-based services for individuals age 65 and older may not exceed a projected amount, which is determined by comparing the amount spent in the base year for such services, increased by factors that take into account increases in the cost of goods and services, the over-age 65 population, and the level of services provided.

(G) PRESCRIPTION DRUG COVERAGE UNDER MEDICAID

(1) Data on Medicaid Prescription Drug Expenditures

Medicaid is the largest outpatient prescription drug program in the United States. Outpatient prescription drugs are provided to Medicaid recipients as part of a comprehensive package of health and medical services made available to low-income individuals under the program.

Outpatient pharmaceutical expenditures for the Medicaid were nearly $8 billion in 1993, an increase of over 17 percent above the 1992 outpatient prescription drug expenditures of $6.8 billion. Total Medicaid program expenditures for services increased by 11 percent from 1992, from about $91.5 billion to $101.7 billion in 1993.[12] About 24 million Americans received outpatient prescription drugs from the Medicaid program in 1993, an increase of 9 percent over 1993, The average Medicaid prescription price in 1992 was approximately $23.8 an increase of about 8 percent over the average of $21.49 in 1992. The average expenditures per recipient for outpatient prescription drugs was $333 in 1993, an 8 percent increase over the 1992 average annual expenditure of $307.[13]

(2) Update on Medicaid Drug Rebate Program

The Medicaid program continued to receive hundreds of millions of dollars in rebates from drug manufacturers in 1993 as a result of the Medicaid rebate provisions of OBRA 90. These rebates helped to offset some of the increase in total drug expenditures by State Medicaid programs, but as is evident, total Medicaid expenditures were still escalating rapidly.

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[12] Health Care Financing Administration, DHHS Pharmaceutical Benefits Under State Medical Assistance Programs. National Pharmaceutical Council, Sept. 1993.

[13] Medicaid State Data (2082) Tables.

In December, the Secretary issued her report to Congress on the Medicaid Drug Rebate Program. The report analyzed various facets of the rebate program using data through calendar year 1992, the last full year for which reliable data were available. The report showed that the Medicaid program received rebates of $1.1 billion in 1992, with $655 billion reflecting the Federal share. There were 469 brand name and generic drug manufacturers participating in the program in that year. The report emphasized the importance of the inflation-adjustment rebate in holding down overall costs for Medicaid. This is the rebate that requires manufacturers to rebate to Medicaid any increase in price over the rate of general inflation as measured by the Consumer Price Index (CPI–U). Without this rebate, Medicaid expenditures would have been higher to pay for drug manufacturer price inflation.

Although the States and the Federal Government have taken steps in recent years to contain overall Medicaid drug program costs, such as through the rebate program, total Medicaid expenditures continued to increase significantly. For example, the Secretary's report found that Medicaid drug program expenditures, after removing the impact of the rebate, still increased by 20 percent between 1990 and 1992. Possible explanations include a significant increase in the number of individuals who were eligible for Medicaid, an increase in the number of prescriptions dispensed per recipient, an expansion in State Medicaid drug formularies, and the increase in the prices of new prescription drugs covered by Medicaid.

While both the Federal and State government currently rely on the Medicaid drug rebate to control prescription drug expenses in the program, significant controversy remains over the drug rebate program. Several studies have pointed to the possibility that drug manufactures adjust prices upward to compensate for the mandated Medicaid rebate, consequently limiting the effectiveness of the program.

(3) Changes in the Medicaid Outpatient Prescription Drug Program

Congress made three significant changes in the Medicaid outpatient prescription drug program in 1993. More specifically, these changes were made to the Medicaid rebate provisions, which were originally enacted as part of OBRA 90. These three changes were the elimination of the prohibition of the State Medicaid program's ability to use drug formularies; repeal of the requirement that State Medicaid programs cover new drugs without any restrictions (such as prior approval) for a period of 6 months; and elimination of the calculation of the Medicaid "additional" or "inflation-adjusted" rebate on the basis of the change in the weighted average manufacturers' price.

Changes were made in the formulary prohibition and the new drug coverage requirement to give the Medicaid programs enhanced ability to manage their outpatient prescription drug benefits, and to save the Medicaid program money as part of OBRA 93. The change in calculation of the additional rebate also produced additional savings for the Medicaid program.

Prior to OBRA 93, State Medicaid programs were prohibited from using drug formularies. A formulary is a list of drugs ap-

proved for use in a certain population or by a specific health care institution. Almost every hospital and many managed care plans use a formulary as a way of controlling drug costs, and improving quality of pharmaceutical care. This formulary prohibition was included in OBRA 90 in return for manufacturers providing rebates to the Medicaid program. These rebates were enacted in order to lower the cost of prescription medications for the Medicaid program. Billions of dollars in rebates have been paid by manufacturers to State Medicaid programs since enactment of OBRA 90.

Under OBRA 93, State Medicaid programs can use formularies, but if a drug is not included on the formulary, the State still has to provide the drug, but can subject the drug to prior authorization. This process requires the physician or pharmacist to obtain approval from the State before the drug can be provided. In order to assure that Medicaid beneficiaries have access to the latest pharmaceuticals, the State may not exclude any drug from the formulary that represents a significant, clinically meaningful therapeutic advantage in terms of safety and efficacy over drugs already on the formulary to treat a particular condition. The State has to provide a written explanation if it decides to exclude a drug from the formulary.

To help develop their formularies, States are required to establish a Committee consisting of physicians and pharmacists. A State may use its Drug Use Review (DUR) Board to serve in this capacity. States are required to establish these DUR Boards to serve in an advisory capacity in designing the State's Drug Use Review program. These DUR programs are further described in the section below.

Under OBRA 93, States are no longer required to cover new drugs unrestricted for a period of 6 months from the time of FDA approval. For example, under OBRA 90, States were not allowed to prior authorize any new drug until 6 months after the day that the drug had been approved by the FDA. This provision was originally included in OBRA 90 to assure that Medicaid beneficiaries had access to the most up-to-date pharmaceuticals that were available. However, the formulary language adopted by the Congress in OBRA 93 assures that Medicaid recipients have access to new drugs that represent significant advances over drugs already on the market. This was the original policy objective in including this language in OBRA 90. Therefore, States can now prior authorize any new drug that does not represent a significant advance over drugs already on the market.

Finally, OBRA 93 repealed the requirement that the "additional" rebate provided by the manufacturers to Medicaid as a result of price increases that exceed the rate of general inflation be calculated on a "weighted average" manufacturers' price (WAMP) method beginning in 1994. This additional rebate has been calculated on a drug-by-drug basis since 1991, and was slated to switch to a WAMP method beginning in 1994. The change in OBRA 93 means that the additional rebate will continue to be calculated on a drug-by-drug basis as long as the rebate program remains in existence. This change was made because of the difficulty that HCFA was having in developing an appropriate WAMP formula.

(4) Medicaid Drug Use Review Program

Under OBRA 90, each State Medicaid program is required to have in place a comprehensive program of Drug Use Review (DUR) by January 1, 1993. The purpose of this program is to assure that drugs are used appropriately, and not likely to result in adverse reactions or other harmful effects in Medicaid recipients.

This DUR program includes a program of prospective and retrospective drug review, and educational interventions for health care providers designed to improve prescribing and dispensing of prescription drugs. Because they are generally in poorer health and therefore take more prescription drugs than the average American, Medicaid recipients are at higher risk for adverse reactions and problems relating to prescription drug use. Under this prospective DUR program, the pharmacist is required to ascertain that prescriptions for Medicaid recipients are appropriate, and will not result in adverse reactions or drug interactions before the prescription is dispensed. The pharmacist must ask the Medicaid recipient if they wish counsel on the proper use of the medication so that the intended medical outcomes are achieved. Information such as when to take the medication, foods to avoid, and potential adverse reactions that may occur are supposed to be discussed by the pharmacist with the Medicaid recipient.

Under the retrospective DUR program, data received from the prescription data system is analyzed by the Medicaid program to identify patterns of inappropriate use of prescription drugs by Medicaid recipients. Physicians and pharmacists are supposed to be alerted by Medicaid to any potential drug use problems with the patient. Medicaid is also required to establish programs to educate health professionals about particular problems identified in drug use among Medicaid recipients, and provide updates about new drugs used to treat medical conditions affecting older Americans.

At the end of 1993, each State had a DUR program in place, and was attempting to improve the quality of drug use among Medicaid recipients.

(5) State Based Pharmaceutical Assistance Programs for Older Americans

To provide financial relief for those low-income elderly who are ineligible for Medicaid's outpatient prescription drug benefit, 10 States have pharmaceutical assistance programs (PAPs) for the elderly. These States are Maine, New York, New Jersey, Pennsylvania, Delaware, Illinois, Rhode Island, Connecticut, Maryland, and Vermont. These are generally State-financed programs which help certain populations of elderly subsidize the costs of prescription drugs. Traditionally, these programs serve elderly patients who are poor, but have income levels that make them ineligible to receive Medicaid.

In 1992, these PAP programs provided additional whole or partial prescription drug coverage for almost 1 million older Americans who were ineligible for Medicaid, accounting for almost $600 million in prescription drug expenditures for low-income elderly. However, there were also millions of other older Americans in these 10

States that had no form of prescription drug coverage and many millions more in States that have no PAP.

These programs have experienced funding problems similar to the Medicaid program, primarily because of drug manufacturer price inflation in the 1980's. Although these programs also buy large quantities of prescription drugs each year, they did not receive any discounts or rebates that pharmaceutical manufacturers traditionally give to large-volume purchasers. However, since the enactment of OBRA 90, several of the State PAPs have enacted their own rebate program.

For example, New York and Pennsylvania enacted rebate programs in 1991. New Jersey and Rhode Island followed the lead of the other States, enacting a rebate program in 1992 that required manufacturers to give these State programs the "best price" that they give to any buyers in the market. Reflecting the incentive incorporated into the Federal rebate program, manufacturers' products are not reimbursed by these State PAP plans if they do not agree to provide the rebates specified under the law.

By lowering the cost of prescription drugs in these PAP programs, States may be able to expand the programs to more elderly who have no insurance but do not have substantial costs for prescription drugs. However, many of these State PAP programs, experiencing funding crises due to the exploding costs of prescription drugs, needed to enact these rebate programs just to maintain the level of services that they are providing.

(H) NURSING HOME QUALITY OF CARE

Recent years have seen significant legislative action and controversy regarding nursing home quality of care. A summary of these actions appears in this section because of Medicaid's role in funding the majority of public costs for nursing home care.

During the 1980's, a series of investigations and studies found that thousands of frail older people were receiving inadequate care in nursing homes. Legislation was passed as part of OBRA 87 to address many of the concerns raised in these investigations. The OBRA 87 provisions relating to nursing homes are often referred to collectively as nursing home reform.

As part of nursing home reform, OBRA 87 eliminated the distinction between skilled nursing facilities and intermediate care facilities, and repealed a requirement that States pay less for ICF services.

There were many provisions relating to the admission and treatment of patients. Nursing homes are now required to conduct a comprehensive assessment of each resident's abilities to perform key activities. This assessment must be used to formulate a written plan of care to describe how each person's medical, psychological, and social needs will be met. In addition, homes must conduct preadmission screening on all patients regardless of payment source, to screen out individuals who do not need nursing home care.

A significant portion of nursing home reform addresses the rights of residents. Nursing homes are required to inform residents orally and in writing of their legal rights, including the rights to choose a physician; be informed in advance about treatment; be free from physical or chemical restraints; have privacy in accommodations,

medical treatment, written and telephone communications; confidentiality of personal and clinical records; and immediate access to a State or long-term care ombudsman.

There were also many provisions relating to staffing (all facilities are required to have an R.N. on duty 8 hours per day, 7 days per week) and training for nurse aides. OBRA 87 also lays out the process of surveying and certifying facilities, as well as the enforcement process. Most of the provisions in OBRA 87 took effect in 1989 and 1990.

The next time nursing home reform was approached legislatively was in OBRA 90, when technical corrections were made to OBRA 87. This followed much frustration on the part of service providers and advocates over some problems with OBRA including lack of guidance from HCFA, concerns among providers and States about the costs of implementation, and Congressional inaction on technical amendments. In 1991 and 1992, there was no legislative action on nursing home reform. After the long-awaited inclusion in OBRA 90 of a variety of 1987 technical provisions, there was a general consensus among Members of Congress who had been active on this issue that the implementation of OBRA 87 would progress more successfully without further legislative intervention—although other minor technicals were made in the Social Security Amendments of 1994.

In the summer of 1995, the final piece of the OBRA 87 nursing home standards—enforcement guidelines and penalties for noncompliance—were enacted. So far the enforcement regulations have had a rocky and rather controversial start. Complaints by nursing home administrators of inappropriate and inconsistent enforcement of the guidelines, forced HCFA to delay certain penalties for facilities found to be out of compliance with the Federal regulations.

Complicating this already difficult transition period to full OBRA 87 enforcement, has been the debate in Congress over changes to the Medicaid program. Several early versions of Medicaid block grant proposals virtually eliminated the OBRA 87 nursing home regulations and allowed States to develop their own quality of care standards. Senator Cohen and Senator Pryor led the charge in the Senate for maintaining the current nursing home laws. While this battle was won in the Senate, the conference agreement on H.R. 2491, the Balanced Budget Act of 1995, significantly weakened many of the OBRA 87 regulations and gave States more authority to develop an enforce Medicaid nursing home standards. The debate over quality of care standards for nursing home care will continue to controversial as Congress considers changes to the Medicaid and Medicare programs.

(I) ASSET TRANSFER AND ESTATE RECOVERY

Legislation enacted as part of the OBRA 93 instituted more stringent limitations on sheltering assets for the purpose of qualifying for Medicaid. Despite earlier provisions that were intended to ensure that assets are used for the cost of care rather than given away, anecdotal reports and recent interview surveys of Medicaid officials suggest that nonpoor elderly persons are successfully using estate planning to avoid applying their wealth to the costs of long-

term care services for the purpose of having Medicaid pay for their care.

According to reports, a number of different strategies have been used to protect assets.[14] One strategy would have persons convert assets that are counted for purposes of Medicaid eligibility, such as savings accounts or CDs, into exempt assets. The home is the most significant asset that is exempt at the time a person applies for Medicaid. Using cash on hand for a new roof or for remodeling a kitchen or for paying off a mortgage will protect those countable assets from having to be applied to the cost of nursing home care.

Another strategy has encouraged persons to transfer assets through joint bank accounts. For example, a son's name may be added to his mother's bank account, and the son may then withdraw all funds from the account and place them in his own account. Because most State banking laws recognize that all tenants in a joint account have full ownership rights to the entire account, the transaction has not been considered a prohibited transfer by State Medicaid plans.

Persons have also been able to shelter assets in trusts. A trust allows a person to give ownership of property to a trustee who will hold and manage the property for the benefit of that person. Frequently trusts are preferred to the actual transferring of assets because they can be arranged to allow persons to retain greater control over how assets and asset income will be distributed over the individual's remaining lifetime and upon death. Not all trusts, however, have allowed persons to shelter assets for purposes of Medicaid eligibility. Medicaid law has used the term "Medicaid qualifying trust" to describe a trust that cannot under any circumstances be used to shelter assets. Medicaid has required that if a trustee has discretion over how the income and principal of a trust is distributed, then the maximum amount that could be made available to the beneficiary must be counted for Medicaid eligibility purposes, regardless of whether the trustee chooses to distribute the amount.

How extensively these and many other strategies are being used to protect assets so that Medicaid ends up paying sooner than it otherwise would is unknown. No comprehensive survey has been conducted to indicate how many people transferred assets or participated in estate planning prior to applying for Medicaid. Nor has research determined what impact estate planning is having on Medicaid expenditures for nursing home care or what impact it will have on future expenditures.

The only empirical evidence of estate planning activity comes from a snapshot picture of Medicaid nursing home applicants in the State of Massachusetts in October 1992. The GAO reviewed a random sample of 403 Medicaid application files for nursing home benefits in Massachusetts for that month.[15] GAO found that more than half of the Medicaid applicants had either converted assets from one form to another, thereby making them unavailable for

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[14] Burwell, Brian, *Middle Class Welfare,* State Responses to Medicaid Estate Planning, Cambridge, SysteMetrics/MEDSTAT, May 1993. Budish, Armond D. *Avoiding the Medicaid Trap: How to Beat the Catastrophic Costs of Nursing Home Care,* New York, Henry Hold and Co., 1989. This discussion draws heavily on these works.

[15] U.S. GAO, Medicaid Estate Planning, July 20, 1993. GAO/HRD–93–29R.

nursing home costs, or transferred assets to another party during the preceding 30-month period.

Asset conversions, the most common form of Medicaid estate planning found by GAO, averaged $5,600 and typically involved setting aside money for burial arrangements. Other less common types of conversions included home repairs and automobile purchases. Asset transfers were far less frequent, but involved larger amounts of money. Slightly more than 10 percent of the total cases involved asset transfers that included cash transfers, real estate transfers, and trusts. Transfers, typically to family members, averaged $46,000, with one of every three transfers for less than $10,000. Of those applicants with transferred assets, half were denied eligibility.

The majority of applicants had neither significant assets nor income. On average, applicants had $38,202 in assets, including the applicants who owned their primary residence. Excluding the value of the primary residences, applicants had an average of $14,875 in assets. Applicants had an average annual income of $11,227, with more than half of the applicants having less than $10,000 and 92 percent having less than $20,000.

In response to concerns of State officials about estate planning activity, as well as concerns of the private insurance industry that the ability of persons to transfer assets undermines the growth of the long-term care insurance market, Congress included amendments to the transfer of assets law in OBRA 93. The amendments will make it more difficult for persons needing long-term care to gain Medicaid eligibility after transferring assets for less than fair market value.

Under the OBRA 93 amendments, States are required to provide for a delay in Medicaid eligibility for institutionalized persons or their spouses who dispose of assets for less than fair market value during a look-back period. This period is defined as the 36 months prior to the first day when the individual is both institutionalized and has applied for benefits. (In the case of trusts described below, the look-back period is 60 months.) At their option, States may also delay eligibility for noninstitutionalized persons who receive certain home care services and who transfer assets for less than fair market value during this look-back period. Assets are defined as including all income and resources of the individual and the individual's spouse, including any income or resources which the individual or spouse is entitled to but does not receive because of action by the individual or spouse or by a person, court, or administrative body acting in place of or on behalf of or at the direction of the individual or spouse.

The actual length of the period of ineligibility is determined by comparing the cost of care and the value of the assets transferred. There is no longer a durational limitation in the ineligibility period for having transferred assets for less than fair market value. The number of months of ineligibility is equal to the total cumulative uncompensated value of the assets transferred divided by the average monthly cost to a private patient of nursing facilities in the State or, at the option of the State, in the community in which the individual is institutionalized. The period of ineligibility begins with the first month during which the assets were transferred and

which does not occur in any other period of ineligibility. Penalties are not applied to transfers to spouses, transfers to minor or disabled children, or transfers to trusts solely for the benefit of disabled persons under 65.

OBRA 93 also addresses the problem of jointly owned bank accounts discussed above. The revised law provides that in the case of an asset held by an individual in common with another person or persons in joint tenancy, tenancy in common, or similar arrangement, the asset will be considered transferred when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

These transfer of asset provisions are effective with respect to assets disposed of after August 10, 1993, the date of enactment of OBRA 93.

In addition, OBRA 93 includes provisions that result in most trusts being considered resources available to the individual for the cost of care, or assets that have been transferred for less than fair market value. An individual is considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if certain persons established the trust. These include the individual; the individual's spouse; a person, including a court or administrative body with legal authority to act in place of or on behalf of the individual or spouse; and a person, including any court or administrative body acting at the direction of or upon the request of the individual or spouse.

The law distinguishes between revocable and irrevocable trusts and establishes rules regarding each. In the case of revocable trusts, the corpus of the trust must be considered resources available to the individual; payments from the trust to or for the benefit of the individual must be considered income of the individual; and any other payments from the trust must be considered transferred assets. In the case of an irrevocable trust, if there are any circumstances under which payments can be made from the trust for the benefit of the individual, then the corpus and payments from the trust shall be treated the same as revocable trusts. An irrevocable trust from which no payments may be made to the individual shall be considered a transfer of assets as of the date of the establishment of the trust; its value is determined by including the amount of any payments made from the trust after this date.

For trusts that are considered transfers, the look-back period is 60 months. The law provides exemptions for trusts containing the assets of a disabled individual under 65, specified income trusts in States using the 300 percent rule for nursing home eligibility, and pooled trusts for disabled persons. States are required to establish procedures for waiving the application of these rules in cases of undue hardship. Trust provisions are effective with respect to trusts established after August 10, 1993, the date of enactment of OBRA 93.

OBRA 93 also includes related amendments on estate recovery. Under Medicaid law, States have had the option of seeking recovery of amounts correctly paid on behalf of an individual under its Medicaid program from the individual's estate if the individual was 65 years of age or older at the time he or she received Medicaid benefits.

OBRA 93 mandates that States recover from an individual's estate amounts paid by Medicaid for nursing facility services, home and community-based care, and related hospital and prescription drug services, or, at the option of the State, any item or service covered under the State Medicaid plan. For purposes of these recovery provisions, estates are defined to include all real and personal property and other assets included within an individual's estate, as defined under State laws governing the treatment of inheritance. At the option of the State, recoverable estates can also include any other real and personal property and other assets in which the individual has any legal title or interest at the time of death, including such assets conveyed to a survivor, heir, or assignee of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. The provisions apply to estates of persons who were 55 years of age or older when they received Medicaid assistance. Special provisions apply to persons who become eligible for Medicaid under a more liberal asset standard used in certain States for those who purchase long-term care insurance. States are required to establish procedures for waiving the application of these rules in cases of undue hardship. These provisions apply to Medicaid payments made for calendar quarters beginning on or after October 1, 1993, with a delay permitted when State legislation is needed.

(J) MEDICAID FINANCING INITIATIVES

In the past few years, many States have grown increasingly frustrated with the rising costs of their Medicaid programs. Health care inflation, new Medicaid mandates, and the recession with its attendant unemployment have all contributed to the rapid growth in the costs of funding Medicaid, for the States and Federal Governments. As a result, many States have begun to explore new sources of Medicaid funding. The most notable example of this is provider-specific taxes and voluntary contributions. These were the focus of debate in 1991, because although they were enthusiastically supported by many States, the Administration was strongly opposed to their use.

The controversy surrounding this issue began in February 1990, when HCFA published proposed rules that would prohibit States from using voluntary donations of funds from hospitals and provider-specific taxes to supplement the State's financial share of the Medicaid program. Congress had placed a moratorium on HCFA's issuance of these regulations, which expired on December 31, 1989. HCFA's rationale for the proposed rule is that the use of these aforementioned funding sources unfairly increases the Federal share of Medicaid payments relative to the State's share. In response to these regulations, a provision was included in OBRA 90 that placed a moratorium on the regulation as it pertained to voluntary contributions to December 31, 1991, and permitted the use of provider-specific taxes.

In September 1991, HCFA published proposed regulations that would prohibit the use of voluntary contributions and severely limit the use of provider-specific taxes. HCFA's actions angered many Members of Congress, as well as those States who had developed new programs, as they believed the regulation (primarily with re-

spect to provider-specific taxes) contradicted the law. After much discussion and debate (and the publication of a revised regulation in October), Congress approved in November 1991 a compromise proposal developed by the National Governors Association and the Administration. This agreement, included in Public Law 102–234, allows States to levy broad-based taxes on providers to raise revenues for their Medicaid programs for the next 3 years, so long as the funds raised do not exceed 25 percent of the State's share of their Medicaid program. The legislation also permits those States which do not have a regular legislative session scheduled until 1993 to keep their existing programs in place until July 1993. Voluntary donations programs are eliminated as of October 1, 1992. Regulations implementing this legislation were published in November 1992.

In 1993, there was further attention to this issue. The most aggressive of a new batch of accounting gimmicks were the "intergovernmental transfers" used by North Carolina to boost its Federal Medicaid reimbursement. They have become critical financing devices in California, Texas, and Michigan. The technique involves transferring funds from one State agency to another to capture Federal matching funds. In the North Carolina plan, four State-run mental hospitals transfer about $100 million a year to the State Medicaid program. That counts as a State contribution to the Medicaid program, and qualifies North Carolina for about $200 million a year in Federal matching funds. After the Federal money has been received, all the money is shifted to the accounts of the State mental hospitals. There, the $200 million in Federal funds is considered to be a "surplus" that the State can use for any purpose.

2. Medicare

(A) INTRODUCTION

The Medicare program, which insures almost 98 percent of all older Americans without regard to income or assets, primarily provides acute care coverage for those age 65 and older, particularly hospital and surgical care and accompanying periods of recovery. Medicare does not cover either long-term or custodial care. However, it does cover care in a skilled nursing facility (SNF), home health care, and hospice care in certain circumstances.

(B) THE SKILLED NURSING FACILITY BENEFIT

In order to receive reimbursement under the Medicare SNF benefit, which is financed under Part A of the Medicare program, a beneficiary must be in need of skilled nursing care on a daily basis for an acute illness. The program pays for neither health-related services nor custodial care in a nursing home.

The SNF benefit is tied to a "spell of illness" which begins when a beneficiary enters the hospital and ends when he or she has not been an inpatient of a hospital or SNF for 60 consecutive days. A beneficiary is entitled to 100 days of SNF care per spell of illness, following a 3-day prior hospitalization. Days 21–100 are subject to a daily coinsurance charge ($89.50 in 1995), which is equal to one-eighth of the hospital deductible.

In 1993, Medicare covered 34,437,000 days of care for aged beneficiaries, which was an average of 40 days for each person served. In comparison, in 1983, there were 9,010,052 days of care, with an average of 35.1 days for each person served.[16] This change is a result of both (1) the number of enrollees being served, and (2) higher reimbursement per covered day of care. Since 1990, the number of persons served has increased from 19 to 24 per 1,000 enrollees; and average reimbursement per day has increased from $98 to $207.

(C) THE HOME HEALTH BENEFIT

Both Part A and Part B of the Medicare program cover home health services without a deductible or coinsurance charge. There is no statutory limit on the number of home health visits covered and no prior hospitalization requirement. The Medicare home health benefit has no statutory limit on the number of days covered; however, it is most often received for short periods of care and only for treatment of an acute care condition or for post-acute care. Below is a brief description of Medicare's home health benefit; developments with regard to this program are discussed in greater detail in Part B of this chapter.

Home health services covered under Medicare include the following:

Part time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;

Physical, occupational, or speech therapy;

Medical social services provided under the direction of a physician;

Medical supplies and equipment (other than drugs and medicines);

Medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and

Part time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must need intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, such as deductibles or coinsurance, for covered home care.

Medicare is playing an increasing role in financing home health care. In the mid–1980's, Medicare certified home health agencies had leveled off at 5,900 due to increasing paperwork and what some advocates said were difficult payment policies. After a successful lawsuit led by Members of Congress including Claude Pepper, home health payment policies were rewritten resulting in a significant increase in Medicare outlays for home care. According to the National Association for Home Care, the number of Medicare certified home health agencies has risen to an all-time high of

[16] Silverman, Herbert A., "Medicare-Covered Skilled Nursing Facility Services," 1967–88, *Health Care Financing Review,* Spring 1991, Volume 12, No. 3, p. 106.

7,521 in 1994. To give an example of how Medicare home health expenditures have risen in recent years, in 1980, Medicare outlays were $662 million. The figure for 1987 was $1.879 billion, and for 1994 was $12.1 billion.

(D) THE HOSPICE BENEFIT

Medicare also covers a range of home care services for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, outpatient drugs, therapy services, medical social services, home health aide services, physician services, counseling, and short term inpatient care. A Medicare beneficiary who elects hospice care waives entitlement to Medicare benefits related to the treatment of the terminal condition or related conditions, except for the services of the patient's attending physician. Payments to providers for covered services are subject to a cap, which was $12,846 in 1994, and enrollees are liable for copayments for outpatient drugs and respite care. Coverage for hospice services was subject to a lifetime limit of 210 days, before this cap was eliminated by OBRA 90 (P.L. 101–508), if the beneficiary is recertified as terminally ill by a physician.

(E) EXPENDITURES

Medicare expenditures for these services generally have been small, but are now rapidly growing. In 1993, Medicare outlays for SNF care were $6.1 billion, which represents 8.8 percent of the total $70 billion spent on nursing home care, and slightly over 4 percent of total Medicare spending.[17] Medicare payments for home health care in 1993 were $9.6 billion, an increase of about 36 percent over 1992. This represents 4,660 visits per 1,000 enrollees, with an average charge of $61 per visit.[18] Expenditures for hospice care in 1993 were $958 million, which represents 153,490 admissions with an average of 62 days of covered care per admission.

3. The Older Americans Act

(A) INTRODUCTION

The Older Americans Act (OAA) provides funding to the network to State units on aging and area agencies on aging to provide a range of home and community-based services. Although the Older Americans Act budget is small compared to the Federal funding available under the Medicare and Medicaid programs, it is an important source of community-based services in some communities.

Although the OAA does not focus exclusively on long-term care, development of programs for persons in need of both home and community-based and institutional long-term care services has been a focus in various amendments to the Act. The purpose of Title III is to foster the development of a comprehensive and co-

[17] Levit, et al., Health Care Financing Review, p. 40.

[18] Committee on Ways and Means, U.S. House of Representatives. Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means, Committee Print 103–27, 103d Congress, 2nd Session, Washington, DC, U.S. Government Printing Office, July 15, 1994. Levit, et al., Health Care Financing Review, p. 49.

ordinated services system that will provide a continuum of care for vulnerable elderly persons and allow them to maintain maximum independence and dignity in a home environment. Title III specifically authorizes funding for many community-based long-term care services, including homemaker/home health aide services, adult day care, respite, and chore services. It also authorizes the long-term care ombudsman program whose purpose is to monitor the quality of care provided to institutionalized older persons. Title III funds a variety of other supportive services and nutrition services. Home care services have been considered a priority service for Title III funding since 1975, and in 1987 Congress authorized a distinct program under Title III for in-home services for the frail elderly. The amount of funding devoted to home care services under Title III represents a small fraction of the amount spent for such services under Medicaid and Medicare; however, the Title III program has the flexibility to provide home care services to impaired older persons without certain restrictions that apply under these programs, for example, the skilled care requirements under Medicare, and the income and asset tests under Medicaid.

The role of the OAA in providing congregate and home-delivered meals to the elderly in an important contribution to the long-term care continuum. Data from a 1987 national study by the Agency for Health Care Policy and Research on the use of home and community-based services indicate that about 6 percent of the estimated 5.6 million functionally impaired elderly use congregate meals, and another 6 percent use home-delivered meals. Recent trends in the nutrition program indicate that State and area agencies on aging have given increased attention to funding meals for the homebound through the Title III program.

The number of home care visits to older persons under the OAA represents only a small fraction of the amount provided under Medicare and Medicaid. The OAA services, however, may be provided without the requirement under Medicare that persons be in need of skilled care and without the strict income and asset tests under the Medicaid program. In some cases, OAA funds may be used to assist persons whose Medicare benefits have been exhausted or who are ineligible for Medicaid.

Congress recognized the growing need for in-home services when it amended the OAA to expand in-home services authorized under Title III. The Older Americans Act Amendments of 1987 (P.L. 100–175) added a new Part D to Title III, authorizing grants to States for nonmedical in-home services for frail older persons. These services include assistance in such areas as bathing, dressing, eating, mobility, or performance of daily activities such as shopping, cooking, cleaning, or managing money. In-home respite services and adult day care for families, visiting and telephone reassurance, and minor home renovation and repair are additional examples of allowable services under Part D.

(B) EXPENDITURES

Unlike the Title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of Title III funds for supportive services, congregate and home-delivered nutrition services, and in-home services for the

frail elderly. States receive allotments of these funds according to the number of persons age 60 and older in the State as compared to all States. Fiscal year 1994 Title III appropriations equaled $950.3 million. The Older Americans Act chapter contains detailed information on spending categories.

The total number of meals served under the nutrition program have increased by 43 percent in the fiscal years 1980 through 1992. Home-delivered meals accounted for the largest share of that growth, increasing by 191 percent during that period, compared to only 2 percent for congregate meals. Home-delivered meals represent about 44 percent of total meals served in fiscal year 1992. There are a number of reasons for this enormous growth in home-delivered meals. From 1980–93, funding for home-delivered nutrition services has increased more rapidly than funding for congregate meal services. Funding for congregate meals increased 39 percent for the period 1980 to 1994, compared to an increase of 87 percent for home-delivered meals over the same period.

The aging of the population is also a factor, because the old-old (those age 85 and older) are more likely to need more in-home services, such as home-delivered meals. States' efforts to develop comprehensive home and community-based long-term care also have had an impact on this growth, as more and more States are working toward providing services to enable older persons to stay in their homes longer. Finally, earlier discharge of elderly patients from the hospital as a result of the incentives in Medicare's PPS reimbursement system has resulted in an increased demand for home-delivered meals.

(C) LONG-TERM CARE OMBUDSMAN PROGRAM

Another important role the OAA plays in long-term care is in the Long-Term Care Ombudsman Program. The long-term care ombudsman program began as a demonstration project in the early 1970's as a part of the Federal response to serious quality-of-care concerns in the Nation's nursing homes. These demonstration ombudsman programs were charged with the responsibility to resolve the complaints made by or on behalf of nursing home residents, document problems in nursing homes, and test the effectiveness of the use of volunteers in responding to complaints. As a result of the success of the early programs, Congress incorporated the ombudsman program into the 1978 amendments to the OAA.

Under the OAA, each State is required to establish and operate a long-term care ombudsman program. These programs, under the direction of a full-time State ombudsman, have responsibilities built upon those outlined above. The programs are to: (1) Investigate and resolve complaints made by or on behalf of residents of long-term care facilities, (2) monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities, (3) provide information as appropriate to public agencies regarding the problems of residents of long-term care facilities, and (4) provide for training staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program. The 1981 amendments to the OAA added the requirement that ombudsmen serve residents of board and care homes.

The primary role of long-term care ombudsmen is that of consumer advocate. However, they are not limited to responding to complaints about the quality of care. Problems with public entitlements, guardianships, or any number of issues that a nursing home resident may encounter are within the jurisdiction of the ombudsman. A major objective of the program is to establish a regular presence in long-term care facilities, so that ombudsmen can become well-acquainted with the residents, the employees, and the workings of the facility. This presence is important because it helps the ombudsmen establish credibility and trust. Further, because about one-half of nursing home residents have no family, many may have only ombudsmen to speak on their behalf.

In fiscal year 1992, there were 571 local ombudsman programs throughout the Nation. According to the Administration on Aging (AOA), which is the Federal agency responsible for the OAA and the ombudsman program, the number of complaints handled by programs across the country more than quadrupled from 1982 to 1992, rising from 41,000 in 1982 to 177,000 in 1992. Of the complaints received in 1992, AOA reports that about 74 percent were fully or partially resolved.

Funding devoted to the ombudsman program has grown in recent years. In fiscal year 1982, States reported that a total of $10.4 million was spent on ombudsman activities, an amount which grew to almost $35 million in fiscal year 1991. Staffing, both paid and volunteer, more than doubled from fiscal year 1982 to fiscal year 1988, from 4,171 to 10,381.

Despite the program's growth and effectiveness, Federal support, in terms of funding and statutory requirements has been inadequate. The Institute of Medicine's report on the quality of care in nursing homes noted that the ombudsman programs varied widely in their effectiveness, and stated the need to make improvements to the program in the future.

To address these concerns, the Older Americans Act Amendments of 1987 (P.L. 100–175) and 1991 (P.L. 102–375) contained several provisions to strengthen and improve the long-term care ombudsman program. Among the provisions in the 1987 legislation was a requirement that States provide access to facilities and to records, and immunity to ombudsmen for good faith performance of duties. The 1987 legislation also required improved AOA reporting on the ombudsman program, including an annual report to Congress on complaints and conditions in long-term care facilities and recommendations on ways to improve conditions, among other things. In addition, the Commissioner of AOA was required to submit a report to Congress on the findings and recommendations of a study on the impact of the long-term care ombudsman program on the care of residents of board and care facilities, and other adult care homes, as well as the effectiveness of recruiting, supervising, and retaining volunteers. The study found that State long-term care ombudsman programs appear to have a significant role in monitoring board and care legislation and regulation, as well as in coordinating with other agencies. The 48 States participating in the study were evenly divided as to whether their impact on board and

care homes was significant, moderate, or slight.[19] The study on the use of volunteers in ombudsman programs found that of the 46 States responding, 26 categorized themselves as using mostly volunteer staff, and 20 used primarily paid staff. However, 80 percent of the paid programs expressed interest in developing or expanding their volunteer capacity.[20]

Congress for the first time established a separate authorization of funds for the ombudsman program in the 1987 OAA Amendments, with an authorization of $20 million in fiscal year 1988, and such funds as may be necessary in fiscal years 1989–91. In 1994, Congress appropriated $9 million for ombudsman and elder abuse activities ($4.4 million for ombudsman activities, and $4.6 million for elder abuse).

Public Law 102–375, the 1992 reauthorization of the OAA consolidates, amends, and expands under a new Title VII, programs that focus on protection of the rights of older persons that were previously authorized under Title III. The title incorporates provisions of a bill, introduced in 1991, S. 1471, and is based on Congressional findings that there is a need to consolidate and expend State responsibility for the development, coordination, and management of statewide programs and services to ensure that older persons have access to, and assistance in securing and maintaining their benefits and rights. Title VII includes separate authorizations of appropriations for the long-term care ombudsman program; programs to prevent elder abuse, neglect, and exploitation; elder rights and legal assistance; and an outreach, counseling, and assistance program for insurance and public benefit programs. The amendments also authorize a new program for Native American elder rights.

In support of activities authorized under Title VII, Public Law 102–375 requires the Commissioner to support a National Center on Elder Abuse and a National Ombudsman Resource Center. Among other things, these Centers would perform research and training in elder abuse prevention and ombudsman activities.

4. Social Services Block Grant

Title XX of the Social Security Act authorizes reimbursement to States for social services, now distributed through the Social Services Block Grant (SSBG). Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are inappropriate.

Although the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the Title XX program has competing demands and can only provide a limited amount of care to the older population.

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[19] "A Study of the Use of Volunteers by State Long-Term Care Ombudsman Programs: The Effectiveness of Recruitment, Supervision, and Retention," prepared for the Administration on Aging by the National Center for State Long-Term Care Ombudsman Resources of the National Association of State Units on Aging, Washington, DC, Dec. 1989.

[20] U.S. GAO, Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met. GAO/HRD–89–50, Feb. 1989.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated, and as a result, data concerning the extent to which Title XX now supports long-term care are very limited. According to an HHS analysis of the States' fiscal year 1989 pre-expenditure reports, home care services, which may include homemaker, chore, and home management services, were provided to adults and children by 46 States; adult day care services were provided by 26 States.

States receive allotments of SSBG funds on the basis of their population, within a Federal expenditure ceiling. There are no requirements for the use of Title XX funds. States have relative freedom to spend Federal Social Service Block Grant funds on State-identified service needs. Appropriations in fiscal year 1993 and fiscal year 1994 are $2.8 billion for each year. For fiscal year 1994 there is an additional $1 billion set aside for temporary social services block grants in enterprise zones and empowerment communities.

C. SPECIAL ISSUES

1. System Variations and Access Issues

One of the key issues in long-term care is the variation in the way States have chosen to structure their systems. Because long-term care has traditionally been a State, rather than a Federal issue, States have developed widely varying systems. This diversity can be a strength. The case can be made that the same system would not work in each State. Indeed, within a single State, the same system will not necessarily work in each community. Another recurring theme in long-term care policy is the fragmentation created by the multitude of funding streams. Several Federal programs contribute to long-term care. These programs have differing eligibility requirements and the agencies that administer them have historical relationships with different agencies at the local level. There are also many State programs for long-term care, some of which work hand-in-hand with Federal programs and some of which are special State-only programs. Finally, communities differ widely in the extent to which local governments and private foundations or philanthropies help finance long-term care services.

The above-listed characteristics of the long-term care system can work together to create, at best, a situation where services are well-coordinated to meet each client's needs, and at worst, a situation of fragmentation and inconsistency that make it difficult to access services. Especially in the community-based services arena, it is important to maintain and improve access so that older people with chronic impairment receive the services they need in the setting they prefer—their own homes so often undesirable and costly institutionalization can be avoided.

2. The Role of Case Management

Case management, also called care management, generally refers to ways of matching services to an individual's needs. In the context of long-term care, case management generally includes the following components—screening and assessment to determine an individual's eligibility and need for a given service or program; development of a plan of care specifying the types and amounts of care to be provided; authorization and arrangement for delivery of services; and monitoring and reassessment of the need for services on a periodic basis.

Some State and local agencies have incorporated case management as a basis part of their long-term care systems development. The availability of Medicaid funds under the home and community-based wavier programs has spurred the development of case management services, but other sources of funds have been used by States to develop case management systems, including State-only funds, SSBG, and the OAA.

Case management is carried out in a wide variety of ways. Organizational arrangements may range from centralized systems to those in which some case management functions are conducted by different agencies. Case management may be provided by many community organizations, including home health agencies, area agencies on aging, and other social service or health agencies. In some cases where statewide long-term care systems have been developed, one agency at the community level has been designated to perform case management functions, thereby establishing a single point of access to long-term care services.

Case management has received a great deal of attention in recent years as a partial solution to the problem of coordination of long-term care services, particularly in community settings. In communities where an older person might have to contact three different agencies, with differing eligibility criteria for providing services, it is easy to see how a case manager's services can be needed to help an individual negotiate their way through the system.

Case management is also important as a way of accomplishing the policy aim of targeting services to those most in need. In cases where a State has established a case management system to coordinate entry into the long-term care system, it is much easier to ensure that limited services are provided to those most in need, and that clients have the services that best meet their individual needs.

There are three basic models for case management, referred to as the service management, broker, and managed care model. In the service management model, the one most often used by States, the case management agency has the authority to allocate services to individuals, but is not at financial risk. In the broker model, case managers help clients identify their service needs and assist in arranging services, but do not have authority over the actual services. The managed care model uses a risk-based financing system to allocate funds to the case management agency based on the anticipated number of eligible clients who will seek assistance, and the amount of money necessary to meet their needs.

Because of the fragmented nature of our long-term care system, it is likely that the importance of case management will continue to increase as Congress approaches health care reform.

3. The Role of Private Long-Term Care Insurance

Long-term care insurance is relatively new, but rapidly growing, market. In 1986, approximately 30 insurers were selling long-term care insurance policies of some type and an estimated 200,000 people were covered by these policies. By 1987, a Department of Health and Human Services Task Force on Long-Term Care Insurance found 73 companies writing long-term care insurance policies covering 423,000 people. As of December 1993, the Health Insurance Association of America (HIAA) found that more than 3.4 million policies had been sold, with 118 insurers offering coverage.

With the growth of entitlement programs such as Medicaid, budget-minded Federal and State legislators are looking to the private market to help pay for a larger portion of long-term care expenses. Chairman William S. Cohen introduced S. 423, "The Private Long-Term Care Protection Act of 1995" to grant favorable tax treatment to long-term care insurance as a way of encouraging individuals to plan and finance their own long-term care needs.

Insurers are also trying to encourage the sale of long-term care insurance products by becoming more responsive to the needs of consumers. The early long-term care products generally limited consumers to indemnity type policies which pay only a limited amount for each day of nursing home care. In response to consumers who wanted better and broader coverage for a variety of long-term care services, today's long-term care products have evolved to more adequately address an individual's particular long-term care needs. Most policies now cover greater amounts of nursing home care, and offer the option to purchase home and adult day care coverage as well. Per diem policies—which offer consumers the greatest flexibility in covering long-term care expenses—have also developed in recent years. These products give policyholders a cash payment when they are determined to be disabled and in need of long-term care. The money can be used in any way the beneficiary and their family sees fit—nursing home care, adult day care, home health care, and even to pay family caregivers. Overall, the insurance industry has responded to early criticism about products offering new policies that provide broadened coverage and fewer restrictions.

In addition, the National Association of Insurance Commissioners (NAIC) has established standards for regulating long-term care insurance that many States have adopted at least some portion of for regulation of these products in their jurisdictions. Legislation, such as S. 423 introduced by Senator Cohen, require long-term care insurance policies to meet these national standards as a condition of receiving favorable tax treatment. Federal standards for long-term care insurance not only strengthen polices for today's purchasers, but help encourage more Americans to think about private insurance as a long-term care financing option.

One of the key issues outstanding in the debate on the role private insurance can play in financing long-term care is the affordability of coverage. HIAA has reported on the premium costs of

policies representing 80 percent of all policies sold in the individual and group markets in 1993. For polices paying $100 a day for nursing home care and $50 a day for home care, with lifetime 5 percent compounded inflation protection and a 20-day deductible period, average annual premiums in 1993 were $1,896 when purchased at the age of 65 and $6,033 when purchased at the age of 79. Obviously, these premiums are unaffordable to many elderly Americans. Therefore, insurers and those in favor of greater private long-term care financing, are encouraging younger Americans to purchase long-term care insurance at an earlier age—when it is more affordable.

Proponents of long-term care insurance also believe that affordability of premiums can be greatly enhanced if the pool of those to whom policies is sold is expanded. The industry has argued that the greatest potential for expanding the pool and reducing premiums lies with employer-based group coverage. Premiums should be lower in employer-based group coverage because younger age groups with lower levels of risk of needing long-term care would be included, allowing insurance companies to buildup reserves to cover future benefit payments. In addition, group coverage has lower administrative expenses.

According to HIAA, employer-based activity has increased steadily over the years. By the end of 1993, over 400,000 policies have been sold across 968 employers. These employer-based plans covered over employees, their spouses, retirees, parents, and parents-in-law. In addition, the number of long-term care riders that permit conversion of at least some portion of life insurance policies to long-term care benefits has grown from 1,300 policies in 1988 to almost 280,000 in 1993.

But just how broad-based employer interest is in a new long-term care benefit is unclear. Many employers currently face unfunded liabilities for retiree pension and health benefits. Also, many employers have recently experienced fairly substantial increases in premiums for their current health benefits plans. Very few employers make contributions to the premium cost of a long-term care plan. Almost all employers require that the employee pay the full premium cost of coverage. In contrast many medium and large size employers pay the full premium cost of regular health care benefits for their employees.

Other proposals would increase the affordability of, and provide incentives to purchase long-term care insurance. For example, many States have been exploring public/private partnerships as an option for encouraging people to purchase insurance coverage according to the level of assets they wish to protect, while still qualifying for Medicaid. Under this approach, States would extend to people buying policies the protection of Medicaid without requiring them to deplete assets as they are required to do now. Instead, people would be able to protect assets according to the amount of long-term care insurance they purchased and obtain Medicaid coverage for care they needed after their private policies had ceased providing coverage.

Seven States (California, Connecticut, Indiana, Iowa, New York, Illinois, and Maryland) have received HHS approval to operate such programs. Most states have implemented programs that pro-

tect a dollar of assets for each dollar a qualified long-term care insurance policy pays out.

Unfortunately, an OBRA 93 amendment now severely threatens the growth of these innovative programs. OBRA 93 requires that any new State seeking approval for these programs include protected assets in an individual's estate subject to recovery for amounts paid by Medicaid for nursing home care. S. 423, "The Private Long-Term Care Family Protection Act of 1995" proposed by Senator Cohen, would repeal this amendment to give more States the opportunity to explore public/private partnerships which encourage the purchase of long-term care protection.

Proposals to provide tax incentives for the purchase of long-term care insurance policies have been introduced by many members of the 104th Congress including Senators Cohen, Kassebaum, Snowe, and Hatch. The Clinton Administration's Health Security Act of 1994, also included provisions to extend the current tax benefits available to health insurance to long-term care insurance. Most recently, the conference agreement on H.R. 2491, the Balanced Budget Act of 1995, included language to allow long-term care insurance premiums to be deducted as medical insurance and would exclude employer-provided long-term care insurance from an employee's taxable income. These proposals reflect the concern that the current tax code does not treat long-term care insurance in the same manner as health insurance, providing a substantial disincentive to individuals to plan for their long-term care needs.

While obstacles of affordability and access to polices by those underwritten due to their medical history are still major hurdles for private long-term care financing, long-term care insurance will continue to be a focus for Federal and State policymakers trying to control the growth in Medicaid spending.

On May 11, 1995, the Senate Special Committee on Aging, chaired by Senator Cohen held a hearing entitled "Planning Ahead: Future Directions in Private Financing of Long-Term Care." The hearing examined what the private market could do to assist families in planning for their future long-term care needs. While no clear consensus was reached on the potential of the private sector financing, most witnesses agreed that long-term care insurance products have improved significantly over the past few years and that the market—while in still in its infancy—is growing rapidly.

4. Acute and Long-Term Care Integration Demonstrations

Another long-term care issue is the question of integrating the acute and long-term care systems. There are several models of integrated systems, which have proven to be successful in providing cost-effective care in limited areas with well-defined populations. Advocates for the elderly generally support integrated models because they offer community-based long-term care providers a greater role in health care, and because a holistic approach has the potential to reduce negative health outcomes.

The Social/Health Maintenance Organizations or SHMOs provide community-based long-term care services on a prepaid capitation basis under the auspices of an HMO that is responsible for providing a full range of Medicare services in addition to long-term care.

The services provided included home health services, home helper services, adult day care, and home-delivered meals.

Another integrated model is the Program of All-Inclusive Care for the Elderly, or PACE. Unlike the programs that rely heavily upon home health services, PACE has as its foundation adult day health care. The PACE programs are funded by both Medicare and Medicaid, and as such have substantial resources to draw upon. However, they are also at greater financial risk than the other integration models because they are responsible for the full range of institutional services as well as home and community-based care.

In the 104th Congress, Majority Leader Robert Dole introduced S. 990, "The Pace Provider Act of 1995." This legislation expands the number of long-term care programs eligible for Medicare and Medicaid waivers under the Program of All-inclusive Care for the Elderly. Programs would be allowed, following a trail period, to become eligible as providers under Medicare and Medicaid.

The Channelling demonstration programs differed from the other models in that elderly participants were served in a financial control model using many agencies. A broad range of services were provided, incorporating Medicare home health as well as other community-based long-term care services. Participants were served without regard to payment source, and services were coordinated by agencies who followed carefully prescribed case management protocols. Channelling projects provided higher levels of home health services than either SHMOs or PACE.

On April 20, 1993, the Senate Special Committee on Aging held a hearing entitled "Controlling Health Care Costs: The Long-Term Care Factor." One of the programs examined was a PACE model located in Rochester, NY. This hearing focused attention on the benefits of integrated model programs in terms of reducing hospital days and enabling participants to live at home longer. Senator Cohen included a demonstration project on the integration of acute and long-term care services in his 1993 long-term care legislation. A similar demonstration project for dually eligible beneficiaries, written by Senator Cohen and several other colleagues, was recently passed in the conference agreement on the Balanced Budget Act of 1995.

5. Ethical Issues in Long-Term Care

As medical advances and lifestyle changes allow for longer lifespans, even when disabilities or chronic conditions are present, ethical challenges will become more numerous and more complex. Ethics is normally thought of as an issue for acute care practitioners only, such as in questions of whether a certain operation should be performed, or which patient should receive an organ transplant.

However, ethics is a burgeoning issue in long-term care, particularly because of the intimate nature of much of the care that is provided, and the multiplicity of some clients' needs. It will be important for institutions and home care providers alike to either initiate or augment frameworks for tackling ethical questions. Ethical issues are not limited to the nursing home setting. They can arise in community-based agencies or senior housing facilities as well. Examples of ethical questions which may confront those who serve older people include whether and how to continue providing serv-

ices to a client who is living in unsafe conditions, how to approach the subject of living wills and health care proxies, what level of risk versus restraint elderly nursing home residents and their families are comfortable with, and how to manage difficult behaviors in group living settings, whether they are in institutional or community-based settings.

D. PROGNOSIS

The need for long-term care reform has been discussed for many years. This issue has been difficult to tackle, because the enormous costs of improving access to long-term care services for the elderly tend to deter interest in comprehensive legislative reform, particularly in light of the need to reduce the Federal budget deficit. In addition, there is no consensus on a variety of issues relating to long-term care, such as the relative roles of public and private financing, what services should be provided and by whom, and how to determine eligibility.

However, the same pressures that have driven the long-term care debate during the past 15 years continue to mount. The two major financing problems in long-term care are the lack of funding for home and community-based care and the potentially impoverishing consequences of needing nursing home care. Also driving the need for reform is the projected future growth in the population needing long-term care. The demand for long-term care services is expected to escalate over the next several years because of the growing population of older Americans. The age 65 and older group is expected to increase from the present level of 25 million to 36 million by the year 2000. More notably, the age 85 and over population (those most at risk of needing institutional care) is expected to increase from 2.5 million at the present time to 5 million in the year 2000—an increase of 100 percent.

The current debate over how to reform the Medicaid program, will have a dramatic affect on the future of long-term care financing. While the proposals vary significantly, virtually all Medicaid reform proposals attempt to limit the growth of the Medicaid program. Thus, in the short term, it appears that the delivery of long-term care must become more efficient and that the private sector will be encouraged to finance a greater share of long-term care expenses. However, given the growth of the elderly population and the limitation of the private market, the Nation will be forced to address comprehensive long-term care reform in the next century.

Chapter 10

HEALTH BENEFITS FOR RETIREES OF PRIVATE SECTOR EMPLOYERS

A. BACKGROUND

Following the enactment of Medicare in the mid-1960's, the prevalence of employer-sponsored retiree health benefit packages increased dramatically. Employers could offer health benefits to their retirees with the assurance that the Federal Government would pay for many of the medical costs incurred by company retirees age 65 and older. Retiree health benefits were often included in large private employer plans and were a major source of Medicare supplemental insurance for retirees.

In the 1990s, however, a number of companies have reduced and sometimes eliminated their retiree health benefits. Some of these curtailments have prompted class-action law suits from retirees who would face higher costs and restrictions on providers (or even requirements they use new providers) or who would have to obtain and pay for individual insurance policies. Employer actions have raised concern that rising health care costs, new accounting rules, and increased competitive pressures are leading to cut-backs at retirees' expense.

A 1997 survey of large employer plans by the consulting firm Towers-Perrin found that costs for retirees age 65 and over increased by an average of 7 percent in 1996. The rate of increase was more than double the previous rise. Much of the increase was caused by rising prices for prescription drugs, which are not covered by Medicare. The survey found that plan costs for early retirees (those under age 65) rose by an average of 4 percent.

Employers are more conscious of retiree health plan costs since accounting rules now require recognition of postretirement benefit liabilities on their balance sheets. While the accounting rules (known as FAS 106) apply only to private sector employers, similar rules may soon apply to State and local governments as well. According to a 1996 Employee Benefit Research Institute report, "FAS 106 has dramatically changed the way most private companies account for their retiree health benefits and other postretirement nonpension benefit obligations." The report cites a 1995 Buck Consultants study of Fortune 1000 companies which found that 51 percent of responding employers modified or were considering modifications to their postretirement benefit programs. The most common modification was a change in cost-sharing provisions (29 percent), followed by caps on company contributions (22 percent) and annual adjustments to retiree contribution amounts (17 per-

cent). About 4 percent of employers were considering terminating plans or ending employer contributions for them.

A 1996 report by Hay/Huggins consultants shows the trend for retiree health benefits for firms in its surveys (primarily large companies). In 1989, 65 percent of the firms provided health benefits to retirees age 65 or over, but in 1995, only 55 percent did. The comparable figures for retirees under age 65 were 66 percent and 59 percent. In 1989, 49 percent of the firms fully paid the costs for retirees age 65 and over, but in 1995 only 34 percent did. The comparable figures for retirees under age 54 were 44 percent and 26 percent.

Most retiree health plans are funded on a pay-as-you-go basis. Very few have been adequately prefunded. As such, they represent large unfunded liabilities to employers. The absence of benefit security has led to a growing concern over whether employers can meet these obligations. Furthermore, rising medical costs, changes in Medicare policy, and new accounting rules have converged to create uneasiness among employers about the wisdom of offering retiree health benefits.

The cost of purchasing an individual health care policy following retirement is often prohibitive for many retirees. Thus, the opportunity for continued participation in an employer's group plan after retirement is of significant value to many retired workers.

1. Who Receives Retiree Health Benefits?

Although privately sponsored retiree health benefits are far from universal, they are nevertheless a major source of health coverage for many retirees. About 40 percent of full-time noninstitutionalized early retirees have health benefits from prior employment, while about 15 percent have employment coverage through another family member. (About 30 percent have another form of insurance—private policies, veteran health care, Medicaid, etc.—and about 15 percent are uninsured.) For full-time Medicare-covered retirees, about 25 percent have health benefits from prior employment and about 4 percent have employment coverage through another family member. (Source: Current Population Survey data for 1993 coverage. Percentages may be different for part-time retirees, spouses of retirees, and spouses of deceased retirees.)

Availability of retiree health benefits tends to increase with workers' income and size of firm. Government workers are more likely to be covered than private-sector employees, though in some industries (communications and utilities, for example) coverage is more common. Retiree health benefits are least common in construction, wholesale and retail trades, personal services, and agriculture, forestry, and fishing. Unionized employees are more likely to have coverage than nonunionized, and full-time employees more than part-time.

2. Design of Benefit Plans

Employers that provide coverage for retired employees and their families in the company's group health plan generally provide full coverage until age 65. At that point, companies may adjust their

plans to take account of the benefits provided by Medicare. There are a variety of plan designs.

The most common are Medicare "carve-out" plans, in which retirees receive the same medical coverage as active employees, but also have the same co-payments and deductibles. Employers pay only the difference between what they would pay in the absence of Medicare and what Medicare pays. Because retirees share costs through co-payments and deductibles, carve-out plans tend to be the least costly for employers.

Under "coordination of benefit" plans, the plan pays the difference between what Medicare pays and the actual cost of the services, up to what the plan would pay without Medicare. In effect, the plan will only reimburse the beneficiary for up to 100 percent of the cost, but no more.

Under "Medicare supplement", or "wrap around" plans, the employer's benefit plan and Medicare benefits are coordinated to give retirees up to 100 percent coverage of Medicare covered services (as well as additional services not covered by Medicare). These plans may impose co-insurance and deductibles.

Finally, there is "exclusion coverage" under which Medicare payments are subtracted from actual charges and employer benefits are applied to the remainder.

3. Recognition of Corporate Liability

Until 1985, companies were not required to disclose the existence of retiree health plans or liabilities on financial statements or other reporting forms subject to public scrutiny. In November 1984, the Financial Accounting Standards Board (FASB)—the independent, nongovernmental authority that establishes accounting principles and standards of reporting in the United States—adopted an interim rule that required plan disclosure, starting in 1985. Specifically, FASB required firms that provide retiree health benefits to footnote certain information on their financial statements, including descriptions of the benefits provided and the employee groups covered, the methods of accounting and the funding policies for the benefits, and the costs of the benefits for the period of the financial statement.

In December 1990, FASB released final rules requiring corporations to report accrued as well as current expenses for retiree health benefits (FAS 106). This requirement went into effect in 1993, with a 2-year delay for small nonpublic plans (companies with fewer than 500 employees) and non-U.S. plans.

According to a GAO study released in 1993, FAS 106 "does not affect how much employers pay for the coverage provided in any year, nor does it require that they set aside funds to pay these future costs . . . it does not appear to have a direct impact on the financial conditions of the companies because it does not affect their cash flow. . . . However, FAS 106 has changed employers' perception of retiree health benefits by making them more aware of the magnitude of their liabilities."

The reporting standard has financial implications for companies that fund their benefits on a pay-as-you-go basis. When a company is required to report accrued liabilities, the financial markets may reassess its value. Investors may look to see whether a company

will be able to fund its retiree health plans and still earn competitive returns. FAS 106 could have a particularly adverse effect on companies that are already in an unstable condition.

In response to the FASB rules, some employers are considering pre-funding retiree health benefits. Others are trying to reduce their liabilities by switching to managed care plans, requiring additional cost-sharing, or discontinuing retiree health benefits altogether.

4. Benefit Protection Under Existing Federal Laws

The legal status of retiree health benefits is analogous to the status of pension plans before the passage of ERISA in 1974. Whether retirees receive health benefits depends upon the labor market position and goodwill of the employer, limited Federal regulation, and some legal precedents which hold that, to the extent there is a contractual obligation to provide health benefits, they should be provided for life unless there is a disclaimer to the contrary in the policy. There are no Federal requirements for vesting (the earning of a nonforfeitable right to a benefit) or funding of retiree health plans, and there are few safeguards to protect retirees from losing their benefits in the event of a plan termination. There is also no insurance mechanism to ensure that benefits will continue if the employer's plan runs out of money.

Companies that have tried to change or terminate retiree health benefits sometimes have been sued by their retirees. Prior to the passage of ERISA, courts tended to fashion contract law theories which looked at retiree health benefits either as deferred compensation or as the result of unilateral contracts with employees. The courts generally ruled that employees who worked the requisite number of years to earn benefits were entitled to them, unless there were clear understandings between the employer and the employees to the contrary. They reasoned that employees had accepted lower salaries to ensure that they would receive benefits in retirement. While nonunion employees generally brought suit under State law, arguing that employers had violated their contractual agreements, union employees sued for contract violations under the Labor Management Relations Act, a Federal law.

The enactment of ERISA provided new legal grounds to challenge employers' attempts to change or terminate health benefits. However, because ERISA resulted from congressional interest in making pensions secure, far fewer protections were provided for health and other welfare benefit plans. The law draws a clear distinction between pensions and welfare benefits (defined to include medical, surgical, or hospital care benefits, as well as other types of welfare benefits). While ERISA sets up explicit vesting and funding standards for pensions, it leaves retiree health and other benefits in a less-protected position. This is especially so because it provides generally that welfare benefit plans are governed exclusively under ERISA. State laws and regulations are preempted.

ERISA does provide additional safeguards in its requirement that employer-sponsored plans comply with specific standards relating to disclosure, reporting, and notification in cases of plan termination, merger, consolidation, or transfer of plan assets. (Plans that cover fewer than 100 participants are partially exempt from

these requirements.) In addition, plan fiduciaries (those responsible for managing and overseeing plan assets) and those who handle the plan's assets or property must be bonded. Fiduciaries must discharge their duties solely in the interest of participants and beneficiaries, and they can be held liable for any breach of their responsibilities. Plan participants and beneficiaries also have the right under ERISA to file suit in State and Federal court to recover benefits, to enforce their rights under the terms of the plan, and to clarify their rights to future benefits.

If the employer clearly states that it reserves the right to alter, amend, or terminate the retiree benefit plan at any time, and communicates that disclaimer to employees and retirees in clear language, then the courts will sustain the right of the employer to cut back or cancel all benefits. Most employers have amended their plans in recent years to include such disclaimers. Employees have countered that retiree health benefits are a form of deferred compensation in that employees forego higher wages to receive these benefits in the future. Employers therefore should be obligated to provide the benefits. Moreover, they argue, ERISA does not prohibit vesting of retiree health benefits.

B. CONGRESSIONAL RESPONSE

1. Continuation of Coverage

For reasons independent of retiree health concerns, Congress included in the Consolidated Budget Reconciliation Act of 1985 (COBRA, P.L. 99–272) provisions requiring employers with 20 or more employees to offer employees and their families the option to continue their health insurance when faced with loss of coverage because of certain events.

A variety of events trigger COBRA continuation of coverage, including termination of reduction in hours of employment (for reasons other than gross misconduct). When a covered employee leaves his or her job, cuts back in hours, or retires, the continued coverage of the employee and any qualified beneficiaries must be provided for 18 months. The employer's health plan may require the employee or beneficiary to pay the premium for the continued coverage, but the premium may not exceed 102 percent of the otherwise applicable premium for that period.

The significance of COBRA is that it provides retirees with continued access to group health insurance for either 18 months or until the individual becomes eligible for Medicare, whichever comes first. For retirees of companies that previously did not provide retiree health benefits, COBRA provides a source of coverage. However, if the employer discontinues the health plan for all employees, COBRA offers no help, because such an action is explicitly specified as a reason for terminating continuation coverage. Thus, COBRA adds only limited protections in Federal law.

In the 1986 Omnibus Budget Reconciliation Act (P.L. 99–509), Congress amended COBRA to require continuation coverage for retirees in cases where the employer files for bankruptcy under Chapter 11 of the U.S. Code. Retired employees who lose coverage as a result of the employer's bankruptcy can purchase continuation

coverage for life. For the surviving spouse or the dependent children of the covered employee, the coverage is limited to 36 months.

The Retiree Benefits Bankruptcy Protection Act of 1988 (P.L. 100–334) provides additional protection in cases of bankruptcy. The Act resulted from an attempt of the LTV Corporation to terminate retiree health and life insurance when it entered bankruptcy in 1986. When a petition is filed under chapter 11 of the Bankruptcy Code, the Act provides that retiree non-pension benefits must be continued without change unless agreed to by the parties or ordered by the court. Retirees are ensured representation in bankruptcy proceedings, and further safeguards are stipulated with respect to trustee proposals and reorganization plans. The Act also amended earlier legislation, P.L. 99–591, to apply its provisions to bankruptcies filed after October 2, 1986, and before June 16, 1988, the effective date on P.L. 100–334.

Finally, the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104–191) may help some retirees obtain private individual insurance upon the exhaustion of their COBRA coverage or termination of their employer plan. Under either Federal or alternative state requirements, qualifying individuals cannot be subject to preexisting condition restrictions and must be offered a choice of certain insurance options. The legislaation allows States to provide financial subsidies or adopt risk spreading arrangements that would help higher risk individuals afford coverage.

2. Pre-Funding

Currently, there are two major tax vehicles for pre-funding retiree health benefits: 401(h) trusts and voluntary employees benefit association plans (VEBAs). Authorized since 1962, 401(h) of the Internal Revenue Code allows employers to make tax deductible contributions to retiree health accounts; account income is tax exempt and benefit payments are excludable from recipients' gross income. The Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508) permits employers to transfer without tax penalty their excess defined benefit pension plan assets to 401(h) accounts for financing retiree health benefits. P.L. 103–465 extended this provision through December 31, 2000. However, statutory restrictions and record-keeping requirements have limited the attractiveness of 401(h) plans: employer contributions must be "incidental" to the pension obligation and no tax deduction is allowed if the pension plan is fully funded. When excess pension funds are transferred, health plan benefits may not be reduced for 5 years.

Current law also allows employers to make contributions to VEBAs for retiree health benefits and other purposes. Provided requirements are met, employers' contributions are deductible and benefit payments are excludable from recipients' gross income. However, the utility of VEBAs is restricted since deductions are limited to the sum of qualified direct costs (essentially current costs) and allowable additions to a qualified asset account for health and other benefits, reduced by after-tax income. While the asset account limit may include an actuarially determined reserve for retiree health benefits, the reserve may not reflect either future inflation or changes in usage, which restricts its usefulness. Collectively bargained and employee-pay-all plans are exempt from ac-

count limits. Earnings on VEBA assets beyond certain amounts may be subject to taxes on unrelated business income.

Pre-funding of retiree health benefits will remain an unattractive option for employers unless tax incentives are provided similar to those available for pensions. Faced with budgetary constraints, Congress probably is unwilling to provide those incentives. The enactment of minimum standards that will guarantee specified benefits for retirees is generally seen as a corresponding trade-off for tax-favored treatment.

C. OUTLOOKS

With the failure of comprehensive health reform proposals in the 103d Congress, options to expand and protect retiree health benefits have become more limited. There are no immediate prospects for providing employers tax incentives to pre-fund retiree health benefits: the additional revenue loss would complicate efforts to balance the Federal budget, and the concomitant need to establish standards for qualified plans and vesting would expand Federal authority over matters that now are largely left up to employers. Ensuring retiree health benefits in any comprehensive manner may have to await future debates over whether Medicare should be restructured to allow private plan options, including those that carry over from earlier employment.

In the immediate future, consideration might be given to extending COBRA continuation coverage from 18 months to three years and to requiring it in cases of chapter 7 (liquidation) bankruptcies. In addition, ERISA possibly might be amended to strengthened employee notification standards, especially in cases of plan termination, or even to limit employer discretion to reduce or eliminate benefits.

Chapter 11

HEALTH RESEARCH AND TRAINING

A. BACKGROUND

During the 104th Congress the Senate Special Committee on Aging held several hearings which examined the importance of focusing medical research on health issues which affect America's aging population. Among these hearings was a joint hearing, with the Senate Committee on Appropriations, which showed that medical research offers tremendous hope for individuals with chronic illnesses and how increasing funding for research is an important strategy in addressing growing health care costs in programs such as Medicare and Medicaid. The hearing also examined the reasons why public financing of all types of medical research is critical and discussed ways in which more money can be directed to the National Institutes of Health through funding mechanisms to supplement the appropriations process. The committee heard moving and compelling testimony from a distinguished panel of witnesses including: General Norman Schwarzkopf who testified on his battle with prostrate cancer; Major League Baseball Hall-of-Famer, Rod Carew, who spoke about his daughter's death due to leukemia; and Travis Roy a 20-year-old Boston University student from Yarmouth, Maine, who suffered an injury during his first college hockey game that left him paralyzed from the neck down.

In 1995, the committee also conducted a hearing which specifically focused on the importance of investing more research dollars in brain research. A report by the Alliance for Aging Research was presented which demonstrated, for example: a five year delay in the onset of Alzheimer's Disease could cut health care spending by as much as $50 billion annually; a five year delay in the onset of stroke could save $15 billion annually; and a five year delay in the onset of Parkinson's disease could save as much as $3 billion each year in health care costs.

In February 1996, the Senate Special Committee on Aging held a hearing on mental health and the elderly. The hearing demonstrated that research and services targeted toward the treatment of mental disorders in the elderly can improve health outcomes and reduce medical costs over time. As a follow up to this hearing, in July, the committee focused on the growing problem of suicide among the elderly and discussed why older men are even more likely to suffer from depression that ultimately causes them to take their lives.

The general population is surviving longer. People with disabilities are also surviving longer because of effective vaccines, preventive health measures, better housing, and healthier lifestyle

choices. With the rapid expansion of the Nation's elderly population, the incidence of diseases, disorders, and conditions affecting the aged is also expected to increase dramatically. The frequency of Alzheimer's disease and related dementias, is projected to triple by the year 2050 if biomedical researchers do not develop ways to prevent or treat it. A commitment to expand aging research could substantially reduce the escalating costs of long-term care for the older population. The ratio of elderly persons to those of working age will have nearly doubled between 1990 and 2050. In addition, older Americans are living longer and longer. In fact, those aged 85 and older—the population most at risk of multiple health problems that lead to disability and institutionalization—are the fastest growing segment of our population. This portion of our population will rise from its current 3.3 million to 9 million Americans 25 years from now, and more than double again by the year 2050.

Although scientific and medical research is helping to decrease or, in some cases, eradicate diseases specifically affecting the elderly population, research has not kept up with the growth rate of this population. Fiscal year 1996 appropriations for the National Institutes of Health (NIH) totaled $11.9 billion, a 5.7 percent increase over the fiscal year 1997 funding. In late September 1996, Congress voted a 6.9 percent increase for fiscal year 1997, giving NIH 12.7 billion to spend this fiscal year.

The National Institute on Aging (NIA) is the largest single recipient of funds for aging research. Fiscal year 1997 NIA appropriations have increased 7.2 percent over fiscal year 1996 funding levels; from $433.9 million in fiscal year 1996 to $453.5 million in fiscal year 1997. This increase in aging research funding is significant to not only to older Americans, but to the American population as a whole. Research in Alzheimer's disease, for example, focuses on causes, treatments, and the disease's impact on care providers. Any positive conclusions that come from this research will help to reduce the cost of long-term care that burdens society as a whole. In addition, research into the effects that caring for an Alzheimer's victim has on family and friends could lead to an improved system of respite care, extended leave from the workplace, and overall stress management. Therefore, the benefits derived from an investment in aging research applies to all age groups.

Several other institutes at NIH are also involved in considerable research of importance to the elderly. The basic priority at NIA is to understand the aging process. What is being discovered is that many changes previously attributed to "normal aging" are actually the result of various diseases. Consequently, further analysis of the effects of environmental and lifestyle factors is essential. This is critical because, if a disease can be specified, there is hope for treatment and, eventually, for prevention and cure. One area receiving special emphasis is women's health research, including a multiyear, trans-NIH study addressing the prevention of cancer, heart disease, and osteoporosis in postmenopausal women.

Currently, it is estimated that 38 percent of all health costs in the United States are spent on the 13 percent of the population over age 65. With the projected rapid expansion of the aging population, it is expected that by the year 2004, one-half of each health cost dollar will be spent on older Americans.

B. THE NATIONAL INSTITUTES OF HEALTH

1. Mission of NIH

The National Institutes of Health (NIH) seeks to improve the health of Americans by increasing the understanding of the processes underlying disease, disability, and health, and by helping to prevent, detect, diagnose, and treat disease. It supports biomedical and behavioral research through grants to research institutions, conducts research in its own laboratories and clinics, and trains young scientific researchers.

With the rapid aging of the U.S. population, one of the most important research goals is to distinguish between aging and disease in older people. Findings from NIH's extensive research challenge health providers to seek causes, cures, and preventive measures for many ailments affecting the elderly, rather than to dismiss them as being the effects of the natural course of aging. A more complete understanding of normal aging, as well as of disorders and diseases, also facilitates medical research and education, and health policy and planning.

2. The Institutes

Much NIH research of particular diseases, disorders, and conditions is collaborative, with different institutes investigating pathological aspects related to their specialty. At least 15 of the NIH research institutes and centers investigate areas of particular importance to the elderly. They are:

National Institute on Aging
National Cancer Institute
National Heart, Lung, and Blood Institute
National Institute of Dental Research
National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Neurological Disorders and Stroke
National Institute of Allergy and Infectious Diseases
National Eye Institute
National Institute of Environmental Health Sciences
National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institute on Deafness and Other Communication Disorders
National Institute of Mental Health
National Institute of Alcohol Abuse and Alcoholism
National Center for Research Resources
National Institute of Nursing Research

(A) NATIONAL INSTITUTE ON AGING

The National Institute on Aging (NIA) was established in 1974 in recognition of the many gaps in the scientific knowledge of aging processes. NIA conducts and supports a multidisciplinary program of geriatric research, including research into the biological, social, behavioral, and epidemiological aspects of aging. Through research and health information dissemination, its goal is to prevent, allevi-

ate, or eliminate the physical, psychological, and social problems faced by many older people.

Specific NIA activities include—diagnosis, treatment, and cure of Alzheimer's disease; investigating the basic mechanisms of aging; reducing fractures in frail older people; researching health and functioning in old age; improving long-term care; fostering an increased understanding of aging needs for special populations; and improving career development training opportunities in geriatrics and aging research.

The longest running scientific examination of human aging, the Baltimore Longitudinal Study of Aging (BLSA), is being conducted by NIA at the Nathan W. Shock Laboratories, Gerontology Research Center (GRC) in Baltimore, MD. More than 1,000 men and women, ranging in age from their twenties to nineties, participate every 2 years in more than 100 physiological and psychological assessments, which are used to provide a scientific description of aging. According to the BLSA publication, Older and Wiser, "the objectives of the BLSA are to measure changes in biological and behavioral processes as people age, to relate these measures to one another, and to distinguish universal aging processes from those associated with disease and particular environmental effects." One of the most significant results of the study thus far is that aging does not necessarily result in a general decline of all physical and psychological functions. Rather, many of the so-called age changes appear to be the result of disease, which can often be prevented. The BLSA has entered into its fourth decade, and there are no plans to conclude the research now being conducted.

(B) NATIONAL CANCER INSTITUTE

The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection, and treatment of cancer. Of all new cancer cases reported, more than half are elderly patients, and more than 60 percent of all persons who die of cancer each year are older Americans.

The incidence of cancer increases with age. Although aging is not the cause of cancer, the processes are related. More than 80 percent of all cancers occur in persons age 50 and older, and 58 percent occur in people age 65 and over. The rate of overall cancer incidence and mortality has been increasing, particularly in those age 55 and older.

In addition to basic and clinical, diagnostic, and treatment research, NCI supports prevention and control programs, such as programs to stop smoking.

(C) NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

The National Heart, Lung, and Blood Institute (NHLBI) focuses on diseases of the heart, blood vessels, blood and lungs, and on the management of blood resources. Three of the most prevalent chronic conditions affecting the elderly—hypertension, heart conditions, and arteriosclerosis—are studied by NHLBI. In 1992, approximately 1.1 million deaths were reported from all of the diseases under the purview of the Institute (half of the U.S. deaths that year). In 1994, associated economic costs were nearly $200 billion, including $150 billion in direct health care expenditures. Over 60

percent of all elderly suffer from hypertension, 25 percent from a chronic heart condition, and 8 percent from arteriosclerosis.

Research efforts focus on cholesterol-lowering drugs, DNA technology, and genetic engineering techniques for the treatment of emphysema, basic molecular biology research in cardiovascular, pulmonary, and related hematologic research, and regression of arteriosclerosis.

NHLBI also conducts an extensive professional and public education program on health promotion and disease prevention, particularly as related to blood pressure, blood cholesterol, and coronary heart disease. This has played a significant role in the 60 percent decline in stroke deaths and the 43 percent decline in heart disease since 1970.

(D) NATIONAL INSTITUTE OF DENTAL RESEARCH

The National Institute of Dental Research (NIDR) supports and conducts research and research training in oral health and disease. Major goals of the Institute include the prevention of tooth loss and the preservation of the oral tissues. Other research areas include birth defects affecting the face, teeth, and bones; oral cancer; infectious diseases; chronic pain; epidemiology; and basic studies of oral tissue development, repair, and regeneration.

In a national study conducted in 1985–86, NIDR found that 42 percent of men and women age 65 and older examined in the survey had lost all of their teeth, compared to only 4 percent of adults between age 18 and 65. Older Americans also face extensive periodontal disease, a major cause of tooth loss. Faced with these findings, the Institute has expanded oral health research with the elderly and is collaborating with the National Institute on Aging and the Veterans Administration in an oral health research, promotion, and disease prevention project.

(E) NATIONAL INSTITUTE OF DIABETES AND DIGESTIVE AND KIDNEY DISEASES

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) conducts and supports research and research training in diabetes, endocrinology and metabolic diseases; digestive diseases and nutrition; and kidney, urologic and blood diseases.

Diabetes, one of the Nation's most serious health problems and the largest single cause of renal disease, affects between 13–14 million Americans at an annual cost to society of nearly $92 billion. Nearly 10 percent of the elderly are believed to be diabetic.

Benign prostatic hyperplasia (BPH), or prostate enlargement, is a common disorder affecting older men. NIDDK is currently studying factors that can inhibit or enhance the growth of cells derived from the human prostate. NIDDK also supports research on urinary tract infections, which affect many postmenopausal women.

(F) NATIONAL INSTITUTE OF NEUROLOGICAL DISORDERS AND STROKE

The National Institute of Neurological Disorders and Stroke (NINDS) supports and conducts research and research training on the cause, prevention, diagnosis, and treatment of hundreds of neu-

rological disorders. This involves basic research to understand the mechanisms of the brain and nervous system and clinical research.

Most of the disorders studied by NINDS result in long-term disabilities and involve the nervous system (including the brain, spinal cord, and peripheral nerves) and muscles. NINDS is committed to the study of the brain in Alzheimer's disease. In addition, NINDS research focuses on stroke, Huntington's disease, Parkinson's disease, and amyotrophic lateral sclerosis. NINDS is also conducting research on neuroimaging technology and molecular genetics to determine the etiology of Alzheimer's disease.

NINDS research efforts in Parkinson's disease include work on causes, such as environmental and endogenous toxins; genetic predisposition; altered motor circuitry and neurochemistry, and new therapeutic interventions such as surgical procedures to reduce tremor.

Strokes, the Nation's third-leading cause of death and the most widespread neurological problem, primarily affects the elderly. New drugs to improve the outlook of stroke victims and surgical techniques to decrease the risk of stroke currently are being studied.

(G) NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

The National Institute of Allergy and Infectious Diseases (NIAID) focuses on two main areas: infectious diseases and diseases related to immune system disorders.

Influenza can be a serious threat to older adults. NIAID is supporting and conducting basic research and clinical trials to develop treatments and to improve vaccines for high-risk individuals. Because older persons also are particularly vulnerable to hospital-associated infections, NIAID research is leading to a vaccine offering protection against one of the most common, difficult to control and often fatal infections, P. aeruginosa.

(H) NATIONAL EYE INSTITUTE

The National Eye Institute (NEI) conducts and supports research and research training on the prevention, diagnosis, treatment, and pathology of diseases and disorders of the eye and visual system. The age 65 and older population accounts for one-third of all visits for medical eye care. Glaucoma, cataracts, and aging-related maculopathy, which are of particular concern to the elderly, are being studied by NEI. Some of this research is intended to serve as a foundation for future outreach and educational programs aimed at those at highest risk of developing glaucoma.

(I) NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES

The National Institute of Environmental Health Sciences (NIEHS) conducts and supports basic biomedical research studies to identify chemical, physical, and biological environmental agents that threaten human health.

Current research activities include work on the breast cancer susceptibility gene, BRCA1, which was isolated and sequenced through the collaborative efforts of NIEHS intramural scientists and colleagues in Utah. NIEHS-scientists are conducting studies to determine whether the continuing depletion of the protective ozone

layer of the atmosphere will lead to increased human exposure to ultraviolet radiation.

(J) NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) investigates the cause and treatment of a broad range of diseases, including osteoporosis and the many forms of arthritis. The Institute supports 30 specialized and comprehensive research centers.

Affecting over 40 million Americans, these diseases are among the more debilitating of the more than 100 types of arthritis and related disorders. Older adults are particularly affected. Almost 50 percent of all persons over age 65 suffer from some form of chronic arthritis. An estimated 25 million Americans, most of them elderly, have osteoporosis.

Topics of research on the cause and treatment of rheumatoid arthritis, a chronic inflammatory disease of unknown cause, include the study of the immune cells present in the synovial fluid around arthritic joints, and the genetic basis for production of rheumatoid factor (an abnormal antibody found in the blood of patients with rheumatoid arthritis).

Research on osteoarthritis, a degenerative joint disease, focuses on changes in the network of surrounding cartilage cells in the joint.

(K) NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS

The National Institute on Deafness and Other Communication Disorders (NIDCD) conducts research into the effects of advancing age on hearing, vestibular function (balance), speech, voice, language, and chemical and tactile senses.

Presbycusis (the loss of ability to perceive or discriminate sounds) is a prevalent but understudied disabling condition. One-third of people age 65 and older have presbycusis serious enough to interfere with speech perception. Studies of the influence of factors, such as genetics, noise exposure, cardiovascular status, systemic diseases, smoking, diet, personality and stress types, are contributing to a better understanding of the condition.

(L) NATIONAL INSTITUTE OF MENTAL HEALTH

The National Institute of Mental Health (NIMH) is involved in extensive research relating to Alzheimer's and related dementia, and the mental disorders of the elderly. NIMH is focusing on identifying the nature and extent of structural change in the brains of Alzheimer's patients to better understand the neurochemical aspects of the disease. NIMH research has discovered a protein specific to Alzheimer's that shows promise of being a positive diagnostic marker for the disease. Research into amnesia is also increasing knowledge about Alzheimer's and other dementia.

Depression is a relatively frequent and often unrecognized problem among the elderly, contributing to the high suicide rate within this population. Currently, white males over age 85 have the high-

est recorded suicide rate of any group in the population (75.1/100,000). Research has shown that nearly 40 percent of the geriatric patients with major depression also meet the criteria for anxiety, which is related to many medical conditions, including gastrointestinal, cardiovascular, and pulmonary disease.

The Centers for Disease Control recently stated that elderly suicide is emerging as a major public health problem. After nearly four decades of decline, the suicide rate for people over 65 began increasing in 1980 and has been growing ever since. In response to the increasing incidence of suicide among the elderly, the Senate Special Committee on Aging held a hearing in July 1996 which focused on warning signs and factors that might put an elderly person at risk for suicide. The hearing also discussed the need for increasing our vigilance towards the signs of depression and how efforts to intervene can prevent the elderly suicides from occurring.

NIMH has identified disorders of the aging as among the most serious mental health problems facing this Nation and is currently involved in a number of activities relevant to aging and mental health.

(M) NATIONAL INSTITUTE OF ALCOHOL ABUSE AND ALCOHOLISM

Alcoholism among the elderly is often minimized due to low reported alcohol dependence among elderly age groups in community and population studies. Also, alcohol-related deaths of the elderly are underreported by hospitals. Because the elderly population is growing at such a tremendous rate, more research is needed in this area.

Although the prevalence of alcoholism among the elderly is less than in the general population, per capita health care utilization by elderly alcoholics is twice as high.

(N) NATIONAL CENTER FOR RESEARCH RESOURCES

The National Center for Research Resources (NCRR) is the Nation's preeminent developer and provider of the resources essential to the performance of biomedical research funded by the other entities of NIH and the Public Health Service.

NCRR grantees of the General Clinical Research Centers (GCRC) program have found that a drug used to treat breast cancer also may increase bone mass in women who are susceptible to osteoporosis. Another grantee discovered that many older people have a lower level of acidity in the stomach than young people. This lower acidity level can affect the absorption of certain drugs. Research studies on older monkeys are yielding data on cerebral glucose metabolism, insulin response, and other physiological parameters relevant to age-related diseases.

(O) NATIONAL INSTITUTE OF NURSING RESEARCH

The National Institute of Nursing Research (NINR) conducts, supports, and disseminates information about basic and clinical nursing research through a program of research, training, and other programs. Research topics related to the elderly include: depression among patients in nursing homes to identify better approaches to nursing care; physiological and behavioral approaches

to combat incontinence; initiatives in areas related to Alzheimer's disease, including burden-of-care; osteoporosis; pain research; and the ethics of therapeutic decisionmaking.

C. ISSUES AND CONGRESSIONAL RESPONSE

1. NIH APPROPRIATIONS

At $12.7 billion, NIH's budget represents about a third of Federal Civilian (non-defense) spending for research and development. When measured in current dollars, the appropriation has grown over five-fold in the last 20 years (the fiscal year 1977 appropriation was $2.5 billion) and has nearly doubled in the last decade (the comparable fiscal year 1987 appropriation was $6.7 billion). Even when inflation is taken into account, the NIH budget grew nearly 34 percent in the period fiscal year 1986–1995. Growth has slowed considerably as pressure to reduce the deficit has increased, but NIH still enjoys strong bipartisan support. When the fiscal year 1996 appropriations bill covering DHHS (H.R. 2127) remained unresolved for several months, Congress rescued NIH by including its full-year funding in January 1996 continuing resolution (P.L. 104–91). Subsequent action on the April 1996 omnibus appropriations act for fiscal year 1996 (P.L. 104–134) set NIH's final level at $11.9 billion, a 5.7 percent increase over the fiscal year 1995 amount, well above the estimated biomedical research inflation rate for fiscal year 1996 of 3.5 percent. For fiscal year 1997, the President requested a $12.38 billion (a 3.8 percent increase over fiscal year 1996), the House approved a $12.75 billion, a 6.9 percent increase (H.R. 3755), H. Rept. 104–659), and the Senate Appropriations Act, 1997 (P.L. 104–208, H. Rept. 104–863 on H.R. 3610). Compared with the President's request, the appropriation is weighted more to the research programs and less to construction of a new Clinical Research Center.

Appropriation levels for the previously mentioned institutes at NIH involved with aging research are as follows:

FISCAL YEAR 1997 APPROPRIATION FOR NIH

[Dollars in millions]

Institute or Center	Fiscal year 1997 Appropriation	Fiscal year 1997 Aging Research (Estimates)
Cancer	$2,382.5	$40.4
Heart/Lung/Blood	1,433.0	35.8
Dental Research	196.0	9.6
Diabetes/Digestive/Kidney	816.0	42.8
Neurology/Stroke	726.7	52.9
Allergy/Infectious Diseases	1,257.2	44.2
General Medical Sciences	998.5	.....
Child Health/Human Development	631.7	5.0
Eye	332.7	57.6
Environmental Health	308.8	5.5
Aging	486.0	463.4
Arthritis/Musculosketal/Skin	257.1	27.4
Deafness/Communication Disorders	188.4	8.3
Nursing Research	59.7	8.2
Alcoholism/Alcohol Abuse	212.0	6.4
Drug Abuse	489.4	0.6
Mental Health	701.6	55.5

FISCAL YEAR 1997 APPROPRIATION FOR NIH—Continued

[Dollars in millions]

Institute or Center	Fiscal year 1997 Appropriation	Fiscal year 1997 Aging Research (Estimates)
Research Resources	415.1	11.9
Human Genome Center	189.7	.....
Fogarty Center	26.6	.....
Library of Medicine	151.1	.....
Office of Director	287.2	0.0
Buildings & Facilities	200.0	.....
Total, NIH	$12,747.0	$875.5

2. NIH Authorizations

Most of the congressional attention to NIH in the 104th Congress focused on budgetary issues, with the Senate also active on reauthorization legislation. The fiscal year 1996 budget process included threatened decreases for NIH in the budget resolutions; an appropriations bill with potential increases, which was derailed as the House and Senate disagreed over several "legislative riders" (non-budgetary provisions added to the bill); and finally, after a strong lobbying effort by the biomedical research community, passage of the continuing resolution mentioned above. The fiscal year 1997 NIH budget faced similar hurdles, though somewhat less extreme. Since support for biomedical research is in perpetual competition with other discretionary programs in the Labor-HHS-Education appropriations bill, most of which have fared worse than NIH in recent years, the 105th Congress can expect to revisit the same difficult choices. For fiscal year 1997, a compromise was reached on the mechanism for funding of AIDS research and the House and Senate concurred in continuing prohibitions on funding of research on human embryos.

Most of NIH's specific authorizations expired at the end of the fiscal year 1996, so new legislation may be expected in the 105th Congress. The fiscal year 1997 Labor-HHS-Education bill was passed by the House in July 1996 and was reported by the Senate Appropriations Committee, but did not go to the Senate floor. A conference agreement was included in the Omnibus Consolidated Appropriations Act, 1997. Funding for NIH totals $12.747 billion, an increase of $820 million or 6.9 percent over the revised fiscal year 1996 appropriation.

In providing additional resources to NIH beyond the requested level, the conference agreement maintained the focus on NIH's two highest priorities—construction of a new Clinical Research Center (CRC), and funding of extramural research through investigator-initiated research project grants. The infrastructure for NIH's clinical research program is its Clinical Center, which is over 40 years old and rapidly becoming obsolete. The Buildings and Facilities account received a 36.8 percent increase to allow NIH to commence construction of a smaller replacement hospital and associated laboratories. A recent report reviewing Clinical Center operations recommended numerous changes in the way it is governed, funded, and managed; these changes will be fully implemented after the new CRC is built. In addition, the conference agreement gave NIH

authority to bill third-party insurers for non-research-related patient services rendered in the Clinical Center.

3. Alzheimer's Disease

Alzheimer's disease is the most common cause of dementia among the elderly. Researchers are beginning to uncover the causes of Alzheimer's, but there is no cure. The risk for the disease, which primarily affects people age 65 and older, increases sharply with advancing age. Currently, an estimated 4 million Americans suffer from Alzheimer's. Lifestyle improvements and advances in medical technology in the decades ahead will lead to a significant increase in the number of people living to very old age and, therefore, the number of people at risk for Alzheimer's. Unless medical science can find a way to prevent the disease, delay its onset, or halt its progress, it is estimated that 14 million Americans will have Alzheimer's disease by the year 2050.

Caring for a person with Alzheimer's can be emotionally physically, and financially stressful. Researchers recently estimated that the annual cost of caring for an Alzheimer's patient is $47,000. Overall, Alzheimer's disease costs the Nation an estimated $82.7 billion a year in medical expenses, round-the-clock care, and lost productivity.

In fiscal year 1997, the National Institutes of Health (NIH) will spend an estimated $314 million on Alzheimer's research. The National Institute on Aging (NIA) at NIH is the lead Federal agency for Alzheimer's research and accounts for more than two-thirds of the research funding. The Office of Alzheimer's Disease Research within NIA coordinates the institute's research activities and promotes Alzheimer's research programs supported by other Federal and State agencies and private organizations. Other institutes at NIH that conduct Alzheimer's research include the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute of Mental Health (NIMH), the National Institute of Allergy and Infectious Disease (NIAID), and the National Institute for Nursing Research (NINR).

In the past three years, a series of important findings have pushed Alzheimer's research to the forefront of biomedical science. The significant advances in our understanding of Alzheimer's come largely on the heels of more fundamental research developments in molecular biology and neuroscience. Several recent genetic discoveries have shed new light on researchers' understanding of the cause and development of Alzheimer's disease. In an important step toward finding treatments for Alzheimer's, scientists have developed a strain of mice that suffer brain damage similar to that seen in humans with the disease. An animal model for Alzheimer's will be extremely useful in designing and testing new therapeutic agents.

One goal of current research is to develop an accurate test for Alzheimer's disease. New technologies for imaging the brain, including positron emission tomography (PET) and magnetic resonance imaging (MRI), may offer a way to establish early diagnosis, determine prognosis, monitor patients, and evaluate treatment efficacy. Harvard University researchers recently reported a simple eye test for detecting the presence of Alzheimer's. They are con-

tinuing to test people with Alzheimer's and other brain disorders to see if the test holds up in groups of people with different types of Alzheimer's.

There currently is no effective way to treat or prevent Alzheimer's disease. However, several drugs are being tested to see if they can slow or reverse the decline in those behavioral and cognitive skills that are impaired by the disease. On September 9, 1993, the FDA approved the drug Tacrine (also known by the trade name Cognex) for the treatment of Alzheimer's disease. Clinical trials of Tacrine have shown that it produces modest improvements in cognitive ability in some patients with mild to moderate Alzheimer's. Because Tacrine can cause mild liver toxicity, the labeling for the drug recommends frequent blood tests in order to identify sensitive patients. Several other experimental drug treatments are available to Alzheimer's patients through clinical trials being conducted at large teaching hospitals and universities.

In 1985, the NIA began funding Alzheimer's Disease Research Centers (ADRCs) at major medical research institutions across the country. The ADRCs provide clinical services to Alzheimer's patients, conduct basic and clinical research, disseminate professional and public information, and sponsor educational activities. By 1989, 15 ADRCs had been established. To make the best use of limited funds, the NIA also established 13 Alzheimer's Diseases Core Centers (ADCCs), which provide resources and expertise to investigators who obtain their primary research support from other sources. The ADCCs provide the investigators with well-characterized patients, patient and family information, and tissue and biological specimens for use in research projects. Five ADCCs were funded in 1990 and eight more in 1991. In 1994, the ADRC at the University of Texas in Dallas converted to a core center thus making a total of 14 of each type of center.

Beginning in 1990, the NIA initiated a program to link satellite diagnostic and treatment clinics to existing centers. The aim of the program is to target minority and rural populations in order to increase the size and diversity of the research patient pool. It also permits special population groups to participate in research protocols and clinical drug trials associated with the parent center. Most of the ADRCs and ADCCs now have satellite clinics associated with them.

NIA has also established the Consortium to Establish a Registry for Alzheimer's Disease (CERAD), a project to develop a national registry for standardized data on Alzheimer's disease. Physicians and researchers at 31 university medical centers are contributing information on diagnosis and treatment to CERAD. The project is also collecting information about Alzheimer's disease in persons of different ethnic origins and educational background.

In an effort to learn about the kinds of services used by people with dementia and their families, Congress included a provision in the Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) to establish the Medicare Alzheimer's Disease Demonstration, through which a limited number of Alzheimer's patients would receive benefits not covered under Medicare. The legislation authorized up to 10 demonstration projects, with an appropriation of $40 million over 3 years. The purpose of the demonstration, which began in

1989, was to determine the cost and impact of providing comprehensive services to Medicare beneficiaries with Alzheimer's disease.

Two models of care were tested in the demonstration. Both provided case management and a variety of in-home and community-based services not normally covered under Medicare, such as adult day care, homemaker/personal care services, companion service, family counseling, and caregiver education and training. The two models varied according to the intensity of case management provided to the patients and the amount of reimbursement available for the services. The results of the demonstration are being analyzed and a final report to Congress is expected soon.

In 1990, the Home Health Care and Alzheimer's Disease Amendments to the Public Health Service Act (P.L. 101–557) established the Alzheimer's Demonstration Grant Program at the Health Resources and Services Administration (HRSA). This program is intended to assist State agencies in planning, establishing, and operating demonstration programs to deliver respite care and supportive services to people with Alzheimer's. One of the main objectives of the program is to explore how existing public and private nonprofit resources within the State could be utilized more effectively to deliver services to Alzheimer's patients and their families. In addition, the program is identifying gaps in the services existing within communities and, where possible, developing approaches to bridge those gaps. The program has received $5 million a year since its inception in fiscal year 1992.

The Alzheimer's Disease and Related Dementias Services Research Act of 1986 (Title IX of P.L. 99–660) established the Federal Council on Alzheimer's Disease, the DHHS Advisory Panel on Alzheimer's Disease, and the Alzheimer's Disease Education and Referral (ADEAR) Center. The role of the council is to coordinate Alzheimer's disease research conducted by and through Federal agencies and identify promising areas of research. Membership includes the directors (or administrators) of all the institutes and agencies within DHHS that conduct Alzheimer's programs. The advisory panel is comprised of research scientists and its role is to set Alzheimer's research priorities and make policy recommendations. The panel prepares an annual report for the Secretary of DHHS, the council, and Congress.

The ADEAR Center at NIA provides information on diagnosis, treatment issues, patient care, caregiver needs, long-term care, education and training, research activities, and ongoing programs, as well as referrals to resources at both national and State levels. The ADEAR Center produces and distributes a variety of educational materials such as brochures, factsheets, and technical publications.

Most of the federally funded research into Alzheimer's disease is being carried out by the National Institute of Aging, National Institute of Neurological Disorders and Stroke, the National Institute of Allergy and Infectious Diseases, the National Eye Institute, the National Center for Nursing Research, the National Institute of Mental Health, the Health Care Financing Administration, and the Administration on Aging. The Administration on Aging has supported research and demonstration programs to develop and

strengthen family and community-based care for Alzheimer's disease victims.

4. Arthritis and Musculoskeletal Diseases

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) conducts the primary Federal biomedical research for arthritis and osteoporosis. Support research for these disorders is also carried out by the National Heart, Lung, and Blood Institute, the National Institute of General Medical Science, the National Center for Nursing Research, and the Office of the Director, NIH.

Osteoporosis is a disease characterized by exaggerated loss of bone mass and disruption in skeletal microarchitecture which leads to a variety of bone fractures. It is a symptomless, bone-weakening disease, which usually goes undiscovered until a fracture occurs. Osteoporosis, is a major debilitating health problem for an estimated 24 million Americans half of all women over age 45 and 90 percent of women over age 75. The annual cost of osteoporosis has been estimated at $10 billion. Without intervention, these costs could reach as much as $60 billion over the next 25 years.

Medical costs, now estimated at more than $10 billion, will increase significantly as the population ages and incidence increases. In September 1996 the Senate Special Committee held its hearing on the savings that can be achieved by investing more in medical research. Robert Lindsay, President of the National Osteoporosis Foundation discussed how the future holds great promise to virtually eliminate osteoporosis within the next decade, if researchers are given enough resources. Recent developments were discussed, such as estrogen replacement therapy which helps protect postmenopausal women from bone loss. This discovery has saved this country an estimated $333 million in patient care costs. Although a number of pharmaceutical agents are now available that are capable of preventing bone loss and osteoporosis, there is still no drug for increasing bone mass in patients who already have the disease. Clearly, there is a continued need for research funding.

A number of experimental therapies for the prevention and perhaps treatment of osteoporosis are being studied. Diphosphonates, such as etidronate, coat bone crystal, which prevents the process of bone resorption. This treatment could be helpful to patients with established osteoporosis. Clinical trials are currently underway for this promising treatment, which is comparatively inexpensive and safe.

In addition to research in osteoporosis, NIAMS is the primary research institute for arthritis and related disorders. The term arthritis, meaning an inflammation of the joints, is used to describe the more than 100 rheumatic diseases. Many of these disorders affect not only the joints, but other connective tissues of the body as well. Approximately one in seven persons has some form of rheumatic disease, making it the Nation's leading crippler. Although no cure exists for the many forms of arthritis, progress has been made through clinical and basic investigations. The two most common forms of arthritis are osteoarthritis and rheumatoid arthritis.

Osteoarthritis (OA) is a degenerative joint disease, affecting more than 16 million Americans. OA causes cartilage to fray, and in ex-

treme cases, to disappear entirely, leaving a bone-to-bone joint. Disability results most often from disease in the weight-bearing joints, such as the knees, hips, and spine. Although age is the primary risk factor for OA, age has not been proven to be the cause of this crippling disease. NIA is focusing on studies that seek to distinguish between benign age changes and those changes that result directly from the disease. This distinction will better allow researchers to determine the cause and possible cures for OA.

Rheumatoid arthritis (RA) is a chronic inflammatory disease affecting more than 2.1 million Americans, two-thirds of whom are women. RA causes joints to become swollen and painful, and eventually deformed. There are no known cures for RA, but research has discovered a number of therapies to help alleviate the painful symptoms. Guanethidine, a regional nerve blocker, has been found to decrease pain and increase finger-pinch-strength in patients with active RA. Another drug, Cyclosporin A, lessens the pain and swelling of the joints. However, its toxicity to the kidney and elsewhere, limits its therapeutic value.

5. Geriatric Training and Education

In May 1996 the Senate Special Committee on Aging held a forum which focused on geriatricians and meeting the needs of the Nation's aging population. Geriatrics is a medical specialty that is specifically designed to address the complex health care needs of older patients. It's emphasis is upon helping older adults to maintain their ability to function independently, even in the presence of chronic age-related disease and disability. The committee's forum focused on the implications of the current national shortage of physicians trained in geriatrics. This shortage will become even more acute when the "baby boom" turns into a "senior boom". By the year 2030, the United States will need over 36,000 physicians with geriatric training—almost 30,000 more than we currently have—to care for more than 65 million older Americans.

Essential to effective, high quality, long-term and other health care for the elderly is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, and gerontological aides. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support has been relatively unrestricted and unfocused, and aimed at increasing the numbers of all types of health care professionals.

Congress is beginning to focus more attention on training and education for geriatric care, although funding still is limited. The Health Professions Special Education Initiatives Program has been established by Congress to carry out high-priority initiatives in the national interest. Funding has been awarded to schools and other institutions that train health professionals for special educational training programs in geriatrics, health economics, health promotion, and disease prevention, and computer-simulated medical procedures.

Under this initiative, geriatric education centers (GECs) provide short-term multidisciplinary faculty training, curriculum, educational resource development, and other assistance in affiliation

with other educational institutions, hospitals, nursing homes, Veterans' Administration hospitals, and community-based centers for the elderly. Many GEC's also serve as geriatric evaluation units which provide clinical training. Congress also has initiated a new trainee and fellowship program under the Public Health Service Act to initiate in-depth training of faculty in geriatrics for the later training of future health care providers in geriatrics.

Although the Federal Government is beginning to recognize the current and future need for health care professionals trained in geriatric care, it has yet to appropriate significant funding for geriatric education and training. This lack of funding poses a dilemma for an aging society in which demands for geriatric and related services by those age 65 and older are increasing at an unprecedented rate. In a 1987 report, "Personnel for Health Needs of the Elderly Through Year 2020," the NIA projected that use of services by the elderly population will be more than twice the 1980 volume by 2020.

NIA also predicted that older adults will compose up to two-thirds of the practices of most physicians and other health caregivers. Primary care practitioners in family and internal medicine are expected to continue to provide most of the medical care for the aged. NIA also predicted that the demand for personnel specifically prepared to serve older people will greatly exceed the current supply.

If current medical school enrollments remain stable, the number of practicing physicians in the year 2020 will be approximately 850,000. NIA estimates that the annual rate of increase of physician supply between 1985 and 2020 will be slightly less than the comparable growth rate of the elderly population during that period. An estimated 14,000 to 29,000 geriatricians may be needed by 2020, according to the study.

The most serious shortage is in the number of faculty members and other leaders who have specialized backgrounds in aging and geriatrics and who can develop and teach undergraduate, graduate, in-service and continuing geriatric education programs. The report stated that only 5 to 25 percent of the teaching faculty and researchers estimated to be needed to develop sufficient education training programs are currently available.

Among the most critical health care issues for the elderly in the future are the personnel and training needs for caregivers who work with residents in nursing homes. Projections through the year 2000 of the need for full-time registered nurses in nursing homes range from 260,000 (about three times the staffing levels in 1983–84) to 838,000. The estimates of demand for other licensed nursing personnel range from 300,000 to 339,000 and for nursing aides, the prediction is that 1 million will be needed by the year 2000.

Inadequate training is one of the many problems facing workers in nursing homes and private homes, according to the Older Women's League. These 1.5 million workers are mostly middle-aged women who receive little or no training, according to OWL's 1988 report entitled "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly."

The Education Extension Amendment of 1992 (P.L. 102–408) reauthorized the program that provides grants and contracts to GECs

and for geriatric training projects to train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. There was $17 million authorized for these programs for each of the fiscal years 1993 through 1995. Under the GEC provisions, grants and contracts can be provided to health professions schools for training related to the treatment of health problems of the elderly.

The appropriations bill for fiscal year 1995 provided $8.3 million for geriatric training programs.

6. Social Science Research and the Burdens of Caregiving

Most long-term care is provided by families at a tremendous emotional, physical, and financial cost. The NIA conducts extended research in the area of family caregiving and strategies for reducing the burdens of care. The research is beginning to describe the unique caregiving experiences by family members in different circumstances; for example, many single older spouses, are providing round-the-clock care at the risk of their own health. Also, adult children are often trying to balance the care of their aged parents, as well as the care for their own children.

Families must often deal with a confusing and changing array of formal health and supportive services. For example, older people are currently being discharged from acute care settings with severe conditions that demand specialized home care. Respirators, feeding tubes, and catheters, which were once the purview of skilled professionals, are now commonplace in the home.

The employed caregiver is becoming an increasingly common long-term care issue. This issue came to the forefront during legislative action on the "Family and Medical Leave Act." While many thought of this only as a child care issue, elderly parents are also in need of care. Adult sons and daughters report having to leave their jobs or take extended leave due to a need to care for a frail parent.

While the majority of families do not fall into this situation, it will be a growing problem. Additional research is needed to balance work obligations and family responsibilities. A number of employers such as AT&T, Stride-Rite, and Travelers have begun to design innovative programs to decrease employee caregiver problems. Some of these include the use of flex-time, referral to available services, adult day care centers, support groups, and family leave programs.

While clinical research is being conducted to reduce the need for long-term care, a great need exists to understand the social implications that the increasing population of older Americans is having on society as a whole.

D. PROGNOSIS

Within the past 50 years, there has been an outstanding improvement in the health and well-being of the American people. Some once-deadly diseases have been controlled or eradicated, and the survival rates for victims of heart disease, stroke, and cancer have improved dramatically. Many directly attribute this success to the Federal Government's longstanding commitment to the support of biomedical research.

The demand for long-term care will continue to grow as the population ages. Alzheimer's disease, for example, is projected to more than triple by the year 2050 if biomedical researchers do not develop ways to prevent or treat it. For the first time, however, Federal appropriations for Alzheimer's disease research will surpass the $300 million mark. The increased support for this debilitating disease indicates a recognition by Congress of the extreme costs associated with Alzheimer's disease. It is essential that appropriation levels for aging research remain consistent so that promising research may continue such research could lead to treatments and possible prevention of Alzheimer's disease, other related dementias, and many other costly diseases such as cancer and diabetes.

Various studies have highlighted the fact that although research may appear to focus on older Americans, benefits of the research are reaped by the population as a whole. Much research, for example, is being conducted on the burdens of caregiving on informal caregivers. Research into the social sciences needs to be expanded as more and more families are faced with caring for a dependent parent or relative.

Finally, research must continue to recognize the needs of special populations. Too often, conclusions are based on research that does not appropriately represent minorities and/or women. Expanding the number of grants to examine special populations is essential in order to gain a more complete understanding of such chronic conditions as Alzheimer's disease, osteoporosis, and Parkinson's disease.

Chapter 12

HOUSING PROGRAMS

OVERVIEW

Relatively few low-income households receive assistance.—Nearly 5 million low-income households now receive Federal rental assistance. This represents only about 25 percent of the low-income households who are eligible to receive help with their rent. The Department of Housing and Urban Developments (HUD) March 1996 report *Rental Housing Assistance at a Crossroads: A Report to Congress on Worst Case Housing Needs*, says that among the 5.3 million unassisted low income households with worst case needs (those paying more than 50 percent of their incomes for housing or living in substandard units), almost 1.2 million are headed by an elderly person. Almost half (49 percent) of these elderly have acute housing needs—severe rent burdens or severely substandard housing. Many large cities no longer accept additions to their waiting list for Federal rental assistance since those at the end of the list will wait at least 5 years before getting help. There is an added concern: the number of households with worst case needs has continued to increase during the 1990s despite relatively favorable economic conditions.

The most pressing housing issue.—Finding enough funds to continue assisting those renters currently being helped is the largest housing issue facing the 105th Congress. Over the next 5 years, there will be a very large and increasing number of rental assistance contracts with private landlords coming up for renewal under HUD's Section 8 program (discussed below). In fiscal year 1998 the nearly 1.9 million units up for renewal will require budget authority of $9.2 billion, according to HUD. This will increase to 2.7 million units and $19.1 billion in fiscal year 2002. These figures can be compared with the entire HUD budget for fiscal year 1997 of $19.3 billion. In March 1997, to calm fears of some assisted tenants, Representative Jerry Lewis, chairman of the House Appropriations Subcommittee for VA, HUD, and Independent Agencies said "This Congress is not about putting people currently receiving assistance out on the street." This has led to another concern—that in an effort to renew all rental contracts, other HUD programs, including the Section 202 program for the elderly (discussed below), public housing operating subsidies, and the "preservation" program could be substantially reduced. For example, in the President's proposed HUD budget for fiscal year 1998, the $645 million approved for fiscal year 1997 for Section 202 would be cut 54 percent to $300 million.

Housing reform bills.—Last year, House and Senate conferees were unable to agree on a compromise version of housing authorization bills H.R. 2406 and S. 1260. The same issues will be revisited this year. A new reform bill, H.R. 2, The Housing Opportunity and Responsibility Act of 1997, generally follows H.R. 2406, addressing public housing and project-based Section 8 admission preferences—who should get priority. Currently, nearly 75 percent of assistance is given to extremely low-income households. There is now a desire to move towards more mixed-income rental buildings with role models. This will require giving more preference to the working poor rather than to the poorest of the poor. H.R. 2 has tenant incentives to work, and provisions for more market-oriented landlord/tenant relationships. A new flexible grant option would deregulate well-run public housing agencies, letting them design programs and set their own priorities, but holding them more accountable for results. Poorly performing agencies would come under more intense scrutiny. The new Senate bill, S. 462, The Public Housing Reform and Responsibility Act of 1997, addresses similar issues. Resident participation would be encouraged in the development of the public housing authority operating plan and incentives for implementing anti-crime policies. It would promote increased residential choice and mobility by increasing opportunities for residents to use tenant-based assistance (vouchers). And it would institute reforms such as ceiling rents, earned income adjustments, and minimum rents which encourage and reward work.

Preserving Section 8 projects.—In addition to expiring Section 8 contracts, there are two important related issues known as the "portfolio re-engineering" and "preservation" programs. Both have to do with Section 8 projects, many with excessive costs and deteriorated physical conditions. Many projects have mortgages insured by HUD's Federal Housing Administration (FHA) for more than the buildings are now worth. HUD is under strong pressure to reduce the excessive costs, but at the same time, avoid driving landlords into foreclosure. A foreclosure would not only be costly to the FHA insurance program, but would be disruptive to the low-income tenants in these projects. Congress has initiated a demonstration program to test for a satisfactory resolution to this problem—" portfolio re-engineering." Rents would be reduced in return for the government forgiving some of the mortgage debt. But a satisfactory resolution is elusive and the issue still looms large for Congress. Some of the elderly in these buildings are concerned that poorly performing landlords might lose their assistance and/or that some tenants might be given vouchers and have to move. Several legislative proposals are expected to be introduced this year.

Also among the Section 8 landlords are those that have the contractual right after 20 years to prepay the remaining debt on their subsidized mortgages and end their obligation to rent to low income households. Here too, Congress is wrestling with the design of a "preservation" program that protects existing low-income tenants, while reducing excessive costs.

Low-income housing not a priority.—Housing assistance for lower income households has not been among the highest priorities of Congress during the past dozen years. The HUD budget was reduced by about 20 percent in nominal dollars, from about $25 bil-

lion in the early 1990s to close to $20 billion in the last three years. If inflation is considered, assistance has been cut even more. Programs for the elderly and handicapped have fared better than most. While pressure to cut the Federal deficit is often given as a reason for HUD budget reductions, this reasoning is not carried over to the much larger ($80 billion in fiscal year 1997) housing assistance that largely goes to upper middle income homeowners receive through the tax code. Another justification for cutbacks in HUD programs is the frustration with excessive costs, poor management, and the seemingly intractable problems that prevent many very low-income households from moving away from welfare and into the economic mainstream.

A continuing flow of new immigrants, both legal and illegal, also guarantees that there will be an increasing number of households in need of housing assistance. While serious management problems are said to be largely confined to the largest public housing projects in the big inner cities, publicity about this and other problems have tainted HUD's reputation.

Housing initiatives on a limited budget.—In recent years, HUD has moved aggressively to combat discrimination against minorities, women, and low-income households in housing and mortgage credit. Although some housing analysts question the appropriateness of homeownership for very low income households, HUD has pushed hard to increase the opportunities for minorities and lower income households to become homeowners. The agency has also made increasing efforts to address the problem of declining neighborhoods in inner cities and older suburbs by encouraging community development organizations to join with the for-profit private sector. This, despite the fact that few housing analysts believe there are sufficient funds being spent to make a significant and lasting difference. There is also little agreement on the best strategies to address urban problems.

At the same time that HUD is taking on major commitments to reform itself and its programs, it has also committed itself to a sharp reduction in its size. Four years ago the agency had 13,000 employees; today, about 10,000; and by the year 2000, it expects to be down to 7,500.

Because of the seemingly intractable nature of housing issues that have come before Congress in recent years, and the limited resources available, there has been a tendency to postpone decisions to to adopt demonstration programs rather than immediately resolve difficult issues. Unfortunately for the 105th Congress, this is getting increasingly difficult to do.

A. RENTAL ASSISTANCE PROGRAMS

1. INTRODUCTION

Beginning in the 1930's with the Low-Rent Public Housing Program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family.

Although the Government has made striking advances in providing affordable and decent housing for all Americans, data indicate

that the 4.5 million assisted units available at the end of fiscal year 1996 were only enough to house approximately 25 percent of those eligible for assistance. However, a large percentage of newly-constructed subsidized housing over the past 10 years have been for the elderly. The relative lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists are expected to grow as the demand for elderly rental housing continues to increase in many parts of the Nation, while budget constraints make assisted housing programs targets for budget savings.

2. Housing and Supportive Services

Congress has a long history of passing laws to assist in providing adequate housing for elderly, but only in recent years has it moved to provide support services. This is done through programs which permit the providers of housing to supply services needed to enable the elderly to live with dignity and independence. The following three programs provide housing and supportive services for the elderly.

(A) SECTION 202 SUPPORTIVE HOUSING FOR THE ELDERLY

Since its revision in 1974 the Section 202 program provided rental assistance in housing designed specifically for the elderly. It is also the Federal Government's primary financing vehicle for constructing subsidized rental housing for elderly persons. In 1990, the program was once again completely revised by the National Affordable Housing Act to provide not only housing for its residents, but services as well.

The Section 202 program is one of capital advances and rental assistance. The capital advance is a noninterest loan which is to be repaid only if the housing is no longer available for occupancy by very-low income elderly persons. The capital advances could be used to aid nonprofit organizations and cooperatives in financing the construction, reconstruction, or rehabilitation of a structure, or the acquisition of a building to be used for supportive housing.

Rental assistance is provided through 20-year contracts between HUD and the project owners, and will pay operating costs not covered by tenant's rents. Tenants portion of rent payment is 30 percent of their income or the shelter rent payment determined by welfare assistance.

Since 1992, organizations providing housing under the Section 202 program must also provide supportive services tailored to the needs of its project's residents. These services should include meals, housekeeping, transportation, personal care, health services, and other services as needed. HUD is to ensure that the owners of projects can access, coordinate and finance a supportive services program for the long term with costs being borne by the projects and project rental assistance.

At the end of 1996, there were approximately 20,000 Section 202 projects eligible for payment, comprised of approximately 234,000 units eligible for payment. The appropriations for fiscal year 1997

provided $645 million for 6,700 additional units of supportive housing for the elderly.

(B) CONGREGATE HOUSING SERVICES

Congregate housing provides not only shelter, but supportive services for residents of housing projects designated for occupancy by the elderly. While there is no way of precisely estimating the number of elderly persons who need or would prefer to live in congregate facilities, groups such as the Gerontological Society of America and the AARP have estimated that a large number of people over age 65 and now living in institutions or nursing homes would choose to relocate to congregate housing if possible.

The Congregate Housing Services Program was first authorized as a demonstration program in 1978, and later made permanent under the National Affordable Housing Act of 1990. The program provides a residential environment which includes certain services that aid impaired, but not ill, elderly and disabled tenants in maintaining a semi-independent lifestyle. This type of housing for the elderly and disabled includes a provision for a central dining room where at least one meal a day is served, and often provides other services such as housekeeping, limited health care, personal hygiene, and transportation assistance.

Under the Congregate Housing Services Program, HUD and the Farmer's Home Administration (FmHA) enter into five-year renewable contracts with agencies to provide the services needed by elderly residents of public housing, HUD-assisted housing and FmHA rural rental housing. Costs for the provision of the services are covered by a combination of contributions from the contract recipients, the Federal Government, and the tenants of the project. Contract recipients are required to cover 50 percent of the cost of the program, Federal funds cover 40 percent, and tenants are charged service fees to pay the remaining 10 percent. If an elderly tenant's income is insufficient to warrant payment for services, part of all of this payment can be waived, and this portion of the payment would be divided evenly between the contract recipient and the Federal Government.

In an attempt to promote independence among the housing residents, each housing project receiving assistance under the congregate housing services program must, to the maximum extent possible, employ older adults who are residents to provide the services, and must pay them a suitable wage comparable to the wage rates of other persons employed in similar public occupations.

Congress appropriated $25 million for the Congregate Housing Program in fiscal year 1995. Since then no further appropriations have been made, but the program is supported by carryovers in funding from previous years.

Since Federal funding for housing program has been reduced dramatically in recent years, some States have established their own housing initiatives, including congregate housing programs in an effort to provide their elderly citizens with needed care without relying on Federal funds. In the last few years, private developers have shown a growing interest in the development of congregate housing. Considering the growing number of elderly who may bene-

fit from congregate housing services, this is one avenue of housing assistance that the States may want to explore more carefully.

Today there are 113 projects housing approximately 4,000 elderly residents, receiving Federal assistance under the Congregate Housing Services Program.

(C) HOPE FOR ELDERLY INDEPENDENCE

Title IV of the National Affordable Housing Act of 1990 is entitled "Homeownership and Opportunity for People Everywhere (HOPE) Programs." The title comprises several programs encouraging homeownership and a higher quality of housing opportunities as well. One of these programs of particular interest here is entitled HOPE for Elderly Independence.

HOPE for Elderly Independence is a five-year demonstration program through which HUD enters into contracts with public housing agencies to provide rental assistance through the use of housing vouchers or certificates and supportive services to frail elderly who are living independently. A limit of 1,500 vouchers and certificates can be funded in any fiscal year for the program.

Supportive services are to be funded as they are under the revised congregate housing program: HUD is to pay 40 percent of the cost, the Public Housing Authority (PHA) is to pay 50 percent, and the person receiving the services would pay the remaining 10 percent. HUD can waive the tenant's portion of the cost if it determines that the tenant is not able to pay their share, and the amount would again be covered by HUD and the PHA in a 50–50 split.

The HUD appropriations for fiscal year 1992 funded $35.8 million to provide 1,500 rental vouchers for the program, and $10 million for the provision of supportive services. Funds were appropriated again in fiscal year 1993 totaling $38.3 million for another 1,500 rental assistance vouchers and $10 million for supportive services. No further funding has been requested or appropriated for the program since 1993.

The effectiveness of the HOPE for Elderly Independence program will be evaluated by HUD in 1998 after the five-year expiration period has expired.

3. PUBLIC HOUSING

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing Public Housing Program has burgeoned into a system that includes 1.4 million units, housing more than 3.7 million people. Approximately 45 percent of public housing units are occupied by elderly persons.

The Public Housing Program is the oldest Federal program providing housing for the elderly. It is a Federally-financed program operated by State-chartered local public housing authorities (PHA's). Each PHA usually owns its own projects. By law, a PHA can acquire or lease any property appropriate for low-income housing. They are also authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects. When the program began, it was assumed that tenant's rents would cover

project operating costs for such items as management, maintenance, and utilities. Rent payments are now set at 30 percent of tenant's adjusted income. However, since fiscal year 1997, PHAs have the option of setting a minimum rent of $25 if they believe it is necessary for the maintenance of their projects. Tenant rents have not kept pace with increased operating expenses, so PHAs receive a Federal subsidy to help defray operating and modernization costs.

A critical problem of public housing is the lack of services for elderly tenants who have "aged in place" and need supportive services to continue to live independently. Congregate services have been used in some projects in recent years, but only about 40 percent of the developments report having any on-site services staff to oversee service delivery. Thus, even if a high proportion of developments would have some services available, there is evidence that these services may often only reach a few residents, leaving a large unmet need.

Under the National Affordable Housing Act of 1990, Congress established service coordinators as eligible costs for operating subsidies. In addition, up to 15 percent of the cost of providing services to the frail elderly in public housing is an eligible operating subsidy expense. Services may include meals, housekeeping, transportation, and health-related services. Although services and service coordinators are an eligible cost for using the operating subsidy, they are not required and therefore, not available in all public housing projects.

Another problem surfacing in public housing in recent years is that of mixed populations living in the same buildings. By "mixed populations" we mean occupancy by both elderly and disabled persons in buildings designated as housing for the elderly.

The Housing and Community Development Act of 1992 addressed the problem of mixed populations in public housing projects. This seems to have become a concern in part because of the broadened definition of "disabled" to include alcoholics and recovering drug abusers, and the increasing number of mentally disabled persons who are not institutionalized. Also, by definition, elderly families and disabled families were included in one term, "elderly" in the housing legislation authorizing public housing.

The 1992 Act provided separate definitions of elderly and disabled persons. It also permitted public housing authorities to designate housing for separate or mixed populations within certain limitations, to ensure that no resident of public housing is discriminated against or taken advantage of in any way.

This action was reinforced in 1996 with the signing into law of (P.L. 104–120), the Housing Opportunity Program Extension Act of 1996. This act contained two provisions of particular interest to persons in public and assisted housing.

Section 10 of the law permitted PHAs to rent portions of the projects designated for elderly tenants to "near elderly persons (age 55 and over) if there were not enough elderly person to fill the units. The law also goes into detail on the responsibilities of PHAs in offering relocation assistance to any disabled tenants who choose to move out of units not designated for the elderly. Persons already occupying public housing units cannot be evicted in order to

achieve this separation of populations. However, tenants can request a change to buildings designated for occupancy for just elderly or disabled persons. Managers of projects may also offer incentives to tenants to move to designated buildings, but they must ensure that tenants' decisions to move are strictly voluntary.

Section 9 of the Housing Opportunity Program Extension Act of 1996 is concerned with the safety and security of tenants in public and assisted housing. This provision of the law makes it much easier for managers of such apartments to do background checks on tenants to see if they have a criminal background. It also makes it easier for managers to evict tenants who engage in illegal drug use or abuse alcohol.

In recent years, the condition of public housing projects has declined noticeably in some areas of the country, particularly in the inner cities. There are varied reasons for the decline of public housing, including a concentration of the poorest tenants in a few projects, an increase in crime and drugs in developments, and a lack of funds to maintain the projects upkeep at a suitable level. Some analysts believe that public housing has outlived its usefulness and should be replaced by providing tenants with rental assistance vouchers that they can use to find their own housing in the private market. Other analysts disagree with this point of view and say that some tenants, the elderly in particular, would have a hard time finding their own housing if they were handed a voucher and told to find their own apartments. These analysts believe that doing away with public housing is not the answer, but that more of an income mix is needed among tenants and funds should be directed to some type of "reward" system to offer incentives to PHAs to improve public housing.

In 1996, the House passed a housing authorization bill, H.R. 2460, which would make many changes in the public housing system. The Senate's housing authorization bill, S. 1206, agreed that public housing needed to be revised, but it did not agree with some of the more drastic provisions in H.R. 2460. When these two bills went to conference, an agreement could not be reached, and the bills died.

In the 105th Congress, a new housing reauthorization bill (H.R. 2) has been introduced which would once again seek to demolish obsolete public housing units, and transform public housing.

4. SECTION 8 Housing Program

Traditional public housing assistance offers few choices as to the location and type of housing units desired by low-income families. Also, some housing advocates believe that many problems plaguing public housing projects could be avoided if the poor were not concentrated in these projects, but given rental assistance to live in privately-owned apartments. To this end, the Section 8 rental assistance program was created in 1974.

Section 8 is designed to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Under the original program, subsidies were paid to landlords on behalf of eligible tenants to not only assist tenants paying rents, but also for promoting new construction and substantial rehabilitation. The program as it was then, came to be seen as too

costly—particularly the costs associated with new construction and rehabilitation. As a result, authority to enter into new contracts for new construction was eliminated and rehabilitation was limited in 1983. While eliminating new construction, and limiting substantial rehabilitation to only projects designated for occupancy by the homeless, the Housing Act of 1983 continued the use of rental assistance certificates, and introduced the Section 8 voucher program as well.

Now, in 1997, the supply of affordable housing is in jeopardy, not only because of budget constraints, but also because many of the subsidized projects are reaching the end of their contract terms, and owners may opt out of providing low-income units. This is particularly true of Section 8 contracts written in the late 1970's and early 1980's that are now reaching their expiration dates. In fact, as they reach the end of their contract terms, some owners of projects that are in revitalized or higher rent areas, are looking for ways to prepay their mortgage and free up their properties. Other owners say they are heavily in debt and unable to raise rents to support the cost of repairs. These owners claim that if they were able to prepay their loans, the projects could be sold to profit-motivated owners who could afford private financing for needed repairs.

The 1990 Housing Act permitted prepayment of mortgages in limited circumstances. The prepayment plan provides complex paths of procedures to be followed by the owner, by HUD and by a possible purchaser. For example, HUD will only approve a prepayment if it concludes that doing so would not cause a hardship for current tenants. In addition, tenants cannot be involuntarily displaced as a result of prepayment unless comparable housing is available without rental assistance. Owners seeking to prepay must also ensure that affordable housing is available for low-income families near employment opportunities.

HUD must permit prepayment if it cannot find sufficient subsidies, known as "incentives", to provide owners with a fair return on their equity when low-income use is continued, or if a buyer with HUD subsidies cannot be found to purchase at a fair market price. All in all, tenants are given a number of protections in the determination process, and tenant-based rental assistance is provided if the owner is allowed to prepay.

5. Vouchers and Certificates

There is one major difference between Section 8 certificates and vouchers. Under the Section 8 certificate program, rents and rent-to-income ratio is capped and subsidy depends on the rent. A family who rents a Section 8 unit pays 30 percent of its income as rent, and HUD pays the rest based on a fair market rent formula. Units are rented from private developers who have Section 8 assistance attached to their projects. Under the Section 8 voucher program, there are no caps and the subsidy is fixed. This means that the family receives a voucher from HUD stating that the Department will pay up to the fair market rent minus 30 percent of the family's adjusted income as a rental subsidy payment. The family is free to find an apartment and negotiate a rent with a landlord. If they find a more expensive apartment that they want to occupy, they will pay more than 30 percent of their income as their share of the

rent since HUD will only pay the fixed amount. Likewise, if they find a less expensive apartment, they would pay less than 30 percent of their income as rent since once again HUD would pay a fixed amount.

Advocates of the voucher program argue that the voucher system would avoid segregation and warehousing of the poor in housing projects, and would allow them to live where they choose at lower cost than new construction programs.

Critics of the voucher program question whether it would really help those most in need and believe they would present potential problems for some elderly renters who need certain amenities such as grabrails and accommodations for wheelchairs that are not found in all apartments. They also doubt that many elderly would be in a position to look for housing in safe, sanitary conditions and negotiate rents with landlords.

HUD seems to favor the certificate and voucher programs and is seeking to combine most of the major housing assistance programs that we know into block grants that would use certificates and vouchers for most housing assistance. However, managers at HUD agree that some project-based housing to accommodate the elderly and disabled would have to be maintained.

In fiscal year 1997, Congress appropriated $4.6 billion for the Section 8 program: $4.4 billion for the renewal and amendment of contracts, and $200 million for certificates and vouchers to prevent families from being displaced by prepayments or other actions of Federal housing programs.

6. Rural Housing Services

The Housing Act of 1949 (P.L. 81–171) was signed into law on October 25, 1949. Title V of the Act authorized the Department of Agriculture (USDA) to make loans to farmers to enable them to construct, improve, repair, or replace dwellings and other farm buildings to provide decent, safe, and sanitary living conditions for themselves, their tenants, lessees, sharecroppers, and laborers. The Department was authorized to make grants or combinations of loans and grants to farmers who could not qualify to repay the full amount of a loan, but who needed the funds to make the dwellings sanitary or to remove health hazards to the occupants or the community.

Over time the Act has been amended to enable the Department to make housing and grants to rural residents in general. The housing programs are generally referred to by the section number under which they are authorized in the Housing Act of 1949, as amended. As noted below, only one of the programs (Section 504 grants) is targeted to the elderly.

Under the Section 502 program, USDA is authorized to make direct loans to very low- to moderate-income rural residents for the purchase or repair new or existing single-family homes. The loans have a 33-year term and interest rates may be subsidized to as low as 1 percent. Borrowers must have the means to repay the loans but be unable to secure reasonable credit terms elsewhere.

In a given fiscal year, at least 40 percent of the units financed under this section must be made available only to very low-income

families or individuals. The loan term may be extended to 38 years for borrowers with incomes below 60 percent of the area median.

Borrowers with income of up to 115 percent of the area median may obtain guaranteed loans from private lenders. Guaranteed loans may have up to 30-year terms. Priority is given to first-time homebuyers, and the Department of Agriculture may require that borrowers complete a homeownership counseling program.

In recent years, Congress and the Administration have been increasing the funding for the guaranteed loans and decreasing funding for the direct loans.

Under the Section 504 loan program, USDA is authorized to make loans to rural homeowners with incomes of 50 percent or less of the area median. The loans are to be used to repair or improve the homes, to make them safe and sanitary, or to remove health hazards. The loans may not exceed $20,000. Section 504 grants may be available to homeowners who are age 62 or more. To qualify for the grants, the elderly homeowners must lack the ability to repay the full cost of the repairs. Depending on the cost of the repairs and the income of the elderly homeowner, the owner may be eligible for a grant for the full cost of the repairs or for some combination of a loan and a grant which covers the repair costs. A grant may not exceed $5,000. The combination loan and grant may total no more than $15,000.

Section 509 authorizes payments to Section 502 borrowers who need structural repairs on newly constructed dwellings.

Under the Section 514 program, USDA is authorized to make direct loans for the construction of housing and related facilities for farm workers. The loans are repayable in 33 years and bear an interest rate of 1 percent. Applicants must be unable to obtain financing from other sources that would enable the housing to be affordable by the target population.

Individual farm owners, associations of farmers, local broad-based nonprofit organizations, federally recognized Indian Tribes, and agencies or political subdivisions of local or State governments may be eligible for loans from the Department of Agriculture to provide housing and related facilities for domestic farm labor. Applicants, who own farms or who represent farm owners, must show that the farming operations have a demonstrated need for farm labor housing and applicants must agree to own and operate the property on a nonprofit basis. Except for State and local public agencies or political subdivisions, the applicants must be unable to provide the housing from their own resources and unable to obtain the credit from other sources on terms and conditions that they could reasonably be expected to fulfill. The applicants must be unable to obtain credit on terms that would enable them to provide housing to farm workers at rental rates that would be affordable to the workers. The Department of Agriculture State Director may make exceptions to the "credit elsewhere" test when (1) there is a need in the area for housing for migrant farm workers and the applicant will provide such housing and (2) there is no State or local body or no nonprofit organization that, within a reasonable period of time, is willing and able to provide the housing.

Applicants must have sufficient initial operating capital to pay the initial operating expenses. It must be demonstrated that, after

the loan is made, income will be sufficient to pay operating expenses, make capital improvements, make payments on the loan, and accumulate reserves.

Under the Section 515 program, USDA is authorized to make direct loans for the construction of rural rental and cooperative housing. When the program was created in 1962, only the elderly were eligible for occupancy in Section 515 housing. Amendments in 1966 removed the age restrictions and made low- and moderate-income families eligible for tenancy in Section 515 rental housing. Amendments in 1977 authorized Section 515 loans to be used for congregate housing for the elderly and handicapped.

Loans under section 515 are made to individuals, corporations, associations, trusts, partnerships, or public agencies. The loans are made at a 1 percent interest rate and are repayable in 50 years. Except for public agencies, all borrowers must demonstrate that financial assistance from other sources will not enable the borrower to provide the housing at terms that are affordable to the target population.

Under the Section 516 program, USDA is authorized to make grants of up to 90 percent of the development cost to nonprofit organizations and public bodies seeking to construct housing and related facilities for farm laborers. The grants are used in tandem with Section 514 loans.

Section 521 established the interest subsidy program under which eligible low- and moderate-income purchasers of single-family homes (under Section 515 or Section 514) may obtain loans with interest rates subsidized to as low as 1 percent.

In 1974, Section 521 was amended to authorize USDA to make rental assistance payments to owners of rental housing (Sections 515 or 514) to enable eligible tenants to pay no more than 25 percent of their income in rent. Under current law, rent payments by eligible families may equal the greater of (1) 30 percent of monthly adjusted family income, (2) 10 percent of monthly income, or (3) for welfare recipients, the portion of the family's welfare payment that is designated for housing costs. Monthly adjusted income is adjusted income divided by 12.

The rental assistance payments, which are made directly to the borrowers, make up the difference between the tenants' payments and the rent for the units approved by USDA. Borrowers must agree to operate the property on a limited profit or nonprofit basis. The term of the rental assistance agreement is 20 years for new construction projects and 5 years for existing projects. Agreements may be renewed for up to 5 years. An eligible borrower who does not participate in the program may be petitioned to participate by 20 percent or more of the tenants eligible for rental assistance.

Section 523 authorizes technical assistance (TA) grants to States, political subdivisions, and nonprofit corporations. The TA grants are used to pay for all or part of the cost of developing, administering, and coordinating programs of technical and supervisory assistance to families that are building their homes by the mutual self-help method. Applicants may also receive site loans to develop the land on which the homes are to be built.

Sites financed through Section 523 may only be sold to families who are building homes by the mutual self-help method. The homes are usually financed through the Section 502 program.

Section 524 authorizes site loans for the purchase and development of land to be subdivided into building sites and sold on a nonprofit basis to low- and moderate-income families or to organizations developing rental or cooperative housing.

Sites financed through Section 524 have no restrictions on the methods by which the homes are financed or constructed. The interest rate on Section 524 site loan is the Treasury cost of funds.

Under the Section 533 program, USDA is authorized to make grants to nonprofit groups and State or local agencies for the rehabilitation of rural housing. Grant funds may be used for several purposes: (1) rehabilitating single family housing in rural areas which is owned by low- and very low-income families, (2) rehabilitating rural rental properties, and (3) rehabilitating rural cooperative housing which is structured to enable the cooperatives to remain affordable to low- and very low-income occupants. The grants were made for the first time in fiscal year 1986.

Applicants must have a staff or governing body with either (1) the proven ability to perform responsibility in the field of low-income rural housing development, repair, and rehabilitation; or (2) the management or administrative experience which indicates the ability to operate a program providing financial assistance for housing repair and rehabilitation.

The homes must be located in rural areas and be in need of housing preservation assistance. Assisted families must meet the income restrictions (income of 80 percent or less of the median income for the area) and must have occupied the property for at least one year prior to receiving assistance. Occupants of leased homes may be eligible for assistance if (1) the unexpired portion of the lease extends for 5 years or more, and (2) the lease permits the occupant to make modifications to the structure and precludes the owner from increasing the rent because of the modifications.

Repairs to manufactured homes or mobile homes are authorized if (1) the recipient owns the home and site and has occupied the home on that site for at least one year, and (2) the home is on a permanent foundation or will be put on a permanent foundation with the funds to be received through the program. Up to 25 percent of the funding to any particular dwelling may be used for improvements that do not contribute to the health, safety, or well being of the occupants; or materially contribute to the long term preservation of the unit. These improvements may include painting, paneling, carpeting, air conditioning, landscaping, and improving closets or kitchen cabinets.

Section 5 of the Housing Opportunity Program Extension Act of 1996 (P.L. 104–120) added Section 538 to the Housing Act of 1949. Under this newly-created Section 538 program, borrowers may obtain loans from private lenders to finance multifamily housing and USDA guarantees to pay for losses in case of borrower default. Under prior law, Section 515 was the only USDA program under which borrowers could obtain loans for multifamily housing. Under the Section 515 program, however, eligible borrowers obtain direct loans from USDA.

Section 538 guaranteed loans may be used for the development costs of housing and related facilities that (1) consist of 5 or more adequate dwelling units, (2) are available for occupancy only by renters whose income at time of occupancy does not exceed 115 percent of the median income of the area, (3) would remain available to such persons for the period of the loan, and (4) are located in a rural area.

The loans may have terms of up to 40 years, and the interest rate will be fixed. Lenders pay to USDA a fee of 1 percent of the loan amount. Nonprofit organizations and State or local government agencies may be eligible for loans of 97 percent of the cost of the housing development. Other types of borrowers may be eligible for 90 percent loans. On at least 20 percent of the loans, USDA must provide the borrowers with interest credits to reduce the interest rate to the applicable Federal rate. On all other Section 538 loans, the loans will be made at the market rate, but the rate may not exceed the rate on 30-year Treasury bonds plus 3 percentage points.

The Section 538 program is viewed as a means of funding rental housing in rural areas and small towns at less cost than under the Section 515 program. Since the Section 515 program is a direct loan program, the government funds the whole loan. In addition, the interest rates on Section 515 loans are subsidized to as low as 1 percent, so there is a high subsidy cost. Private lenders fund the Section 538 loans and pay guarantee fees to USDA. The interest rate is subsidized on only 20 percent of the Section 538 loans, and only as low as the applicable Federal rate, so the subsidy cost is not as deep as under the Section 515 program. Occupants of Section 515 housing may receive rent subsidies from USDA. Occupants of Section 538 housing may not receive USDA rent subsidies. All of these differences make the Section 538 program less costly to the government than the Section 515 program.

It has not been advocated that the Section 515 program be replaced by the Section 538 program. Private lenders may find it economically feasible to fund some rural rental projects, which could be funded under the Section 538 program. Some areas may need rental housing, but the private market may not be able to fund it on terms that would make the projects affordable to the target population. Such projects would be candidates for the Section 515 program.

Authority for the Section 538 program expired on September 30, 1996, and legislation has been introduced in the 105th Congress (H.R. 28) which would permanently authorize the program.

7. Federal Housing Administration

The FHA is a HUD insurance program that helps insure both mortgages on individual home purchases and loans on multifamily rental buildings. The FHA program is particularly important to those who are building or rehabilitating apartment buildings. Lenders are much more willing to finance these sometimes risky projects since the FHA insures them against losses. Of particular importance to the elderly is the revision that Congress made to the National Housing Act in 1994. Under changes made to Section 232, many senior and assisted housing projects, and facilities providing

health-care related services, that now have short-term financing are now be able to refinance their debt with long-term, fully amortising FHA-insured loans.

8. Low Income Housing Tax Credit

The LIHTC, created by the Tax Reform Act of 1986, provides tax credits to investors who build or rehabilitate rental housing that must be kept affordable to lower income households for long periods of time. Administered at the state level by housing finance agencies, this $3.5 billion a year program is said by the National Council of State Housing Finance Agencies to have helped create as many as 900,000 apartment units. A significant but unknown number are occupied by low-income elderly households. Investors can receive tax credits worth as much as 90 percent of the amount spent to develop the units themselves, but must claim the credits over a ten year period. In return, they must keep the units rented to households whose incomes are no more than 60 percent of the median income in the area for up to 30 years and sometimes longer. In many cases, the tax credits do not provide enough financial support by themselves to make a project economically viable. This is particularly the case where state housing finance agencies negotiate agreements with investors to provide special services to tenants or where apartments must be rented to those with incomes significantly lower than that generally required. In cases such as these, the tax credit is often combined with funds from various HUD programs, primarily Community Development Block Grant and HOME money, and sometimes Section 8 rental assistance. The use of tax-exempt bond financing is also common.

Despite substantial political support, some critics contend that this supply side "project-based" program is an expensive way to provide housing assistance compared to other alternatives. Little is known about how much rents are being reduced by this program compared with how much the units really cost when all public subsidies are considered. There is some concern that service to renters may deteriorate or that the units will not be adequately maintained over the long run since investors receive the tax credits during the first 10 years of the project's life. But housing advocates point out that as HUD programs have been cut, the tax credit has become even more necessary to provide affordable housing to lower income households. The basic formula that determines the amount of tax credits that each State can allocate each year, $1.25 per capita, has not been changed or adjusted for inflation since the program's beginning. Supporters are calling for such an increase with an annual built-in inflation adjustment. In 1995 the General Accounting Office (GAO) was asked by Congress to conduct a study of the program. Their report is expected to be completed in the Spring of 1997. If the GAO report finds significant problems, the Congress may wish to make changes in the program.

B. PRESERVATION OF AFFORDABLE RENTAL HOUSING

1. INTRODUCTION

In addition to addressing to the expiration of Section 8 rental contracts, another basic issue is what to do about the excessive costs and poor conditions at a number of Section 8 "project-based" rental complexes. Over the past several decades, HUD's FHA has insured the mortgages on Section 8 rental projects with about 860,000 low income units. For a variety of reasons, including rigid "annual adjustment factor" rent increases, the rents at many projects are now 20 percent or more above competitive market levels. At the same time, many buildings have also deteriorated from lack of maintenance and capital improvements. Whether this is because of poor management, purposeful disinvestment, or factors beyond the landlord's control remains an important issue. But the result is that many projects are insured for more than they are currently worth. This has created a dilemma: because many of these apartments are costly to operate and maintain, HUD must either pay larger sums to the owners on behalf of the assisted tenants (pay more of the above-market rents), or—to the extent that HUD ceases to support these high rents or tenants obtain flexibility to move elsewhere (housing vouchers)—the projects become financially unworkable and HUD losses money as the insurer of the mortgage. The Federal Government must pay either way. With substantial pressure to balance the Federal budget, Congress has wrestled over what to do for several years now. There is considerable pressure to reduce excessive subsidies going to some landlords. The elderly in many of these projects have become concerned that Congressional efforts at reforms might mean they would have to pay more rent or to move elsewhere.

If excessively high rents and deteriorating conditions sound contradictory, they may be. HUD has just announced a $50 million effort to crack down on Section 8 landlords in 50 of the biggest cities who take substantial Federal housing subsidies but allow their apartments to fall into serious disrepair. There will be more investigators sent into the field, and more civil and criminal charges filed. But this does not get to the root of the problems. Aside from the serious design flaw of fully insuring these mortgages, the problems highlight a fundamental difficulty with project-based assistance. In the regular rental market, tenants will move if conditions or services deteriorate beyond a certain point. This possibility keeps most landlords on their toes. But in Section 8 projects, tenants cannot or will not move because they would lose their rent subsidy.

2. PORTFOLIO RE-ENGINEERING PROGRAM

Under Public Law 104–204, last year's appropriation bill for HUD, the agency was authorized to proceed with a demonstration of various approaches to restructuring Section 8 FHA-insured mortgages. In addition, HUD estimates it would save $1.25 billion between 1998 and 2002 under a proposal it will soon submit to Congress. Generally, a certain amount of the mortgage debt would be forgiven in return for reducing rents to competitive market levels.

Since under current Federal tax law, the debt that would be forgiven would be considered taxable income to the project owner, one possibility would allow owners to spread this tax liability over a 10-year period. Under the proposal, HUD would phase out project-based assistance and give vouchers to tenants. Tenants would have the option of staying in their current unit or moving elsewhere.

Other legislative proposals are being developed, including a new bill similar to last year's S. 2042. Among the difficult issues are who is going to pay for the billions of dollars necessary to repair these buildings, what landlords will be required to do in return for tax benefits, what to do with irresponsible owners, and how to adjust rents over time so that they stay attuned with competitive markets. With the continuing downsizing of HUD limiting its capacity to take on new complicated tasks, much of the debt restructuring is expected to be farmed out to third parties, particularly housing finance agencies.

3. Preservation Program

Beginning in the 1960s, a number of investors received below-market interest rate loans to build rental housing, along with long-term rental assistance contracts. A key feature was that these contracts allowed owners to prepay their mortgages after 20 years and end their obligations to rent to low income households. As the 20-year periods started ending in the late 1980s, there was concern about what would happen to low-income tenants if landlords were to prepay. Congress passed legislation to address the prepayment concerns: The Emergency Low-Income Housing Preservation Act of 1987 and the Low-Income Housing Preservation and Resident Homeownership Act of 1990. These laws prohibited prepayment, but provided incentives for owners to remain in the program or for them to sell to others (including local governments, non-profits, and State or local housing finance agencies) who would continue to rent to low income households.

There has been criticism of HUD that overly generous financial incentives have been given to landlords to remain in the program who probably had no feasible alternative but to continue renting to low income tenants. HUD has not requested funds for this program in the last few years, suggesting that many of the units in these project-based rentals should be "vouchered out." Nevertheless, Congress appropriated $624 million in fiscal year 1966, and $350 million in fiscal year 1997. There appears to be sufficient money to protect existing low-income tenants but not to finance all the requested project sales by landlords who wish to sell.

C. HOMEOWNERSHIP

1. Homeownership Rates

Many homeowners have benefited from the relatively low mortgage interest rates of the past four years. An estimated 5 million owners have been able to refinance their high-rate mortgages and substantially reduce their mortgage payments. But few elderly homeowners have been able to take advantage of this because more than 80 percent of households with heads age 65 and older have

fully paid their home loan. To the contrary, many elderly have seen the earnings on their saving accounts drop as interest rates have fallen. Elderly homeowners have benefited from generally stable home prices which have slowed increases in property tax assessments. A number of local governments have programs to help elderly homeowners with moderate incomes, including programs that reduce or postpone the payment of property taxes.

During the 1980s and early 1990s, there was much concern over the declines in the homeownership rates for young people. Some elderly households were no doubt aware that their children or grandchildren were having difficulty becoming first-time buyers. Some may even have found their children or grandchildren looking to them for financial assistance. The homeownership rate for households headed by those age 25 to 29, an age when first homes are often purchased, went from 43 percent in 1980 down to 34 percent in 1992. In the 30 to 34 year old group, ownership went from 61 percent in 1980 to 51 percent in 1992.

Thus, much attention was recently given to the fact that the national homeownership rate increased to 65.4 percent at the end of 1996, the highest in 16 years. A convergence of factors over the past few years has made this an opportune time for minorities, lower-income households, and those living in neighborhoods often underserved by lenders, to apply for an receive a home mortgage. Vigorous enforcement of fair housing laws and the Community Reinvestment Act, homeownership efforts by the government-sponsored enterprises Fannie Mae and Freddie Mac, and a variety of affordable home lending initiatives by HUD and others have made mortgage credit more available to lower income home buyers than ever before.

Over the past four years, homeownership rates have increased for all non-elderly age groups. The rate for those with a head of household age 25 to 29 years went from 33.6 percent in 1992 to 34.9 percent in 1996. For those age 30 to 34, the rate went from 50.5 percent in 1992 to 52.9 percent in 1996. The rate for black households increased from 42.6 percent in 1992 to 44.5 percent in 1996 and for Hispanics, from 39.9 percent to 42.8 percent. There is some concern, however, that many of the purchases by lower-income households have been made with relaxed credit standards and with very small down payments. In 1994, nearly 31 percent of loans insured by HUD's FHA program were made with less than a 3 percent down payment and almost 62 percent with less than 5 percent down. The economic climate has been very favorable in recent years, but during a period of rising unemployment, many of these new low-income buyers could face difficulty.

The homeownership rate for households with heads age 65 or over stood at 79.2 percent at the end of 1996.

No one can predict interest rates or house prices over the long run. There is some concern that the demand for homes could fall as baby boomers begin to retire in another dozen years or so. However, in the immediate years ahead, the number of homeowners is expected to increase rapidly as housing program initiatives for minorities and lower-income households continue and as immigration remains at a high level.

2. Homeownership Tax Provisions

The largest Federal housing programs help primarily upper-middle and upper income homeowners with their housing costs through the mortgage interest and property tax deductions. The Congressional Joint Committee on Taxation reports the cost of these for fiscal year 1997 at $41.3 and $15.6 billion respectively. These two provisions are of little importance to most elderly homeowners because, as noted above, most have fully paid their mortgages, and rather than itemizing, take the standard deduction. The "rollover" provision in the tax code ($18.8 billion in fiscal year 1997), that allows homeowners to sell an existing home without paying tax on the financial gain if a more expensive home is purchased, is probably also of little importance to most elderly homeowners. However, homeowners age 55 and older can exclude up to $125,000 of gain from the sale of a principal residence ($4.9 billion in fiscal year 1997). This allows older households to downsize to smaller homes or other housing alternatives without large tax consequences. The four homeowner tax preferences have a total cost of over $80 billion in fiscal year 1997 (compared to the fiscal 1997 Department of Housing and Urban Development budget of $19.5 billion).

3. Home Equity Conversion

It is estimated that more than 23 million American homeowners have no mortgage debt, and that the average age of the such owners is 64.3 years. For many of the elderly homeowners, the equity in their homes represents their largest asset, and estimates of their collective equity range from $600 billion to more than $1 trillion.

Many elderly homeowners find that while inflation has increased the value of their homes, it has also eroded the purchasing power of those living on fixed incomes. They find it increasingly difficult to maintain the homes while also paying the needed food, medical, and other expenses. Their incomes prevent them from obtaining loans. "House rich and cash poor" is the phrase that is often used to describe their dilemma. One option is to sell the home and move to an apartment or small condominium. For a variety of reasons, however, many of the elderly prefer to remain in the homes for which and in which they may have spent most of their working years.

Since the 1970s, parties have sought to create mortgage instruments which would enable elderly homeowners to obtain loans to convert their equity into income, while providing that no repayments would be due for a specified period or (ideally) for the lifetime of the borrower. These instruments have been referred to as reverse mortgages, reverse annuity mortgages, and home equity conversion loans. Active programs are described below.

The Department of Housing and Urban Development (HUD) Demonstration Program is the first nationwide home equity conversion program which offers the possibility of lifetime occupancy to elderly homeowners. The Housing and Community Development Act of 1987 (P.L. 100–242) authorized HUD to carry out a demonstration program to insure home equity conversion mortgages for elderly homeowners. The borrowers (or their spouses) must be el-

derly homeowners (at least 62 years of age) who own and occupy one-family homes. The interest rate on the loan may be fixed or adjustable. The homeowner and the lender may agree to share in any future appreciation in the value of the property.

Authority for the HUD program has been extended through September 30, 2000 and up to 50,000 mortgages may be made under the program. The program was recently revised to permit the use of it for 1- to 4- family residences if the owner occupies one of the units. Previous law only permitted only 1-family residences.

The mortgage may not exceed the maximum mortgage limit established for the area under section 203(b) of the National Housing Act. The borrowers may prepay the loans without penalty. The mortgage must be a first mortgage, which, in essence, implies that any previous mortgage must be fully repaid. Borrowers must be provided with counseling by third parties who will explain the financial implications of entering into home equity conversion mortgages as well as explain the options, other than home equity conversion mortgages, which may be available to elderly homeowners. Safeguards are included to prevent displacement of the elderly homeowners. The home equity conversion mortgages must include terms that give the homeowner the option of deferring repayment of the loan until the death of the homeowner, the voluntary sale of the home, or the occurrence of some other events as prescribed by HUD regulations.

The Federal Housing Administration (FHA) insurance protects lenders from suffering losses when proceeds from the sale of a home are less than the disbursements that the lender provided over the years. The insurance also protects the homeowner by continuing monthly payments out of the insurance fund if the lender defaults on the loan.

When the home is eventually sold, HUD will pay the lender the difference between the loan balance and sales price if the sales price is the lesser of the two. The claim paid to the lender may not exceed the lesser of (1) the appraised value of the property when the loan was originated or (2) the maximum HUD-insured loan for the area.

The Federal National Mortgage Association (Fannie Mae) has been purchasing the home equity conversion mortgages originated under the demonstration program.

A company named Freedom Home Equity Partners has begun to make home equity conversion loans in California. The borrower must be at least age 60 and own a one-to-four family home that is not a mobile home or cooperative. The borrower receives a single lump sum which may be used to purchase an immediate annuity to provide monthly cash advances for the remainder of the borrower's life. An equity conservation feature guarantees that at least 25 percent of the value of the home will be available to the borrower or to heirs when the loan is eventually repaid. The company reportedly intends to expand the program to other States.

Transamerica HomeFirst has begun to market home equity conversion loans in California, New Jersey, and Pennsylvania. To qualify for this so-called "HouseMoney" plan, the borrower may own a one-to-four family home that is not a mobile home or cooper-

ative. A manufactured home may qualify if it is attached to a permanent foundation.

There is no minimum age requirement, per se, but the borrower's age and home value must be sufficient to generate monthly cash advances of at least $150. For borrowers less than age 93, the cash advance is paid in two ways. First, the borrower receives monthly loan advances for a specified number of years based on life expectancy. Second, the borrower begins receiving monthly annuity advances after the last loan advance is received. The annuity advance continues for the remainder of the borrower's life. A borrower, aged 93 or more when obtaining a HouseMoney loan, receives monthly loan advances for a fixed number of years as selected by the borrower. No annuity advances are available to such borrowers. Reportedly, this company also intends to expand the program to other States.

In November 1995 the Federal National Mortgage Association (Fannie Mae) announced the introduction of the "Home Keeper Mortgage." This is the first conventional reverse mortgage that will be available on nearly a nationwide basis. (Texas does not permit reverse mortgages.) An eligible borrower must (1) be at least age 62, (2) own the home free and clear or be able to pay off the existing debt from the proceeds of the reverse mortgage or other funds, and (3) attend a counseling course approved by Fannie Mae. The loan becomes due and payable when the borrower dies, moves, sells the property, or otherwise transfers title. The interest rate on the loan adjusts monthly according to changes in the 1 month CD index published by the Federal Reserve. Over the life of the loan the rate may not change by more than 12 percentage points. In some States the borrower will have the option of agreeing to share a portion of the future value of the property with the lender and in return will receive higher loan proceeds during the term of the loan.

(A) LENDER PARTICIPATION

The FHA and Fannie Mae plans have the potential for participation by a large number of lenders. Lenders in 49 States have expressed an interest in the Fannie Mae program, but the program is new, so actual lender participation is not known yet. In theory, any FHA-approved lender could offer home equity conversions loans. In practice, it appears that the mortgages are only being offered by a few lenders. Several factors could account for this. From a lender's perspective, home equity conversion loans are deferred-payment loans. The lender becomes committed to making a stream of payments to the homeowner and expects a lump-sum repayment at some future date. How are these payments going to be funded over the loan term? What rate of return will be earned on home equity conversion loans? What rate could be earned if these funds were invested in something other than home equity conversions? Will the home be maintained so that its value does not decrease as the owner and the home ages? How long will the borrower live in the home? Will the institution lose "goodwill" when the heirs find that most or all of the equity in the home of a deceased relative belongs to a bank?

These issues may give lenders reason to be reluctant about entering into home equity conversion loans. For lenders involved in the HUD program, the funding problem has been solved since the Federal National Mortgage Association has agreed to purchase FHA-insured home equity conversions from lenders. The "goodwill" problem may be lessened by FHA's requirement that borrowers receive third-party counseling prior to obtaining home equity conversions. Still, many lenders do not understand the program and are reluctant to participate.

(B) BORROWER PARTICIPATION

Likewise, many elderly homeowners do not understand the program and are reluctant to participate. After spending many years paying for their homes, elderly owners may not want to mortgage the property again.

Participants may be provided with lifetime occupancy, but will borrowers generate sufficient income to meet future health care needs? Will they obtain equity conversion loans when they are too "young" and, as a result, have limited resources from which to draw when they are older and more frail and sick? Will the "young" elderly spend the extra income on travel and luxury consumer items? Should home equity conversion mechanisms be limited as last resort options for elderly homeowners?

Will some of the home equity be conserved? How would an equity conversion loan affect the homeowner's estate planning? Does the homeowner have other assets? How large is the home equity relative to the other assets? Will the homeowner have any survivors? What is the financial position of the heirs apparent? Are the children of the elderly homeowner relatively well-off and with no need to inherit the "family home" or the funds that would result from the sale of that home? Alternatively, would the ultimate sale of the home result in significant improvement in the financial position of the heirs?

How healthy is the homeowner? What has been the individual's health history? Does the family have a history of cancer or heart disease? Are large medical expenses pending? At any given age, a health borrower will have a longer life expectancy than a borrower in poor health.

What has been the history of property appreciation in the area? Will the owner have to share the appreciation with the lender?

The above questions are interrelated. Their answers should help determine whether an individual should consider home equity conversion, what type of loan to consider, and at what age home equity conversion should be considered.

(C) RECENT PROBLEMS WITH HOME EQUITY CONVERSION LOANS

Telemarketing operations may obtain data on homeownership, mortgage debt, and age of the homeowner. Recently, some "estate planning services" have been contacting elderly homeowners and offering to provide "free" information on how such homeowners may turn their home equity into monthly income at no cost to themselves. The companies did little more than refer loan applications to mortgage lenders participating in the HUD reverse mortgage program or to insurance companies offering annuities. Report-

edly, the estate planning services were pocketing 6 to 10 percent of any loan that the referred homeowner received.

On March 17, 1997, HUD issued Mortgage Letter 97–07 which informed FHA-approved lenders that, effective immediately, HUD would no longer insure reverse mortgages obtained with the assistance of estate planning services. Lenders were notified that HUD would take action to withdraw FHA approval from lenders who continue to use certain estate planning services.

Six estate planners were identified that charge high fees for information on reverse mortgages: America's Trust Inc. of San Juan Capistrano, CA; Patriot, Inc. of San Juan Capistrano, CA; Paramount Trust and Financial Services of Oceanside, CA; Senior Informational Services of Dana Point, CA; America's Financing, Inc. of Las Vegas, NV; and Senior Financial Services of Washington and Alaska, Inc., of Issoquoh, WA. This information is useful, but the organizations may change their names frequently or work through franchise arrangements.

HUD asked lenders to inform senior citizens that counseling is provided at little or no cost through HUD-approved, non-profit counseling services. Lenders were given a telephone number that homeowners may call to receive the name and phone number of a HUD-approved counseling agency near their home.

4. Possible Changes to Residential Tax Provisions

There could be overall tax reform in 1997 in which several changes to the laws affecting residential real estate have been mentioned. One would be to allow a penalty free (but not necessarily tax free) withdrawal from an Individual Retirement Account for the purchase of a first home. Some previous proposals of this kind would also have allowed a parent or grandparent to make a penalty free withdrawal for the purchase of a first home by their child or grandchild. There is some concern that parents and grandparents could feel obligated to help with a home purchase even though this might not be in their best interest. Another possible provision in a 1997 tax bill would allow home sellers to sell their home at any age, and each time, avoid paying a tax on up to $500,000 of gains ($250,000 for single homeowners). This would replace the existing rollover and $125,000 exclusion provisions. Currently, most homeowners are able to avoid a capital gains tax. Only a small percentage of sellers, often those with unfortunate circumstances (such as a divorce or serious financial setback) that forces them to sell without another purchase, do not pay this tax. The proposed change would benefit this group but would also allow many other homeowners to end the need to save a lifetime of financial documents on home purchases, sales, and spending on improvements. A third provision likely to be considered would allow losses from the sale of home to be treated as a capital loss, the same as losses from the sale of stocks, bonds, and other investments. Currently, losses on a sale of a home are not deductible.

D. INNOVATIVE HOUSING ARRANGEMENTS

1. Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs), also called life-care communities, typically provide housing, personal care, nursing home care, and a range of social and recreation services as well as congregate meals. Residents enter into a contractual agreement with the community to pay an entrance fee and monthly fees in exchange for benefits and services. The contract usually remains in effect for the remainder of a resident's life.

The American Association of Homes and Services for the Aging states that CCRC residents obtain easy access to health care, exercise opportunities and nutritious meals. A supportive environment is offered by staff and other residents which often make the residents more likely to engage in healthy behaviors.

The definition of CCRCs continues to be confusing and inconsistent due to the wide range of services offered, differing types of housing units, and the varying contractual agreements. According to the American Association of Homes for the Aging (AAHA), "continuing care retirement communities are distinguished from other housing and care options for older people by their offering of a long-term contract that provides for housing, services and nursing care, usually all in one location." In its study on life care, the Pension Research Council of the University of Pennsylvania developed a definition of life-care communities. It includes providing specified health care and nursing home care services at less than the full cost of such care, and as the need arises.

There are approximately 700–800 continuing care retirement communities with an estimated 230,000 residents, which represent about 1 percent of the elderly population. While most life-care communities are operated by private, nonprofit organizations and some religious organizations, there has been an increasing interest on the part of corporations in developing such facilities.

Continuing care retirement communities are often viewed as a form of long-term care insurance, because communities protect residents against the future cost of specified health and nursing home care. Like insurance, residents who require fewer health and nursing home care services in part pay for those who require more of such services. Entrance fees are usually based on actuarial and economic assumptions, such as life expectancy rates and resident turnover rates, which is also similar to insurance pricing policies.

Entry fees and monthly fees vary greatly among CCRCs (and sometimes even within a CCRC) depending on the type of unit occupied and the contract offered. Generally, determinants of fee structures include: size of unit, number of occupants, refundability of the entry fee, the amount of health-care coverage provided, the number of meals provided, additional services provided and the CCRCs amenities.

A 1996 Profile of the CCRC Industry asked respondents to a questionnaire to indicate the lowest and highest entry fees and monthly fees charged for selected unit types with one occupant. Out of 484 communities reporting fees, 62 communities (13 percent) reported having monthly fees but no entry fees. Of the remaining communities, a range of entry fees and monthly fees by

unit type were determined. The data indicate that entrance fees for a studio ranged from $56 to $235,000; for a one-bedroom ranged from $70 to $450,000; for a two-bedroom ranged from $120 to $659,243; and for the largest unit entrance fees ranged from $500 to $850,000. Monthly fees ranged from $65 to $3,120 for a studio; $30 to $4,150 for a one-bedroom; $30 to $5,000 for a two-bedroom; and $30 to $5,355 for the largest unit. This wide range of results is attributable to such factors as the social and health care services provided, the size and quality of independent living units, and the amount of health care coverage provided. CCRCs do not usually cover acute health care needs such as doctor visits and hospitalization. Studies have shown that the average age of persons entering life-care communities is 75. In independent living units, personal care units, and nursing home units the average ages are 80, 84, and 85, respectively.

Problems have been discovered in some communities, such as those using lifespan and health projections that are not actuarially sound, as well as incorrect revenue and cost projections. Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned on a pro-rated basis. According to AAHA's guidebook to CCRCs, the many variations of contracts can be grouped into three types: extensive, modified, and fee-for-service. All three types of contracts include shelter, residential services, and amenities. The difference is in the amount of long-term nursing care services. The extensive contract includes unlimited long-term nursing care. A modified contract has a specified amount of long-term nursing care. This specified amount may be 2 months, for example, after which time the resident will begin to pay a monthly or per diem rate for nursing care. The fee-for-service contract guarantees access to the nursing facility, but residents pay a full per diem rate for all long-term nursing care required. Emergency and short-term nursing care may, but not always, be included in the contract. (The consumer guidebook for CCRCs is available from the American Association of Homes for the Aging.)

2. Shared Housing

Shared housing can be best defined as a facility in which common living space is shared, and at least two unrelated persons (where at least one is over 60 years of age) reside. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Also, Section 8 housing vouchers can be used by persons in a shared housing arrangement.

Shared housing can be agency-sponsored, where four to ten persons are housed in a dwelling, or, it may be a private home/shared housing situation in which there are usually three or four residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with financial assistance to aid in the maintenance of that home.

There are a number of shared housing projects in existence today. Anyone seeking information in establishing such a project can contact two knowledgeable sources. One is called "Operation Match", which is a growing service now available in many areas of the country. It is a free public service open to anyone 18 years or older. It is operated by housing offices in many cities and matches people looking for an affordable place to live with those who have space in their homes and are looking for someone to aid with their housing expenses. Some of the people helped by Operation Match are single working parents, persons in need of short-term housing assistance, elderly people hurt by inflation or health problems, and the disabled who require live-in help to remain in their homes.

The other knowledgeable source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a link between individuals, groups, churches, and service agencies that are planning to form shared households.

3. Accessory Apartments and Granny Flats

Accessory apartments have been accepted in communities across the Nation for many years, as long as they were occupied by members of the homeowner's family. Now, with affordable housing becoming even more difficult to find, various interest groups, including the low-income elderly, are looking at accessory apartments as a possible means of source, affordable housing.

Accessory apartments differ from shared housing in that they have their own kitchens, bath, and many times, own entrance ways. It is a completely private living space installed in the extra space of a single family home.

The economic feasibility of installing an accessory apartment in one's home depends to a large extent on the design of the house. The cost would be lower for a split-level or house with a walk-out basement than it would be for a Cape Cod. In some instances, adding an accessory apartment can be very costly, and the benefit should be weighed against the cost.

Many older persons find that living in accessory apartments of their adult children is a way for them to stay close to family, maintain their independence, and have a sense of security. They are less likely to worry about break-ins and being alone in an emergency if they occupy an accessory apartment.

Not everyone, however, welcomes accessory apartments into their areas. Many people are skeptical, and see accessory apartments as the beginning of a change from single-family homes to multifamily housing in their neighborhoods. They are afraid that investors will buy up homes for conversion to rental duplexes. Many worry about absentee landlords, increased traffic, and the violation of building codes. For these reasons, in many parts of the country, accessory apartments are met with strong opposition.

Some communities have found ways to deal with these objections. One way is to permit accessory apartments only in units that are owner-occupied. Another approach is to make regulations prohibiting exterior changes to the property that would alter the character of the neighborhood. Also, towns can set age limits as a condition for approval of accessory apartments. For example, a town

may pass an ordinance stating that an accessory apartment can only be occupied by a person age 62 or older.

Because of the opposition and building and zoning codes, the process of installing and accessory apartment may be intimidating to many people. However, anyone seriously considering providing an accessory apartment in his home should seek advice from a lawyer, real estate agents and remodelers before beginning so that the costs and benefits can be weighed against one another.

4. Granny Flats or Echo Units

Another innovative housing arrangement being examined in this country is the "granny flat" or "ECHO unit." The granny flat was first constructed in Australia as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence. In the United States, we call this concept ECHO units, an acronym for elder cottage housing opportunity units.

ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit organizations or local housing authorities.

The National Affordable Housing Act of 1990 authorized a demonstration program to determine whether the durability of ECHO units is appropriate to include them for funding under the Section 202 program of providing housing for the elderly. The Housing and Community Development Act of 1992 authorized a reservation of sufficient Section 202 funds to provide 100 ECHO units for this five-year demonstration program. HUD is to present Congress with a report on the ECHO demonstration program in 1998.

E. FAIR HOUSING ACT AND ELDERLY EXEMPTION

The Fair Housing Amendments Act of 1988 amended the Civil Rights Act of 1968, and made it unlawful to refuse to sell, rent, or otherwise make real estate available to persons or families, based on "familial status" or "handicap." This amendment was put into law to end discrimination in housing against families with children, pregnant women, and disabled persons.

In passing this law, however, Congress did grant exceptions for housing for older persons. The Act does not apply to housing: (1) provided under any State or Federal program (such as Sec. 202) specifically designed and operated to assist elderly persons; (2) intended for and solely occupied by persons 62 years of age or older; or (3) intended and operated for occupancy by at least one person 55 years of age or older per unit, subject to certain conditions.

In 1994, the Department of Housing and Urban Development (HUD) proposed a rule which would determine whether or not a project occupied by senior citizens would be exempt from the law. The proposal was met with negative responses from many elderly advocacy groups promoting congressional response.

On December 28, 1995, P.L. 104–76, the Housing for Older Persons Act of 1995, was signed into law. This law defined senior

housing as a "facility or community intended and operated for the occupancy of at least 80 percent of the occupied units by at least one person 55 years of age or older." The law also requires that projects or mobile home parks publish and adhere to policies and procedures which would show its intent to provide housing for older persons.

F. HUD HOMELESS ASSISTANCE

The plight of the homeless continues to be one of the Nation's pressing concerns. One of the most frustrating and troubling aspects of the homeless issue is that no definitive statistics exist to determine the number of homeless persons. Numerous studies have produced an array of answers to the causes of homelessness and to the question of how many people are homeless at any one point in time in the U.S. During the 1990's, HUD has generally operated on the Urban Institute's finding that as many as 600,000 people are homeless on any given night.

Homelessness stems from a variety of factors, including unemployment, poverty, lack of affordable housing, social service and disability cutbacks, changes in family structure, substance abuse, and chronic health problems. About three quarters of homeless people are single adults without children. Families with children make up another fifth. The great majority of these families are headed by single women. It is estimated that one half of the homeless adults have current or past substance abuse problems. In addition, approximately 40 percent of the adult males are veterans. The homeless are often separated into two broad categories which sometimes overlap. In the first category are persons living in persistent poverty who do not have the resources to overcome disruptions or crises that results in bouts of episodic homelessness. In the second category are the long-term homeless. These individuals usually have chronic disabilities, mental illness, and/or substance abuse problem.

Homelessness among the elderly stems largely from the lack of affordable housing due to skyrocketing rents and the elimination of single-room-occupancy hotels. In the meantime, the number of people on waiting lists for low-income public housing continues to rise.

During the early 1980's, the policy of deinstitutionalization of the mentally ill was credited as a leading cause of homelessness in America. However, deinstitutionalization was initiated over 25 years ago, and most surveys report that only a modest percentage of homeless persons are former residents of mental hospitals. Today, many observers believe that "noninstitutionalization" (individuals lack of access to or choice of mental health treatment) is a critical factor contributing to homelessness.

The Federal Government's primary response to addressing the problems of the homeless has been the programs of the Stewart B. McKinney Homeless Assistance Act of 1987. The McKinney Act's homeless assistance has covered a wide range of programs providing emergency food and shelter, transitional and permanent housing, primary health care services, mental health care, alcohol and drug abuse treatment, education, and job training. The Department of Housing and Urban Development (HUD) currently administers approximately 70 percent of the McKinney Act funds. The Federal

Emergency Management Agency (FEMA) and four other departments (Health and Human Services, Veterans Affairs, Labor, and Education) are involved with McKinney grant programs. Most of the McKinney Act programs provide funds through competitive and formula grants. An exception is FEMA's Emergency Food and Shelter Program in which assistance is available through the local boards that administer FEMA funds. The assistance programs also focus on building partnerships with States, localities, and not-for-profit organizations in an effort to address the multiple needs of the homeless population.

The numerous programs created by the McKinney Act have been praised for their efforts and accomplishments. At the same time, the fragmented approach has raised concerns; critics and proponents have recommended a reorganization and/or consolidation of the programs.

On May 19, 1993, President Clinton signed an executive order to develop a comprehensive plan to deal with of homelessness. This order provides that: (1) Federal agencies acting through the Interagency Council on the Homeless, shall develop a single coordinated Federal plan for "breaking the cycle" of existing homelessness and for preventing future homelessness; (2) the plan shall recommend Federal administrative and legislative initiatives identifying ways to streamline and consolidate existing programs; (3) the plan shall make recommendations on how current funding programs can be redirected, if necessary, to provide links between housing, support, and education services, and to promote coordination among grantees; and (4) the Council shall consult with representatives of State and local governments, advocates for the homeless, homeless individuals, and other interested parties. In May 1994, the council submitted a Federal plan in a report entitled "Priority: Home! The Federal Plan to Break the Cycle of Homelessness."

In an effort to simplify the administration of HUD homeless assistance programs and to use McKinney Act funds more efficiently, HUD has proposed consolidating six homeless assistance programs: Shelter Plus Care, Supportive Housing, Emergency Shelter Grants, Section 8 Moderate Rehabilitation Single Room Occupancy (SRO), Rural Homeless Grants, and Safe Havens. This approach has not been enacted by Congress.

In 1995 and 1996 HUD overhauled the application process used by the Department for the distribution of competitively award McKinney Act funds. The intent was to shift the focus from individual projects to community-wide strategies for solving the problems of the homeless. The new options in the application process incorporate HUD's continuum of care strategy. Four major components are considered on this approach: prevention (including outreach and assessment), emergency shelter, transitional housing with supportive services, and permanent housing with or without supportive services. The components are used as guidelines in developing a plan for the community that reflects local conditions and opportunities. This plan becomes the basis of a jurisdiction's application for McKinney Act homeless funds. All members of a community interested in addressing the problems of homelessness (including homeless providers, advocates, representatives of the business commu-

nity, and homeless persons) can be involved in this continuum of care approach to solving the problems of homelessness.

The new application model established a combined application process for all of HUD's McKinney Act programs with the exception of Emergency Shelter Grants. There are three major programs: the Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation Single Room Occupancy.

In the application process, a jurisdiction presents funding requests for all projects addressing the problem of homelessness. Gaps in homeless service provisions and housing are identified and priorities are set.

The following is a description of the four programs contained in a December 1996 HUD report entitled: "The Continuum of Care: A Report on the New Federal Policy to Address Homelessness."

Emergency Shelter Grant (ESG) Formula Program provides money to convert, renovate, or rehabilitate buildings into emergency shelters. It also provides funds for food, consumable supplies, and beds and bedding. Through this program, HUD is able to help communities maintain and create places where homeless people may go to quickly to put a roof over their heads and to perhaps get initial service provision.

Supportive Housing Program (SHP) emphasizes supportive services in transitional living arrangements, although it also has a permanent housing component for people with disabilities. SHP has four components:

- *Transitional Housing* helps move homeless individuals and families into housing within 24 months. The temporary housing may be combined with support services that prepare individuals and families for living as independently as possible by promoting residential stability and increased job and other skills.
- *Permanent Housing for Persons with Disabilities* provides long-term community-based housing for people with mental, physical, or drug/alcohol disabilities.
- *Supportive Services* Only addresses the specific service needs of homeless persons but does not provide housing. (However, there must be a demonstrated connection to addressing housing needs.)
- *Safe Haven* provides supportive housing for homeless persons with severe mental illness who live on the streets and have been unwilling or unable to participate in supportive services. These are 24-hour residences that provide shelter for an unspecified duration and private or semi-private accommodations for up to 25 persons.

Shelter Plus Care Program (S&C) is intended to provide supportive permanent housing and service for people with disabilities by providing grantees, e.g., service providers, with several flexible ways to provide rental assistance for their clients. It has four major components:

- *Tenant-based Rental Assistance* allows homeless assistance providers to make rental assistance available to participants who then choose appropriate housing (within certain con-

straints), with the flexibility to continue the assistance if they move.

• *Sponsor-based Rental Assistance* provides rental assistance through a contract between the grantee, e.g., a homeless service provider, and a non-profit organization that owns or leases the housing units. This provides service providers with an avenue to permanent housing for their program participants.

• *Project-based Rental Assistance* provides rental assistance to homeless people through a contract between a nonprofit and a building owner that allows program participants to stay housed for up to ten years, and for buildings to be rehabilitated.

• *SRO-based Rental Assistance* provides rental assistance for housing in a single room occupancy building where the units to be used need some rehabilitation.

Section 8 Moderate Rehabilitation Single Room Occupancy Program (SRO Section 8) is designed to increase the supply of single room occupancy apartments; the kind of permanent housing that has historically housed poor, single men who were episodically homeless. It provides funds for rehabilitating singe room units within a building of up to 100 units. Like the Shelter Plus Care program, it is designed to provide permanent housing. Unlike Shelter Plus Care, however, the provision of supportive services is optional.

Congressional action resulted in a single appropriation for homeless assistance grants in fiscal years 1995 and 1996. The funding for homeless assistance in 1995 was $1.12 billion in 1996 funding was reduced to $823 million.

G. HOUSING COST BURDENS OF THE ELDERLY

Housing costs are a serious burden for many low- and moderate-income households, particularly for elderly households living on fixed incomes. Figures from the Department of Labor's Consumer Expenditure Survey for 1995 show that households headed by those age 65 and over, who had an average income of $22,180 in 1995, spent $7,590 or 34 percent of their income on housing. The figure for consumer units of all ages was 28 percent. This category includes not only the cost of shelter itself, but utilities and household operations, housekeeping supplies, and household furnishings (see table below). While the percentage of income spent of mortgage interest drops sharply for households age 65 and over, other housing costs remain high. Even though household income falls significantly for the elderly, ($22,180 compared to the average household income of $36,948 in 1995), the amount of property taxes paid by the elderly is higher than that paid by the average household ($973 in 1995 versus $932 for the average household). The elderly spend 4.4 percent of income for property taxes; the average household, about 2.5 percent. The elderly spend nearly 9 percent of their income on utilities, including telephone, and water, compared to about 6 percent for the average household.

TABLE 1.—HOUSING EXPENSES OF ELDERLY HOUSEHOLDS

Item	All consumer units	65 and over	65 and 74	75 and over
Number of consumer units (in thousands)	103,024	21,759	11,924	9,835
Consumer Unit Characteristics:.				
Income before taxes	$36,948	$22,180	$25,589	$18,205
Income after taxes	33,893	21,097	24,237	17,826
Age of reference person	48.0	74.4	69.3	80.6
Housing tenure:.				
Homeowner (%)	64	79	82	76
With mortgage (%)	38	14	20	8
Without mortgage (%)	26	65	62	68
Market-value of owned home ($)	$71,751	81,303	$86,743	$74,708
Renter	36	21	18	24
Housing	10,465	7,590	7,927	7,184
Shelter	5,932	3,668	4,018	3,243
Owned dwellings	3,754	2,401	2,819	1,895
Mortgage interest and charges	2,107	511	732	242
Property taxes	932	973	1,071	855
Maintenance, repairs, insurance, other expenses	716	917	1,015	798
Rented dwellings	1,786	931	783	1,111
Other lodging	392	335	416	238
Utilities, fuels, and public services	2,193	1,982	2,152	1,777
Natural gas	268	284	295	271
Electricity	870	801	888	697
Fuel oil and other fuels	87	129	120	139
Telephone and other public services	708	517	578	443
Water and other public services	260	251	271	226
Household operations	508	466	343	615
Personal services	258	127	26	249
Other household expenses	250	339	317	366
Housekeeping supplies	430	423	481	351
Laundry cleaning supplies	110	90	112	62
Other household products	194	195	224	160
Postage and stationary	125	138	145	130
Household furnishings and equipment	1,403	1,051	934	1,197
Household textiles	100	67	93	36
Furniture	327	143	172	107
Floor coverings	177	366	85	712
Major appliances	155	132	159	98
Small appliances, miscellaneous housewares	85	58	70	44
Miscellaneous household equipment	557	284	353	200

Source: U.S. Department of Labor. Bureau of Labor Statistics. Consumer Expenditure Survey, 1995.

Chapter 13

ENERGY ASSISTANCE AND WEATHERIZATION

OVERVIEW

Energy costs have a substantial impact on the elderly poor. Often they are unable to afford the high costs of heating and cooling fuel, and they are far more vulnerable than younger adults in winter and summer.

The high cost of energy is a special concern for low-income elderly individuals. The inability to pay these costs causes the elderly to be more susceptible to hypothermia and heat stress. Hypothermia, the potentially lethal lowering of body temperature, is estimated to be the cause of death for up to 25,000 elderly people each year. The Center for Environmental Physiology in Washington, DC. reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. Hypothermia can set in at indoor temperatures between 50 and 60 degrees Fahrenheit. Additionally, extremes in heat contribute to heat stress, which in turn can trigger heat exhaustion, heatstroke, heart failure, and stroke.

Two Federal programs exist to ease the energy cost burden for low-income individuals: The Low-Income Home Energy Assistance Program (LIHEAP) and the Department of Energy's Weatherization Assistance Program (WAP). Both LIHEAP and WAP give priority to elderly and handicapped citizens to assure that these households are aware that help is available, and to minimize the possibility of utility services being shut off. In the past, States have come up with a variety of means for implementing the targeting requirement. Several aging organizations have suggested that Older Americans Act programs, especially senior centers, be used to disseminate information and perform outreach services for the energy assistance programs. Increased effort has been made in recent years to identify elderly persons eligible for energy assistance and to provide the elderly population with information about the risks of hypothermia.

Although these programs have played an important role in helping millions of America's poor and elderly meet their basic energy needs, and to weatherize their homes, there is a dramatic gap between existing Federal resources and the needs of the population these programs were intended to serve. According to HHS data, in 1981, 36 percent of eligible households received heating and/or winter crisis assistance benefits. By 1994, only 21 percent of eligible households received those benefits.

Low-income households pay three to four times what all households combined pay for residential home energy costs; 11–12 per-

cent versus 3–4 percent, respectively. For example, in fiscal year 1994 LIHEAP households spent $1,137 or 12.1 percent of their income on residential energy, as compared to $1,289, or 3.3 percent of total income for households of all income levels. All low-income households (annual incomes under 150 percent of the poverty line or 60 percent of the State's medium income) spent $1,102, or 9.8 percent of their income, on their residential energy needs.

Both the LIHEAP and weatherization programs are vital to the households they serve, especially during the winter months. According to a recent HHS study, since major cuts in LIHEAP began in 1988, the number of low-income households with "heat interruptions" due to inability to pay has doubled. Thus, many low-income people go to extraordinary means to keep warm when financial assistance is inadequate, such as going to malls, staying in bed, using stoves, and cutting back on food and/or medical needs.

A. BACKGROUND

1. The Low-Income Home Energy Assistance Program

In the 1970's, prior to LIHEAP, there were a series of modest, short-term fuel crisis intervention programs. These programs were administered by the Community Services Administration (CSA) on an annual budget of approximately $200 million. However, between 1979 and 1980 the price of home heating oil doubled. As a result, Congress sharply expanded aid for energy by creating a three-part, $1.6 billion energy assistance program. Of this amount, $400 million went to CSA for the continuation of its crisis-intervention programs; $400 million to HHS for one-time payments to recipients of Supplemental Security Income (SSI); and $800 million to HHS for distribution as grants to States to provide supplemental energy allowances.

In 1980, Congress passed the Hone Energy Assistance Act as part of the crude oil windfall profit tax legislation, appropriating $1.85 billion for the program. At present, LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981) as amended by the Human Services Reauthorization Acts of 1984, 1986, 1990, the National Institutes of Health Revitalization Act of 1993, and the Human Services Amendments of 1994.

LIHEAP is one of the seven block grants originally authorized by OBRA and administered by HHS. The purpose of LIHEAP is to assist eligible households in meeting the costs of home energy. Grants are made to the States, the District of Columbia, approximately 124 Indian tribes and tribal organizations, and six U.S. territories. Each grantee's annual grant is a percentage share of the annual Federal appropriation (grants to Indian tribes are taken from their State's allocation). The percentage share is set by a formula established in 1980, for LIHEAP's predecessor. If the Federal appropriation is above $1.975 billion, a new formula takes effect, and grants are allocated by a formula based largely on home energy expenditures by low-income households. Annual Federal grants can be supplemented with the following funds: oil price overcharge settlements (money paid by oil companies to settle oil price control violation claims and distributed to States by the En-

ergy Department); State and local funds and special agreements with energy providers; money carried over from the previous fiscal year; authority to transfer funds from other Federal block grants; and payments under a $24 million-a-year special incentive program for grantees that successfully "leverage" non-Federal resources.

Financial assistance is provided to eligible households, directly or through vendors, for home heating and cooling costs, energy-related crisis intervention aid, and low-cost weatherization. Some States also make payments in other ways, such as through vouchers or direct payments to landlords. Homeowners and renters are required to be treated equitably. Flexibility is allowed in the use of the grants. No more than 15 percent may be used for weatherization assistance (up to 25 percent if a Federal waiver is given), and up to 10 percent may be carried over to the next fiscal year. A maximum of 10 percent of the grant may be used for administrative costs.

States establish their own benefit structures and eligibility rules within broad Federal guidelines. Eligibility may be granted to households receiving other forms of public assistance, such as SSI, Aid to Families With Dependent Children (AFDC), Temporary Assistance to Needy Families (TANF—the Personal Responsibility and Work Opportunity Reconciliation Act of 1996—requires states to replace their AFDC programs with the TANF program by July 1, 1997), food stamps, certain needs-tested veterans' and survivors' payments, or those households with income less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Lower income eligibility requirements may be set by States and other jurisdictions, but not below 110 percent of the Federal poverty level.

LIHEAP places certain program requirements on grantees. Grantees are required to provide a plan which describes eligibility requirements, benefit levels, and the estimated amount of funds to be used for each type of LIHEAP assistance. Public input is required in developing the plan. The highest level of assistance must go to households with the lowest incomes and highest energy costs in relation to income. Energy crisis intervention must be administered by public or nonprofit entities that have a proven record of performance. Crisis assistance must be provided within 48 hours after an eligible household applies. In life-threatening situations, assistance must be provided in 18 hours. A reasonable amount must be set aside by grantees for energy crisis intervention until March 15 of each year. Applications for crisis assistance must be taken at accessible sites and assistance in completing an application must be provided for the physically disabled.

The most recent figures from HHS concerning LIHEAP are for fiscal year 1996. They indicate that States provided heating assistance to 4.1 million households in fiscal year 1996. Additionally, 762,490 households received winter crisis assistance, 109,493 received cooling assistance, 58,520 received weatherization assistance and 30,527 received summer crisis assistance. Previous state estimates indicate that about two-thirds of the national total of households receiving winter crisis assistance also receive regular heating assistance. Based on this overlap among households receiving both types of assistance, an estimated 4.3 million households were ex-

pected to receive help with heating costs in fiscal year 1996, compared with 5.5 million households in fiscal year 1995, and 6.0 million in fiscal year 1994.

For fiscal year 1995, the total unduplicated number of households receiving LIHEAP assistance could not be calculated because some households received more than one type of LIHEAP assistance.

About 70 percent of LIHEAP recipients have an annual income of less than $8,000. Most are elderly or single-parent households. The State reported data for fiscal year 1994 indicates that 41.5 percent of households with elderly members received summer crisis assistance. Additionally, 40.7 percent of households with elderly members received cooling assistance, 29.8 percent received heating assistance, 29.5 percent received weatherization assistance, and 12.8 percent received winter/year round crisis assistance.

The fiscal year 1994 HHS LIHEAP report to Congress revealed:

On average, residential energy expenditures for all households increased from $1,255 in fiscal year 1993 to $1,289 in fiscal year 1994. LIHEAP recipient households increased their average residential energy expenditures by 6.6 percent, from $1,067 in fiscal year 1993 to $1,137 in fiscal year 1994;

Low-income households, especially LIHEAP recipients, are more likely to heat their homes with bulk fuels (fuel oil, kerosene, and liquefied petroleum gas), while all households are more likely to use electricity;

On average, low-income households consume about 15 percent less for space heating, about 38 percent less for space cooling, about 23 percent less for appliances, and about 8 percent less for water heating than the average for non low-income households;

Average annual home heating expenditures for all households was about $413 and for LIHEAP recipients it was $420;

Home heating expenditures represented a higher percentage of annual household income for low-income households (about 3.3 percent) than for all households (about 0.8 percent);

While electricity is used by most households to cool their homes, low-income households are less likely than all households to cool their homes;

Average annual home cooling expenditures for all households that cooled was about $145, and for LIHEAP recipients that cooled was about $89;

Cooling expenditures represented a higher percentage of average annual income for low-income households that cooled (0.9 percent) than for all households that cooled (0.4 percent);

Households that received summer crisis assistance were among the poorest households within the LIHEAP-eligible population;

Households receiving summer crisis assistance represented the greatest portion of assisted households (12.3 percent) with annual income under $2,000, and households receiving weatherization assistance represented the greatest portion of assisted households (10.6 percent) with annual incomes of $15,000 and over;

The national annual average benefit was $188 for heating assistance, which increased to $213 when heating and winter/year round crisis benefits were combined; and

Nationally, the average LIHEAP benefit for assistance with heating costs was $213 in fiscal year 1994. The average home heating expenditures for LIHEAP recipient households was $420 in fiscal year 1994. Consequently, the average benefit offset 50.7 percent of average heating expenditures for LIHEAP recipient households in fiscal year 1994, compared to 48.8 percent in fiscal year 1993.

According to HHS, in fiscal year 1994, LIHEAP provided States $1.063 billion ($887.5 million in 1995 and $652.4 million in 1996) for heating assistance, $24.9 million ($54 million in 1995 and $14.5 million in 1996) for cooling assistance, $225.6 million ($200.6 million in 1995 and $138.4 million in 1996) for energy crisis intervention or crisis assistance, and $214.3 million ($159 million in 1995 and $110.6 million in 1996) for low-cost residential weatherization or other energy-related home repair.

In fiscal year 1994, LIHEAP was funded at $1.473 billion; the appropriation also included a contingency fund for weather emergencies of $600 million. In fiscal year 1995, LIHEAP was funded at $1.319 billion, the appropriation also included a weather emergency fund of $600 million. In fiscal year 1996, LIHEAP was funded at $900 million; the appropriation also included an emergency fund of $300 million.

Public Law 104–208 (the fiscal year 1997 omnibus appropriations legislation), signed into law on September 30, 1996, included LIHEAP appropriations of $1 billion for fiscal year 1997 and an advance LIHEAP appropriation of $1 billion for fiscal year 1998. In addition, (P.L. 104–134) (the fiscal year 1996 omnibus appropriation legislation, signed into law on April 26, 1996) provided that any of the fiscal year 1996 contingency fund for weather emergencies that were unobligated at the end of fiscal year 1996 would remain available for obligation in fiscal year 1997 (i.e. $120 million). Public Law 104–134 also authorized an additional $300 million in contingency funds for weather emergencies in fiscal year 1997.

During January 1997, President Clinton released $215 million in emergency LIHEAP funds, citing this year's cold weather and a recent price hike in fuel costs. As of March 1997, $205 million remained in the weather emergency contingency fund.

2. The Department of Energy Weatherization Assistance Program

Federal efforts to weatherize the homes of low-income persons began on an ad hoc, emergency basis after the 1973 oil embargo. A formal program was established, under the Community Services Administration (CSA), in 1975. The Department of Energy (DOE) became involved in 1976 with passage of Public Law 94–385. In 1977 and 1978, DOE administered a grant program that paralleled and supplemented the CSA program; DOE provided money for the purchase of material and CSA was responsible for labor. In 1979,

DOE became the sole Federal agency responsible for operating a low-income weatherization assistance program.

The DOE's Weatherization Assistance Program is authorized under Title IV of the Energy Conservation and Production Act (P.L. 94–385, as amended). The goals of the Weatherization Assistance Program (WAP) are to decrease national energy consumption and to reduce the impact of high fuel costs on low-income households, particularly those of the elderly and the handicapped. Additionally, the program seeks to increase employment opportunities through the installation and manufacturing of low-cost weatherization materials. The 1990 legislation reauthorizing the program also permits and encourages the use of innovative energy saving technologies to achieve these goals.

The Weatherization Assistance Program is a formula grant program which flows from the Federal to State governments to local weatherization agencies. There are 51 State grantees (each State and the District of Columbia), and approximately 1,103 local weatherization agencies, or subgrantees.

To be eligible for weatherization assistance, household income must be at or below 125 percent of the Federal poverty level. States, however, may raise their income eligibility level to 150 percent of the poverty level to conform to the LIHEAP income ceiling. States may not, however, set it below 125 percent of the poverty level. Households with persons receiving AFDC, SSI, or local cash assistance payments are also eligible for assistance. Priority for assistance is given to households with an elderly individual, age 60 and older, or a handicapped person.

Although the law is not specific, Federal regulations specify that each State's share of funds is to be based on its climate, relative number of low-income households and share of residential energy consumption. Funds made available to the States are in turn allocated dollars to nonprofit agencies for purchasing and installing energy conserving materials, such as insulation, and for making energy-related repairs. Federal law allows a maximum average expenditure of $1,600 per household, unless a state-of-the-art energy audit shows that additional work on heating systems or cooling equipment would be cost-effective.

Since its inception through 1996, the weatherization program has served more than 4.7 million homes. In approximately 36 percent of the homes weatherized, at least one resident was 60 years of age or older. An estimated 105,973 homes were weatherized in fiscal year 1995 and 56,545 in fiscal year 1996.

In 1993, the DOE issued a report entitled *National Impacts of the Weatherization Assistance Program in Single Family and Small Multifamily Dwellings.* The report represents 5 years of research that shows DOE's Weatherization Assistance Program saves money, reduces energy use, and makes weatherized homes a safer place to live. Two researchers at DOE's Oak Ridge National Laboratory concentrated on data from the 1989 program year (April 1 through March 31) in which 198,000 single-family and small multifamily buildings and 20,000 units in large multifamily buildings were weatherized in that year. Of that amount, 14,970 dwellings were weatherized in that year. Of that amount, 14,970 dwellings weatherized in that year were studied. The report revealed:

The Weatherization Assistance Program saves $1.09 in energy costs for every $1 spent;

The average energy savings per dwelling was $1,690, while it cost $1,550 to weatherize the average home, including overhead;

The program was most effective in cold weather States in the Northeast and upper Midwest, which may be due to DOE's early emphasis on heating rather than cooling;

States with cold climates produced the highest energy savings. For natural gas consumption, first-year savings represented a 25-percent reduction in gas used for space heating and a 14-percent reduction in total electricity use;

Weatherization reduced the average low-income recipient's energy bill by $116, which represents approximately 18 percent of the total home heating bill of $640;

Energy savings through weatherization reduces U.S. carbon emissions by nearly 1 million metric tons. Savings were the most dramatic in single-family, detached houses in cold climates; and

The average low-income household in the North is particularly hard hit by home energy costs, spending 17 percent of income on residential energy. Elsewhere across the country, low-income people typically spend 12 percent of their income on energy, compared to only 3 percent for other incomes.

In fiscal year 1996, the appropriation for the Weatherization Assistance Program was $111.7 million. The fiscal year 1997 appropriation is $120.8 million. The President has proposed $154.1 million for fiscal year 1998.

B. CONGRESSIONAL RESPONSE

On February 4, 1993, Senator Patrick Leahy introduced S. 309, the Rural Jobs and Investment Act of 1993. S. 309 makes emergency supplemental appropriations to provide a short-term stimulus to promote job creation in rural areas of the United States. Title II of the bill makes supplemental fiscal year 1993 appropriations for these Department of Energy programs: (1) low-income weatherization assistance; and (2) institutional energy conservation and State energy conservation. The bill would provide $150 million to enable the Secretary of Energy to make grants under Title III of the Energy Conservation and Production Act for the Weatherization Assistance Program for low-income persons. The bill was referred to the Committee on Appropriations.

Representative Barney Frank introduced H.R. 3321, a bill to provide increased flexibility to States in carrying out the Low-Income Home Energy Assistance Program on October 20, 1993. The bill, which passed the House on November 15, 1993, amends the Housing and Community Development Act of 1992 to create a limited exception to the general requirement of equal treatment to permit States greater flexibility in structuring their LIHEAP programs. States would continue to be prohibited from implementing a blanket disqualification of subsidized housing tenants with energy costs. They would, however, be permitted to consider tenants' utility allowances, provided by local public housing authorities, in de-

termining or adjusting the amount of LIHEAP benefit to be granted. Any reductions in LIHEAP benefits, however, would have to be reasonably related to the amount of the heating or cooling component of the utility allowance and would be subject to the longstanding requirement in the LIHEAP statute that the highest LIHEAP awards be provided to households with the greatest energy burdens. This amendment makes clear that the prohibition on discrimination against tenants paying heating or cooling costs in subsidized housing would remain in force for any programs other than LIHEAP that may be available to serve these tenants. On November 22, 1993, the measure passed in the Senate by unanimous consent. (A provision of this bill is identical to a provision in S. 1299, Housing and Community Development Act of 1993.) On December 14, 1993, the legislation was signed into law (P.L. 103–185, 107 Stat. 2244) by the President.

Senator J. Bennett Johnston introduced S. 991, the Lower Mississippi Delta Initiative Act 1993 on May 19, 1993. The bill directs the Secretary of the Interior and the Secretary of Energy to undertake initiatives to address needs in the lower Mississippi Delta Region, and for other purposes. Section 206 of the bill amends the Energy Conservation and Production Act to direct the Secretary of Energy to make grants to States and Indian tribal organizations in the Delta region for weatherization of low-income dwelling units. S. 991 authorizes $20 million in fiscal years 1995, 1996, and 1997, and requires that these grants be in addition to grants that are provided under existing programs. The bill was referred to the Committee on Energy and Natural Resources, on October 5, 1993, it was ordered to be reported out of Committee with an amendment in the nature of a substitute. The measure, as amended, passed the Senate by unanimous consent on November 20, 1993.

C. PROGNOSIS

There has been a substantial reduction in LIHEAP funding levels in the past decade from a high of $2.1 billion in fiscal year 1985 to the current level of $1 billion in fiscal year 1997. (Moreover, LIHEAP has been advance funded $1 billion for fiscal year 1998). In fiscal year 1985, 6.8 million households received LIHEAP assistance to reduce their heating costs. In fiscal year 1996, the number of LIHEAP households helped with heating assistance had dropped to 4.3 million. During the late 1980's, much of the decrease in LIHEAP and Weatherization was made up by a large share of the oil overcharge refunds (approximately $2 billion). Virtually all of those funds have now been expended. In 1993, approximately 10 percent of funding for the Weatherization Assistance Program came from the LIHEAP Block Grant. Cuts in LIHEAP would severely decrease or possibly eliminate the use of LIHEAP funds for weatherization.

There is little doubt that LIHEAP has been successful in providing emergency energy relief to millions of poor Americans, a significant percentage of whom are elderly. Much of this success is due to the ability of the States to assume the responsibility of this prominent block grant program and their ability to administer it in the way they see best even with decreasing funds. At the same time, DOE's weatherization assistance program has reduced the

energy expenditures for many persons living in poverty. Nevertheless, the debate over funding levels for these programs will likely persist.

Chapter 14

OLDER AMERICANS ACT

HISTORICAL PERSPECTIVE

The Older Americans Act (OAA), enacted in 1965, is the major vehicle for the organization and delivery of supportive and nutrition services to older persons. It was created during a time of rising societal concern for the needs of the poor. The OAA's enactment marked the beginning of a variety of programs specifically designed to meet the social and human needs of the elderly.

The OAA was one in a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvement was needed beyond the existing health and income-transfer programs. Although older persons could receive services under other Federal programs, the OAA was the first major legislation to organize and deliver community-based social services exclusively to older persons.

The OAA followed similar social service programs initiated under the Economic Opportunity Act of 1964. The OAA's conceptual framework was similar to that embodied in the Economic Opportunity Act and was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When enacted in 1965, the OAA established a series of broad policy objectives designed to meet the needs of older persons. Although the OAA then lacked both legislative authority and adequate funding, it did establish a structure through which the Congress would later expand aging services.

Over the years, the essential mission of the OAA has remained very much the same: To foster maximum independence by providing a wide array of social and community services to those older persons in the greatest economic and social need. The key philosophy of the program has been to help maintain and support older persons in their homes and communities to avoid unnecessary and costly institutionalization.

The Act authorizes a wide array of service programs through a nationwide network of 57 State agencies on aging and 660 area agencies on aging (AAAs). It supports the only federally sponsored job creation program benefiting low-income older persons and is a major source of Federal funding for training, research, and demonstration activities in the field of aging. It also authorizes a separate program for supportive and nutrition services for older Native

Americans and Native Hawaiians and authorizes a program to protect the rights of older persons.

The Act establishes the Administration on Aging (AOA) within the Department of Health and Human Services (HHS) which administers all of the Act's programs except for the Senior Community Service Employment Program administered by the Department of Labor (DOL), and the commodity or cash-in-lieu of commodities portion of the nutrition program, administered by the U.S. Department of Agriculture (USDA).

The original legislation established AOA within HHS and established a State grant program for community planning and services programs, as well as authority for research, demonstration, and training programs. The Act has been amended 13 times since the original legislation was enacted. Major amendments included the creation of the national nutrition program for the elderly in 1972 and the network of area agencies on aging in 1973. Other amendments established the long-term care ombudsman program and a separate grant program for older Native Americans in 1978, and a number of additional service programs under the State and area agency on aging program in 1987, including in-home services for the frail elderly, programs to prevent elder abuse, neglect and exploitation, and health promotion and disease prevention programs, among others. The most recent amendments in 1992 created a new Title VII to consolidate and expand certain programs that focus on protection of the rights of older persons (which under prior law were authorized under Title III).

During the 1970's, Congress significantly improved the OAA by broadening its scope of operations and establishing the foundation for a "network" on aging under a Title III program umbrella. In 1973, the area agencies on aging were authorized. These agencies, along with the State Units on Aging (SUAs), provide the administrative structure for programs under the OAA. In addition to funding specific services, these entities act as advocates on behalf of older persons and help to develop a service system that will best meet older Americans' needs. As originally conceived by the Congress, this system was meant to encompass both services funded under the OAA, and services supported by other Federal, State, and local programs.

Increased funding during the 1970's allowed for the further development of AAAs and for the provision of other services, including access (transportation, outreach, and information and referral), in-home, and legal services. Expansion of OAA programs continued until the early 1980's when, in response to the Reagan Administration's policies to cut the size and scope of many Federal programs, the growth in OAA spending was slowed substantially, and for some programs was reversed. For example, between fiscal years 1981 and 1982, Title IV funding for training, research, and discretionary programs in aging was cut by approximately 50 percent. Fortunately, there is widespread bipartisan congressional support of OAA programs, especially the nutrition and senior community service employment programs. With the elderly population increasing, the need and importance of funding for OAA programs will continue to increase. Unfortunately, until real progress is made in

remedying the Federal deficit, the OAA programs will continue to face problems and opposition to increased funding.

A. THE OLDER AMERICANS ACT 1993 TITLES

The following is a brief description of each Title of the Older Americans Act:

1. TITLE I—OBJECTIVES AND DEFINITIONS

Title I outlines broad social policy objectives aimed at improving the lives of all older Americans in a variety of areas including income, health, housing, long-term care, and transportation.

2. TITLE II—ADMINISTRATION

Title II establishes the AOA to administer most OAA programs and to act as the chief Federal agency advocate for older persons. It also authorizes the Federal Council on Aging to advise the President and Congress regarding the needs of older persons. Council members are appointed by the President, the Speaker of the House, and the President pro tempore of the Senate.

3. TITLE III—STATE AND COMMUNITY PROGRAMS ON AGING

Title III authorizes grants to State and area agencies on aging to act as advocates on behalf of programs for the elderly and to coordinate programs for this group. This program supports 57 State agencies on aging, 660 area agencies on aging, and over 27,000 service provider organizations. This nationwide network of supportive, nutrition, and other social services programs receive most of the Act's total Federal funding (65 percent in fiscal year 1997).

Funds for supportive, nutrition, and home care services are distributed to States by AOA based on a formula which takes into account State population age 60 or over. The majority of Title III funding is for congregate and home-delivered meals (65 percent in 1997). In addition to formula grant funds awarded to States by AOA, States also receive assistance from the USDA in the form of commodities or cash-in-lieu of commodities.

The supportive services and centers program authorizes a wide range of services to older persons including supportive services (with priority on access, in-home services, and legal assistance). Also, Title III authorizes school-based meals for volunteer older persons and multigenerational programs; in-home services for the frail elderly; assistance for special needs; disease prevention and health promotion activities and supportive activities for caretakers of the frail elderly.

The program requires that services be available to all older persons, but be targeted on those persons in greatest social and economic need, with particular attention to low-income minority older persons. Means tests are prohibited, but older persons are encouraged to make contributions toward the costs of services.

4. Title IV—Training, Research, and Discretionary Projects and Programs

The Title IV program authorizes the Assistant Secretary on Aging to award funds for a broad array of training, research, and demonstration projects in the field of aging. Funds are to be used to expand knowledge about aging and the aging process and to test innovative ideas about services and programs for older persons.

Title IV supports a wide range of demonstration projects, including, for example, projects on community-based long-term care, adult literacy, Alzheimer's disease support services, and career preparation and continuing education in the field of aging.

5. Title V—Community Service Employment for Older Americans

The Community Service Employment Program authorizes funds to subsidize part-time community service jobs for unemployed, low-income persons 55 years of age or older. This program is the only direct job creation program for older persons. The Department of Labor awards funds to operate the program to 10 national organizations and to State agencies, primarily State agencies on aging, which recruit, train, and place enrollees in jobs. National sponsors received 78 percent of funds, and State sponsors received 22 percent. National organizations that receive funds are Associacion Pro Personas Mayores, the National Caucus and Center on Black Aged, National Council on Aging, American Association of Retired Persons, National Council of Senior Citizens, National Urban League, Inc., Green Thumb, National Pacific/Asian Resource Center on Aging, National Indian Council on Aging, and the U.S. Forest Service. In program year 1996–97 (July 1, 1996–June 30, 1997), Title V supported 48,000 jobs. Fiscal year 1996 funds will support over 61,000 employment positions for national organizations and 15,000 for State agencies.

Enrollees are paid the higher of the Federal or State minimum wage or the local prevailing rate or pay for similar employment, and work in a wide variety of community service activities, such as health care, senior centers, and education. Title V wages are not considered when determining eligibility for Federal housing and food stamp programs.

6. Title VI—Grants for Native Americans

Title VI authorizes funds for supportive and nutrition services for older Native Americans, under Part A, and for older Native Hawaiians under Part B.

Under Part A, a tribal organization is eligible for Title VI funds if it has at least 50 older Native Americans. The law allows older Native Americans to receive assistance under Title VI, as well as under Title III programs.

Part B, the Native Hawaiian Program, retains a separate authorization under Title VI. Like tribal organizations, the Native Hawaiian organizations are eligible for funds if they represent at least 50 Native Hawaiians who are 60 years of age or older.

In fiscal year 1996, over 200 Native American Tribal organizations and one Native Hawaiian organization received Title VI funds.

7. Title VII—Vulnerable Elder Rights Protection Activities

Title VII authorizes funds for activities that protect the rights of the vulnerable elderly. Programs authorized are—The Long-Term Care Ombudsman Program; programs to prevent elder abuse, neglect, and exploitation; elder rights and legal assistance, outreach, counseling, and assistance programs on insurance and public benefits. Title VII also authorizes an elder rights program for Native American elderly. Funds are distributed to State agencies on aging based on a formula which takes into account State population age 60 or over.

B. SUMMARY OF MAJOR ISSUES IN THE 102ND AND 104TH CONGRESSES

Legislation reauthorizing the Older Americans Act was reviewed for reauthorization during the 102d Congress. On September 30, 1992, the President signed into law legislation (P.L. 102–375) reauthorizing the Act through fiscal year 1995. Amendments to the Older Americans Act include modification and expansion of the nutrition program for the elderly; assurance of more effective targeting of services to low income and minority older persons; creation of a new Title VII to protect the rights of vulnerable older persons; and expanded initiatives on long-term care programs. Public Law 102–375 also increased the USDA reimbursement for meals, limited State authority to transfer funds between certain Title III services; authorized programs for assistance to caregivers of the frail elderly; clarified the role of Title III agencies in working with the for-profit sector; and required improvements in AOA data collection.

1. 102nd Congress Legislation

Authorization of appropriations for the OAA expired at the end of fiscal year 1991. In preparation for the 1992 reauthorization, the Special Committee on Aging held a series of workshops in 1990 which focused on a number of reauthorization issues, including information systems and information flow within the aging network; legal assistance and the ombudsman program; and the role of the AOA. In addition, the Committee conducted a nutrition workshop in February 1991 which focused in part on OAA-funded nutrition programs, and a hearing in July 1992 on grandparents who are raising their grandchildren.

Based on the findings of these workshops and hearing, the Chairman of the Special Committee on Aging, Senator David Pryor introduced four separate bills to amend the Act: (1) S. 974 to improve information and assistance, legal assistance, the long-term care ombudsman program, data collection, and transportation services for the elderly; (2) S. 1477, to improve the quality, safety, and wholesomeness of meals served by OAA-supported nutrition programs; (3) S. 1740, to redistribute Title III funds to alleviate the burden placed on States with a disproportionate number of low-in-

come elderly persons; and (4) S. 3236, to establish the National Resource Center for Grandparents. Most of the major provisions of the first three bills have been incorporated into Public Law 102–375. Senator Pryor reintroduced the fourth bill in March 1993 as S. 621. The bill has been referred to the Senate Committee on Labor and Human Resources.

In addition, Senator Pryor sponsored two other initiatives which are included in the new legislation: (1) Provisions for special projects in comprehensive long-term care, and for several long-term care resource centers including one devoted exclusively to long-term care issues affecting the rural elderly; and (2) grants to States for developing comprehensive and coordinated senior transportation systems, and grants to area agencies on aging to assist them in leveraging additional resources to deliver transportation services.

Bills to reauthorize the Act through fiscal year 1995 were passed by the House and the Senate in 1991, but legislation was not enacted until 1992. H.R. 2967 was passed by the House on September 12, 1991, and S. 243 was passed by the Senate on November 12, 1991. Final passage of the reauthorization bill was delayed due to inclusion of amendments added on the Senate and House floors to eliminate or liberalize the Social Security earnings test. Compromise language on the Older Americans Act approved by the House Education and Labor Committee and the Senate Labor and Human Resources Committee was passed by the House on April 9, 1992. On September 15, 1992, S. 3008, the Senate version of the compromise reauthorization bill was passed by the Senate without an earnings test amendment. The compromise bill was subsequently passed by the House on September 22, clearing the measure for the President.

2. 104TH CONGRESS LEGISLATION

Authorizations of appropriations for the Older Americans Act expired in fiscal year 1995. During the 104th Congress, authorizing committees in both houses reported legislation that would have reauthorized the Act through fiscal year 2001. H.R. 2570 (Cunningham), the Older Americans Amendments of 1995, was reported by the House Economic and Educational Opportunities Committee on April 25, 1996. S. 1643 (Gregg) was reported by the Senate Labor and Human Resources Committee on July 31, 1996. However, neither the House or the Senate took action on the committee-reported bills. Until Congress enacts reauthorization legislation, current law remains in effect. In the meantime, the Omnibus Consolidated Appropriations Act, 1997, has provided funds to continue the program through fiscal year 1997.

(A) CONSOLIDATION AND RESTRUCTURING OF AGING SERVICE PROGRAMS

In keeping with various 104th Congress initiatives to consolidate or restructure a variety of Federal domestic assistance programs and to give more flexibility to States, various proposals were considered to consolidate and/or restructure the Older Americans Act and related programs. These included proposals to consolidate and

restructure programs that are currently separately authorized; to include under the Act's umbrella related aging service programs not currently authorized as part of the Act; and to change the Federal administrative authority for some aging services programs. Other proposals to consolidate some Older Americans Act programs into other block grant programs were considered, but ultimately were rejected by Congress.

(B) CONSOLIDATION AND RESTRUCTURING OF PROGRAMS IN THE OLDER AMERICANS ACT

Current law contains 20 separate authorizations of appropriations for programs under the Act. This includes nine programs under Title III (grants for State and community programs on aging), five programs under Title VII (vulnerable elder rights protection activities), as well as authorizations of appropriations for AOA activities, the Federal Council on Aging, the senior community service employment program, research, training, and demonstration activities, and grants for Native Americans.[1]

Both H.R. 2570 and S. 1643 would have consolidated a number of these programs and therefore would have eliminated some of the separate authorizations of appropriations that now exist. H.R. 2570 would have reduced the number of authorized programs to seven, and S. 1643 would have reduced the number to nine.

Under H.R. 2570, programs that are currently separately authorized under Title III and Title VII would have been consolidated into a generic supportive services program under Title III, Grants for State and Community Programs on Aging. S. 1643 would have restructured the Act by creating a new Title II, State Programs on Aging. It would have consolidated certain programs that are now separately authorized, as well as retained separate authorizations of appropriations for certain programs now contained in Titles III, V, and VII of the Act. Some programs currently authorized under Title III would have been authorized under a new Title III, Local Programs on Aging.

Both bills would have significantly restructured the senior community service employment program. H.R. 2570 would have included separate authorization of appropriations for the program under Title III of the Act, and S. 1643 would have incorporated the program under its proposed Title II State Programs on Aging. Both bills would have eliminated a separate title for research, training, and demonstration activities, but would have retained separate authorization of appropriations for these activities. Under both bills, grants to Native American organizations would have remained a separate title. Both bills would have eliminated the authorization of appropriations for the Federal Council on Aging; however, the

[1] Some programs authorized have never been funded. In addition, fiscal year 1996 and fiscal year 1997 appropriations legislation consolidated or eliminated separate funding for some programs that were previously separately funded. Programs under Title III that were funded in fiscal year 1995 were supportive services and centers; congregate nutrition services; home delivered nutrition services; U.S. Department of Agriculture (USDA) assistance; disease prevention and health promotion services; and in-home services for the frail elderly. Programs funded under Title VII were long term care ombudsman services; elder abuse prevention services; and outreach, counseling, and assistance. For further information, see U.S. Library of Congress. Congressional Research Service. *Older Americans Act: Programs and Funding.* CRS Report for Congress No. 95–917 EPW, by Carol O'Shaughnessy and Molly Forman. Washington, 1996.

104th Congress has effectively eliminated the Council since funding of its activities has not been approved since fiscal year 1995.

3. Targeting of Services

Congress has intended that services provided under Title III of the Older Americans Act be available to all older persons who need assistance, and that program participation not depend on income status alone. Successive amendments have required that nutrition and supportive services be focused on those persons in greatest social or economic need, with particular attention to low-income minority older persons. In recent years, Congress has expressed concern about the need to improve targeting of supportive and nutrition services to older persons most in need, especially low-income minority older persons.

How to improve targeting was a major focus of the 1992 reauthorization process. Although the OAA has required that State and area agencies on aging give preference to the elderly with the greatest economic or social need, especially low-income minority individuals, some advocates stress that all relevant sections of the OAA should specify this preference in order to emphasize the importance of serving these groups.

The 1992 reauthorization hearings documented that participation by minorities in Title III programs continued to decline. Reasons cited for the decline included that minority persons often felt that OAA programs were not responsive to their needs and priorities, meals were not culturally appropriate, non-English publications seldom were available, and there was insufficient publicity about OAA programs and referral services. Additional reasons given were that outreach to minority older persons by area agencies on aging was poor and that minorities were absent or excluded from the service delivery planning process on local advisory councils.

During the 1992 reauthorization, attention focused on the use of intrastate funding formulas to target services to those in greatest economic or social need and methods for improving AOA's data collection methods. Public Law 102–375 strengthened prior statutory requirements in a number of ways. Formulas used by State agencies on aging for distribution of Title III funds within the State are required to take into account the distribution of older persons with greatest economic and social need, with particular attention to low-income minority older persons. The Act also clarified that these intrastate funding formulas must be approved by the Assistant Secretary on Aging. In addition, State and area agencies are required to set specific objectives for providing services to low-income minority persons and to initiate specific activities to serve these groups.

Targeting of services to low-income minority older persons continued to be a subject of review during the 104th Congress, as it has during past reauthorizations of the Act. Current law contains numerous requirements that State and area agencies on aging target services to persons in greatest social and economic need, with particular attention on low-income minority older persons. It also requires that the agencies set specific objectives for serving low-income minority older persons and that program development, advocacy, and outreach efforts be focused on these groups. Service pro-

viders are required to meet specific objectives set by area agencies for providing services to low-income minority older persons, and area agencies are required to describe in their area plans how they have met these objectives.

Both H.R. 2570 and S. 1643, as approved by the respective committees, would have required that in providing services, preference be given to older persons in greatest social and economic need, with particular attention to low-income minority older persons, and that in conducting outreach to persons eligible for services, particular emphasis be given to low-income minority older persons. In the mark-up of H.R. 2570 an amendment that would have restored to the bill some other references to serving low-income minority older persons that are in current law was rejected. The 105th Congress may again review the current law targeting provisions to assess what provisions might be included in reauthorization proposals.

4. Elder Rights

A number of Title III programs are specifically directed at promoting services that protect the rights, autonomy, and independence of older persons. Public Law 102–375 consolidated, amended, and expanded under a new Title VII of the Act, programs that focus on the protection of the rights of older persons that were previously authorized under Title III. Title VII is designed to expand the responsibility of State offices on aging for the development, coordination, and management of statewide activity to assist older persons securing rights and services. Title VII includes separate authorizations of appropriations for the long-term ombudsman program; programs to prevent elder abuse, neglect, and exploitation; elder rights and legal assistance; and outreach, counseling, and assistance program for insurance and public benefit programs. The amendments also authorize a new program for Native American elder rights.

In support of activities authorized under Title VII, Public Law 102–375 required the Assistant Secretary to support a National Center on Elder Abuse and a National Long Term Care Ombudsman Resource Center. The Elder Abuse Center is required to annually compile, publish, and disseminate research and training materials on abuse, neglect, and exploitation. The Center is also required to serve as a clearinghouse on abuse, neglect, and exploitation of older individuals. The Ombudsman Resource Center was established through a Cooperative Agreement with the National Citizens Coalition For Nursing Home Reform. The Center acts as a resource for policy analysis and more effective organization and operation of Federal, State, and local long-term care ombudsman programs through technical assistance, consultation, and information dissemination.

Action on the Older Americans Act during the 104th Congress would have significantly restructured the Act's elderly rights programs.

H.R. 2570 would have eliminated Title VII as a separate title for elder rights protection activities and incorporated authority for the ombudsman program into the supportive services program. Under this approach, States would have been required to carry out the ombudsman program, but there would have been no separate au-

thorization of appropriations. The bill would also have placed a ceiling on the amount of Title III funds that States could use to support the program, that is, their fiscal year 1995 amount, or up to 150 percent of the amount they spent in fiscal year 1995.

S. 1643 would also have eliminated the separate title for elder rights protection activities. However, it would have continued to authorize a separate stream of funds for the ombudsman program under its proposed Title II State Programs on Aging. It also would have authorized long-term care ombudsman services under the supportive services program in its proposed Title III Local Programs on Aging.

H.R. 2570 would have eliminated the requirement that States operate the ombudsman program through an Office of the State Long Term Care Ombudsman. S. 1643 retained this requirement. Among other things, both bills would have retained provisions similar to current law, including mandatory access of ombudsmen to long-term care facilities, residents, and resident records; protection of ombudsmen from liability under State law for good faith performance of official duties; access of ombudsman to legal representation; and prohibition of interference of other parties with the performance of official ombudsman duties. S. 1643 contains most of the specificity of current law for these provisions.

5. Nutrition Programs

Public Law 102–375 included a number of amendments to the nutrition programs as follows: (1) Restricted the amount of funds that may be transferred between Title III supportive and nutrition services in future years; (2) liberalized requirements on daily dietary allowances when a nutrition project serves more than one meal a day; (3) liberalized requirements on the number of weekly meals to be provided by projects operating in rural areas; (4) required State agencies on aging to develop nonfinancial eligibility criteria for receipt of home-delivered meals; (5) required meal programs to comply with Dietary Guidelines for Americans published by the Secretary of Agriculture and the Secretary of HHS; (6) required the Assistant Secretary on Aging to designate a full-time Federal officer to administer the program; (7) required nutrition projects to operate the program with the advice of dietitians; and (8) required the Assistant Secretary to conduct a national evaluation of the program.

In action on the Act's nutrition program during the 104th Congress, both H.R. 2570 and S. 1643 would have consolidated authorization of appropriations for the congregate and home-delivered nutrition programs. Under the bills, States would receive one allotment of funds for these services. This approach would eliminate the need to transfer funds between the programs. However, both bills would have required State and area agencies to assess the need for both congregate and home-delivered meal services and provide services based on the identified need.

Under current law, there is a separate authorization of appropriations for USDA assistance. Funds are provided to States based on a prescribed per meal reimbursement rate and States are allowed to choose to receive reimbursement in the form of cash or commodities. In recent years, most States have chosen to receive

the bulk of their reimbursement in the form of cash. In fiscal year 1995, about 97 percent of total funds were provided to States in the form of cash. Both H.R. 2570 and S. 1643 would have retained a separate authorization of appropriations for USDA assistance and funds would have been allotted to States based on the number of meals served the prior year. Under the bills, States would have continued to be able to choose to receive USDA assistance in the form of cash or commodities, as under current law. Under H.R. 2570, Federal administration of this assistance program would have been transferred from USDA to AOA (as also proposed by the Administration in its reauthorization proposal, introduced as H.R. 2056). S. 1643 would not have changed Federal administration of the program.

Under both H.R. 2570 and S. 1643, meals are required to meet one-third of the Recommended Daily Allowances (RDA) of the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, and comply with the Dietary Guidelines for Americans, as under current law. Among other provisions, nutrition projects would have been required to solicit the advice of dieticians or others with comparable experience in planning nutrition services; give flexibility to providers to design meals that are appealing to program participants; encourage providers to limit the amount of time meals spend in transit before they are consumed; encourage arrangements with school and other facilities to promote intergenerational meals programs; and provide for nutrition screening, education, and counseling.

6. Community Service Employment for Older Persons

The Title V Community Service Employment Program, funded at $463 million in fiscal year 1996 (32 percent of the Act's total fiscal year 1997 funding), provides subsidized part-time employment to low-income persons aged 55 and older. Public Law 102–375 included requirements that the program serve older persons with poor employment prospects and that projects assess participants' skills, need for supportive services, and physical capabilities. It also required that persons eligible for Title V programs be considered eligible for programs under the Job Training Partnership Act (JTPA) when Title V and JTPA projects are jointly operated.

In 104th Congress legislation, both H.R. 2570 and S. 1643 would have been eliminated Title V as a separate title and would have significantly restructured the program. H.R. 2570 would have incorporated the program into Title III, and S. 1643 would have incorporated the program into its proposed Title II State Programs on Aging. Under both bills, the program would have a distinct authorization of appropriations and would be administered by AOA rather than DOL.

Beyond this, both H.R. 2570 and S. 1643 would have made substantial changes in how the program operates. Restructuring of the program was proposed, in part, to respond to a 1995 General Accounting Office (GAO) report which reviewed certain administrative issues related to the program, including DOL's method of awarding funds, formula allocation of funds, and grantee use of

funds.[2] In addition, the proposals were made to give States more control of the administration of the program and to introduce competition for funds among prospective grantee organizations. Proposals included in the committee reported bills included changes in (1) the distribution of funds by the Federal Government, (2) formula allocations to grantees, and (3) requirements regarding use of funds by grantees for enrollee wages and fringe benefits, administration, and other enrollee costs, as discussed below.

Distribution of Funds by the Federal Government.—Currently, DOL awards funds to 10 national organizations and all States, with 78 percent of funds allocated to national organizations[3] and 22 percent to States. This division has been stipulated by Congress in appropriation legislation for many years.[4] In contrast, both H.R. 2570 and S. 1643 would have stipulated that all funds be allocated to States. National organizations would no longer have received funds directly from the Federal Government. Under the bills, States would have had the authority to award funds to a variety of organizations to operate the program within the State, including public or private nonprofit organizations, political subdivisions of States, tribal organizations, and area agencies on aging. In addition, both bills would have required States to use a competitive process when awarding funds. H.R. 2570 would have required that, in making awards to organizations, States give special consideration to organizations that received funding in fiscal year 1995 and that demonstrate effectiveness in carrying out community service employment projects.

Formula Allocations to Grantees.—Under current law, funding is distributed to national organizations and states using a combination of factors, including a "hold harmless" for employment positions held by national organizations in each State in 1978, and a formula based on States' relative share of persons aged 55 and over and per capita income. In fiscal year 1996 about 63 percent of funds are allocated according to the hold harmless provision ($252 million out of $401 million in fiscal year 1996 (July 1, 1996–June 30, 1997)), with the balance distributed according to age and per capita income. Because the hold harmless provision is based on a 1978 state-by-state distribution of positions held by national organizations, it does not ensure equitable distribution across all States based on relative measures of age and per capita income of States. In its report on the program, GAO recommended that if Congress wishes to ensure equitable distribution of funds, it should consider eliminating or amending the hold harmless provision.

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[2] General Accounting Office. Senior Community Service Employment Program Delivery Could Be Improved Through Legislative and Administrative Actions. GAO/HEHS–96–4. Nov. 1995.

[3] The 10 national organizations are: American Association of Retired Persons; Association Nacional Pro Personas Mayores; Green Thumb; National Asian Pacific Center on Aging; National Center and Caucus on the Black Aged; National Council on Aging; National Council of Senior Citizens; National Indian Council on Aging; National Urban League; and the U.S. Forest Service.

[4] In action on fiscal year 1997 appropriations for the senior community service employment program, the House proposed a shift in previous appropriation legislation provisions regarding how much funding is to be allocated to national organizations and States. The bill would have increased the amount of funding allocated to States to 35 percent of the total, thereby reducing funds to national organizations to 65 percent. In final action on fiscal year 1997 appropriations (P.L. 104–208), Congress continued to stipulate the 78 percent/22 percent split for national organizations and States, as it has done in the past.

Both H.R. 2570 and S. 1643 would have altered the method for distribution of funds and the hold harmless provision. Under H.R. 2570, the formula would have been changed to require that States receive no less than they received in fiscal year 1996; any funds appropriated in excess of the fiscal year 1996 level would have been distributed on the basis of States' relative share of persons age 55 and over and per capita income. S. 1643 would have gradually eliminated the 1978 hold harmless funding provisions, and made the transition to a formula that is totally based on States' relative population of persons aged 55 and over and per capita income. At the end of the transition period (fiscal year 2000), all funds would have been awarded to States based only on these population and income factors.

Use of Funds for Enrollee Wages/Fringe Benefits, Administration, and Other Enrollee Costs.—Both H.R. 2570 and S. 1643 would have changed how funding may to be used by grantees. Currently, funds are used for (1) enrollee wages and fringe benefits; (2) administration; and (3) other enrollee costs. DOL regulations require that at least 75 percent of funds be used for enrollee wages and fringe benefits. The law specifies that grantees are allowed to use up to 13.5 percent of Federal funds for administration (and up to 15 percent in certain circumstances). Any remaining funds may be used for "other enrollee costs," which, under current DOL regulations, may include such things as recruitment and orientation of enrollees and supportive services for enrollees, among other things.

Both bills would have required that a higher proportion of funding be used for enrollee wages and fringe benefits than is required by current DOL regulations. H.R. 2570 would have required that at least 85 percent of funds be used for enrollee wages and fringe benefits. S. 1643 would have required that, in general, at least 90 percent of funds be used for enrollee wages and fringe benefits, and, in small States, at least 85 percent of funds.

In its review, GAO found that most national organizations and some States sponsors had budgeted administrative costs in excess of the statutory limit by classifying them as other enrollee costs. Both bills would have address this issue by reducing amounts available for administration, although they differed in approach. H.R. 2570 would have consolidated administrative expenses for its three Title III programs—community service employment, supportive services, and nutrition services—and allowed up to 7 percent of these funds (or $800,000 whichever is greater) to be used for administration across these three programs. (Under current law, States may use up to 5 percent of funds, or $500,000 whichever is greater, for administration of their supportive service, and congregate and home-delivered nutrition services programs.) S. 1643 would have specified that a maximum of 10 percent would be available for administration, and in small States, 15 percent. In addition, both bills would have allowed a portion of funds to be used for other enrollee costs. The bills differed in their definitions of these costs and in the amounts to be used.

The restructuring of the senior community service employment program generated substantial controversy during the 104th Congress. Some existing national grantees expressed concern about their continued existence if the program were to be shifted to

States and if States, rather than the Federal Government, were to make decisions about which organizations would receive funds. They were also concerned about the reduction in administrative cost limits proposed by the legislation. National organizations also were concerned that the restructuring would result in disruption of jobs for some existing enrollees.

In response to some of these concerns, DOL requested the Urban Institute to prepare an analysis of the proposed legislation.[5] Based on its analysis, the report indicated that while some of the proposed changes have potential to improve the distribution of funds and to increase State involvement, the study found substantial support for the program and little criticism of how it currently operates. Among other things, the report noted that it is impossible to determine whether allocating all funds to States is a better alternative to the current system. The report warned that transferring the program to the States might result in decreased number of persons served and that lowering of administrative cost limits will mean fewer resources to serve participants. It also indicated that an ample transition period is necessary to avoid disruption of services.

The modifications to the program were debated during markup of the bills by the House Economic and Educational Opportunities Committee and the Senate Labor and Human Resources Committee, with certain members of the Committees voicing objections to the proposed restructuring. An amendment to S. 1643 to maintain direct award of funding to national organizations by the Federal Government offered by Senator Mikulski during the Labor and Human Resources Committee markup was not approved.[6] Although the amendment would have incrementally increased the proportion of funds to be awarded to States over time, it would have continued to have the Federal Government award the majority of funding to national organizations. The amendment would have authorized AOA to award 75 percent of funds to national organizations in fiscal year 1997, 70 percent in fiscal year 1998, and 65 percent for fiscal year 1999 through fiscal year 2001. Among other provisions, the amendment would have required AOA to award funds to national organizations on a competitive basis. It would have also required States to award their portion of the funds on a competitive basis. It would have established performance goals for both national organizations and States.

Although the Labor and Human Resources Committee voted to reject the amendment, Senator Mikulski stated that the restructuring of the Title V program would be revisited when S. 1643 reached the Senate floor.

7. Cost-Sharing

Cost-sharing by older persons for receipt of Title III services has been a recurring issue in past reauthorizations. While current law prohibits mandatory fees, nutrition and supportive services provid-

[5] The Urban Institute. *Analysis of the Impacts of Proposed Legislative Changes in the Senior Community Service Employment Program.* March 8, 1996. Washington, DC. Prepared for the Department of Labor.

[6] During the markup of H.R. 2570 by the House Economic and Educational Opportunities Committee, a similar amendment was rejected.

ers are allowed to solicit voluntary contributions from older persons toward the cost of services. Service providers, however, are required to protect older persons' privacy with respect to their contributions. Older persons may not be denied a service because they will not or cannot make a contribution. Funds collected from voluntary contributions are to be used to expand services.

Given the reality of limited funding, the issue of cost-sharing was an issue in the 1992 reauthorization. Some observers, including representatives of State and area agencies on aging, continued to advocate that the Title III voluntary contributions policy be changed in the 1992 amendments so that contributions for certain services would be mandatory. Although Congress considered the various proposals, Public Law 102–375 made no change in the contributions policy.

In 104th Congress legislation, there was a shift in the longstanding policy regarding cost-sharing. Both H.R. 2570 and H.R. 2056 would have allowed States to apply cost sharing to most Title III services on a sliding scale basis. The bills would have prohibited cost sharing for information and assistance, outreach, benefits counseling, case management, and ombudsman and other protective services. Both bills would have prohibited States from imposing cost sharing on individuals with low income (in the House bill, income that is not lower than 125 percent of the poverty level, and in the Senate bill, income that is not lower than 150 percent of the poverty level). They also would have required that incomes of older persons be determined on a self-declaration basis. Both bills also would have prohibited States from denying older persons services because of an inability to pay, and would have continued to allow older persons to make voluntary contributions for services, as under current law.

State and area agencies on aging have been in favor of a policy that would allow them to impose cost sharing for certain services, arguing, in part, that such a policy would eliminate barriers to coordination with other state-funded services programs that do require cost sharing, and would improve targeting of services to those most in need. Some representatives of aging services programs, such as those representing minority/ethnic elderly, have been opposed to cost sharing, arguing, in part, that a mandatory cost sharing policy would discourage participation by low-income and minority older persons and would create a welfare stigma. In the last two reauthorizations of the Act, Congress considered, but ultimately rejected, proposals to change the current voluntary contributions policy.

C. NEW ISSUES AND LEGISLATION

1. Administration on Aging Studies

(A) NUTRITION EVALUATION STUDY

The 1992 amendments required that the Assistant Secretary on Aging conduct a national evaluation of the AOA's nutrition program for the elderly. Pursuant to this requirement, AOA awarded a contract to Mathematica Policy Research, Inc., of Princeton, NJ, in September 1993. The study was completed in June 1996.

In carrying out the evaluation mentioned above, Mathematica delineated key characteristics of the program participants; scrutinized the impact of the program's nutritional components; determined the efficiency and effectiveness of the program's administration and service delivery elements; and described and assessed the sources of the program funding.

Following are a number of key findings of the evaluation.[7]

Compared to the total elderly population, nutrition services participants are older and more likely to be poor, to live alone, and to be members of minority groups. They are also more likely to have health and functional limitations that place them at nutritional risk.

People who receive meals have higher daily intakes of key nutrients than similar nonparticipants.

Despite participants' low income levels, voluntary personal contributions account for 20 percent of meal costs.

The majority of those receiving home-delivered meals have never participated in a congregate meal program, dispelling the myth that most home-delivered participants are the large numbers of congregate participants who have "aged in place."

Most nutrition projects report that hospitals and nursing homes are the first and second most common sources of referral for home-delivered participants.

Forty-one percent of home-delivered meals programs have waiting lists highlighting the need for more focused attention on this particular part of the elderly nutrition programs as the aging population grows.

Federal elderly nutrition program grants to tribal organizations are the primary source of funding for elderly nutrition programs for Native American elders.

Federal elderly nutrition program dollars are highly leveraged with money from other sources, such as State, local and private funds, donations, and participant contributions. Older Americans Act funding accounts for 37 percent of congregate costs, and 23 percent of home-delivered costs. Typically, $1.00 of Title III funds spent on congregate services is supplemented by an additional $1.70 from other sources. The amount of leveraging is substantially higher for Title III home-delivered services.

(B) STUDY ON EFFICIENCY OF OMBUDSMAN PROGRAM

The 1992 OAA amendments required the AOA to prepare a study on the effectiveness of the ombudsman program. In October 1993 HHS awarded $732,650 to the Institute of Medicine (IOM) to conduct the study.

The 1995 evaluation concluded that the program serves a vital public interest, but that it is understaffed and underfunded to carry out its broad and complex responsibilities of investigating and resolving complaints of the over two million elderly residents of nursing homes and broad and care facilities. The report rec-

[7] U.S. Department of Health and Human Services. Mathematica Policy Research, Inc. Serving Elders at Risk, The Older Americans Act Nutrition Programs, National Evaluation of the Elderly Nutrition Program, 1993–1995, June 1996.

ommended increased funding to allow States to carry out the program as stipulated by law, and greater program accountability.

2. Technical Amendments and Regulations

The AOA is currently working on the regulations to implement the 1992 amendments. At the time this went to print the regulations had not been published.

D. OLDER AMERICANS ACT AUTHORIZATION AND APPROPRIATIONS

1. Older Americans Act Authorization

Public Law 102–375 provides the following authorization levels from fiscal year 1992 through fiscal year 1995:

TABLE 1.—AUTHORIZATION OF APPROPRIATIONS FOR OLDER AMERICANS ACT, WHITE HOUSE CONFERENCE ON AGING, AND SPECIAL LONG-TERM CARE STUDIES, AS CONTAINED IN PUBLIC LAW 102–375, FISCAL YEARS 1992–95

[Dollars in thousands]

	Fiscal year—			
	1992	1993	1994	1995
Title II: Administration on Aging:				
Federal Council on Aging	$300	(1)	(1)	(1)
AOA program administration	[2] 17,000	[2] $20,000	[2] $24,000	[2] 29,000
Board and care facility quality study [3]	1,500	(1)	(1)	(1)
Home care quality study [3]	1,000	(1)	(1)	(1)
Title III: Grants for State and Community Programs on Aging:				
Supportive services and centers	461,376	(1)	(1)	(1)
Disease prevention and health promotion [4]	25,000	(1)	(1)	(1)
Nutrition services:				
Congregate meals	505,000	(1)	(1)	(1)
Home-delivered meals	120,000	(1)	(1)	(1)
USDA commodities	[5] 250,000	[5] 310,000	[5] 380,000	[5] 460,000
School-based meals/multigenerational activities	15,000	(1)	(1)	(1)
In-home services for the frail elderly	45,388	(1)	(1)	(1)
Assistance for special needs	(1)	(1)	(1)	(1)
Supportive activities for caretakers	15,000	(1)	(1)	(1)
Title IV: Training, Research and Discretionary Projects and Programs	72,000	(2)	(2)	(2)
Training of service providers	450	450	450	450
Title V: Community Service Employment for Older Americans	[6] 470,671	(1, 6)	(1, 6)	(1, 6)
Title VI: Grants for Native Americans	[7] 30,000	(7)	(7)	(7)
Title VII: Vulnerable Elder Rights Protection Activities: [8]				
Long-term care ombudsman	40,000	(1)	(1)	(1)
Elder abuse prevention	15,000	(1)	(1)	(1)
Elder rights and legal assistance	10,000	(1)	(1)	(1)
Outreach, counseling, and assistance	15,000	(1)	(1)	(1)
Native Americans elder rights program	5,000	(1)	(1)	(1)
White House Conference on Aging	(1)	(1)	(9)	(9)

[1] "Such sums as may be necessary."
[2] Plus additional sums to employ not fewer than 300 full-time equivalent employees.
[3] This study is paid for by the Secretary of HHS in cooperation with the National Academy of Sciences. The authorization for this study is not an amendment to the Older Americans Act.
[4] Under prior law, this program was called Health Education and Promotion.
[5] Requires the Secretary of Agriculture to maintain for FY 1992 a per meal reimbursement rate equal to the amount appropriated divided by the number of meals served in the prior fiscal year, or 61 cents, whichever is greater. For FY 1993 and subsequent years, the per meal rate is to be adjusted for inflation.
[6] Plus such sums to provide at least 70,000 part-time employment positions.
[7] Ninety percent of this amount is authorized for grants to Indian tribal organizations and 10 percent for Native Hawaiian organizations.
[8] New title created by the 1992 amendments to the Older Americans Act.
[9] None.

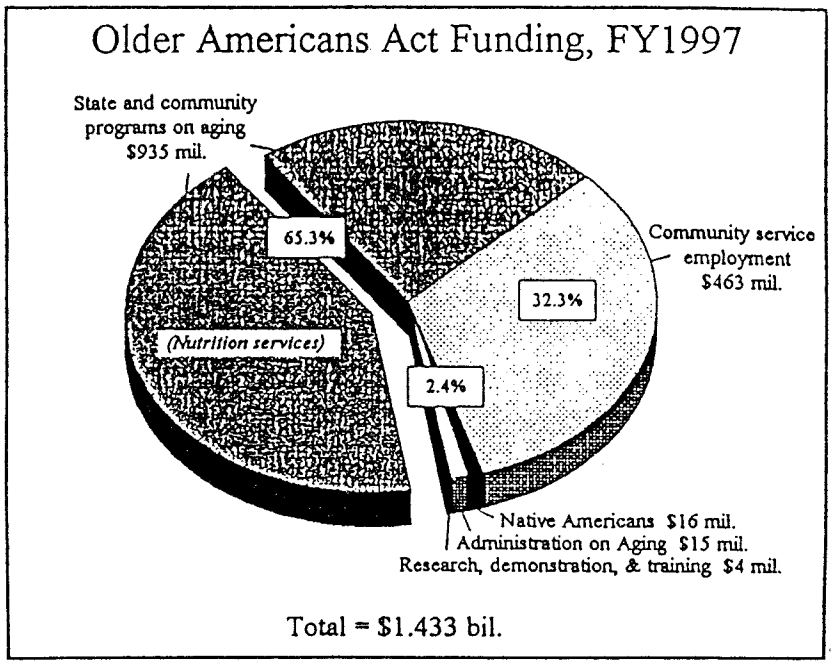
2. Older Americans Act Appropriations

Appropriations for the Older Americans Act for the last two years, fiscal year 1996 and fiscal year 1997, have been about $1.4 billion for all programs under the Act.

The Title III nutrition program is the Act's largest program. Fiscal year 1997 funding of $610 million represents 43 percent of the Act's total funding and 65 percent of Title III funds. Most recent data show that in fiscal year 1995 the program provided 242 million meals to over 3.4 million older persons. Fifty-one persons of the meals were provided in congregate settings, such as senior centers and 49 percent were provided to frail older persons in their homes.

Fiscal year appropriations.—Fiscal year 1996 appropriations for OAA programs totaled $1.352 billion. Funding for nutrition services was $630 million, the same amount as fiscal year 1995. Funding levels were shifted so that congregate meals was reduced by 3 percent and home-delivered meals were increased by 12 percent as compared with fiscal year 1995. Funding for supportive services and centers was reduced by 2 percent to $301 million. However, of this amount, $9 million was earmarked for elder abuse prevention and long-term care ombudsman activities, the same amount that these activities received in fiscal year 1995 as separate programs authorized under Title VII. The remaining $291 million available for supportive services and centers represented a 5 percent reduction from the fiscal year 1995 appropriation. The community service employment and training program received 6 percent less than the fiscal year 1995 post-rescission funding level. Funding for Title IV research, training, and demonstration was cut by 90 percent. Preventive health and AOA program administration were both cut by 8 percent and grants for Native Americans was cut by 5 percent. No funding was provided for the Federal Council on Aging and in-home services for the frail elderly was funded at its fiscal year 1995 level.

Fiscal year 1997 appropriations.—Fiscal year 1997 funding for programs under the Act totals $1.433 billion, nearly $81 million more than in fiscal year 1996, representing a 6 percent increase over fiscal year 1996. A substantial portion of this increase is due to a $90 million increase for the senior community service employment program (Title V), provided to cover the cost of the recent increase in the minimum wage. An increase is also to cover the cost of the recent increase in the minimum wage. An increase is also included for research, training, and demonstration. Total funding for the nutrition program is slightly lower than the fiscal year 1996 level due to a decrease in the USDA commodities program and funding for AOA administration is slightly reduced. Other programs were funded at fiscal year 1996 levels.



Both congregate and home-delivered services received the same amount as in fiscal year 1996, $365 million and $105 million, respectively. The USDA commodities program received $140 million (finalized by P.L. 104–180),[8] a reduction of $10 million from its fiscal year 1996 level. Supportive services and centers received $301 million, the same as in fiscal year 1996. Congress did not provide separate funding for elder abuse prevention and long-term care ombudsman activities. In fiscal year 1996, these two activities received earmarks under supportive services and centers equivalent to fiscal year 1995 funding levels for the separately authorized programs under Title VII. While, the Senate Appropriations Committee recommended similar earmarks for fiscal year 1997, these were not incorporated into the final measure.[9]

The community service employment and training (Title V) is funded at $463 million for fiscal year 1997, and increase of $90 million (24 percent) over fiscal year 1996 funding. However, $28 mil-

[8] Programs under the Older Americans Act, with the exception of the USDA commodities program are funded annually under appropriations legislation for the Departments of Labor, Health and Human Services, and Education and Related Agencies. Funding for the USDA commodities program is included in appropriations legislation for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies.

[9] According to AOA, States were instructed to continue spending at fiscal year 1996 levels ($4.449 million for ombudsman activities and $4.732 million for elder abuse prevention) for fiscal year 1997.

lion of this amount is to be spent for fiscal year 1996, making $401 million available that year. The remaining $435 million is available for fiscal year 1997, representing a 6 percent increase over available fiscal year 1996 funds. The increase, added during final funding negotiations, is to cover salary increases for enrollees resulting from the recently enacted increase in the Federal minimum wage.[10] (By law, Title V enrollees are paid at the higher of the Federal or State minimum wage or the local prevailing rate.) Without the increase, a reduction in the number of job slots would have been needed to provide for the required salary increases. The current distribution of funds, that is 78 percent to national organizations and 22 percent to States, is unchanged.

TABLE 2.—OLDER AMERICANS ACT AND WHITE HOUSE CONFERENCE ON AGING AND ALZHEIMER'S DEMONSTRATION PROGRAM, FISCAL YEARS 1995–1998

[Dollars in millions]

	Fiscal year—			
	1995 Approp.	1996 Approp.	1997 Approp.	1998 Request
Title II: Administration on Aging	$16.700	$15.170	$14.795	$14.795
Federal Council on Aging	0.176	none	none	none
AOA program administration	16.524	15.170	14.795	14.795
Title III: Grants for State and Community Programs on Aging	952.830	945.316 [c]	953.316	926.135
Supportive services and centers	306.711	300.556 [c]	300.556 [c]	291.375
Preventive health	16.982	15.623	15.623	15.623
Nutrition services:	619.874	619.874	609.874	609.874
Congregate meals	(375.809)	(364.535)	(364.535)	(359.810)
Home-delivered meals	(94.065)	(105.339)	(105.339)	(110.064)
USDA commodities	(150.000)	(150.000)	(140.000)	(140.000)
School-based meals/multi generational activities	none	none	none	none
In-home services for the frail elderly	9.263	9.263	9.263	9.263
Assistance for special needs	none	none	none	none
Supportive activities for caretakers	none	none	none	none
Title IV: Training, Research, and Discretionary Projects and Programs	25.735 [a]	2.850	4.000	4.000
Training of service providers	none	none	none	none
Title V: Community Service Employment for Older Americans	396.060 [b]	373.000 [d]	463.000 [d]	440.200
Title VI: Grants for Native Americans	16.902	16.057	16.057	16.057
Title VII: Vulnerable Elder Rights Protection Activities	11.157	[c]	[c]	[e]
Long-term care ombudsman program	4.449	[c]	[c]	4.449
Elder abuse prevention	4.732	[c]	[c]	[e]
Elder rights and legal assistance	none	none	none	[e]
Outreach, counseling, and assistance	1.976	none	none	[e]
Native Americans elder rights program	none	none	none	none
Total—Older Americans Act Programs	1,419.834[a,b]	1,352.393	1,433.168	1,410.368
White House Conference on Aging	3.000	.....	.....	.....
Alzheimer's Demonstration Grants [f]	.....	[f]	[f]	8.000 [f]

[a] Reflects $0.9 million rescission to Title IV made by P.L. 104–19.
[b] Reflects $14.4 million rescission to Title V made by P.L. 104–19.
[c] P.L. 104–134 included earmarks for long-term care ombudsman activities ($4.449 million) and elder abuse prevention activities ($4.732 million) for fiscal year 1995 as part of supportive services and centers. AOA instructed States to continue spending at this level for fiscal year 1996.
[d] Fiscal year 1997 appropriation includes $28 million for use in fiscal year 1996 (making $401 million available for fiscal year 1996). The remaining $435 million is for fiscal year 1997.
[e] For fiscal year 1998, a total of $4.732 million is requested for elder abuse prevention, legal assistance, and outreach and counseling under Title VII.
[f] To be transferred from HRSA to AOA, 10/1/97. Funded at $3.980 million in fiscal year 1996 and $5.999 million for fiscal year 1997.

[10] From $4.25 per hour to $4.75 per hour beginning on October 1, 1996 rising to $5.15 per hour beginning September 1, 1997.

E. PROGNOSIS

When first enacted in 1965, the OAA set out a series of objectives aimed at improving the lives of older Americans in such areas as income, health, housing, employment, community services, and gerontological research and education. Since its inception, the gradual evolution of the programs and services authorized by the OAA has been remarkable. However, this progress has not been without some growing pains.

As originally conceived, the congressional intent underlying the OAA was to establish a coordinated and comprehensive system of services at the community level. Such a system, it was asserted, would provide opportunities for, and assistance to, vulnerable older persons who, despite advancements in income security and health programs, still needed social services support. Additionally, the structure would provide the support necessary to promote independent living and reduce the risk of costly institutionalization.

To that end the Older Americans Act has been successful. The needs of older persons have been identified and the means for meeting those needs have evolved. There is now an "aging network" of 57 State units on aging, 660 area agencies on aging, more than 27,000 local supportive and nutrition service providers, and approximately 6,400 senior centers. Additionally, the OAA has been the vehicle for the education and training of thousands in the field of aging.

The programs operated under the Older Americans Act continue to be overextended and underfunded. Area agencies on aging out of necessity must raise funds from many other sources to support the programs.

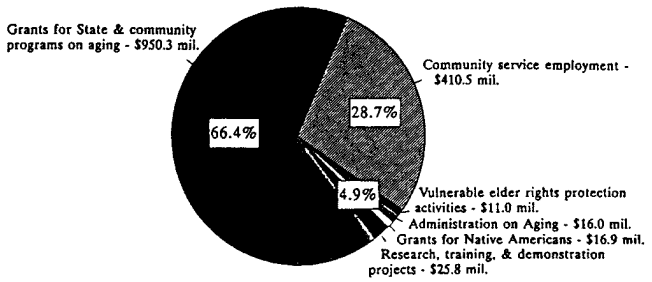
Targeting available resources to specific categories of older persons—those most in need—is a natural consequence of limited funding. It is also inevitable that those who are most pressed for funding resources on the State and local levels will continue to advocate cost-sharing. However, even if cost-sharing is implemented in the next reauthorization, it is unlikely to generate sufficient funds to finance services necessary to address successfully the many unmet needs of numerous older Americans.

State and area agencies have placed increased emphasis on the development of long-term care systems development and have assumed increasing responsibilities for case management. It is likely that this trend will continue in the future and may raise difficult issues, such as potential conflicts of interest, that will need to be resolved in the years to come.

Without question, future demographic changes can only place increasing burdens on the programs provided by the Older Americans Act. The elderly population is growing, as well as getting older. The population aged 85 years and over is one of the fastest growing age groups in the country and is expected to more than double from the years 1990 to 2030. In addition, the number of persons aged 65 and over will more than double by the middle of the 21st century. This growth in the elderly population and the expected changes in the family relationships and living arrangements of future generations of elderly, will undoubtedly have major implications for the demand for community-based services. The challenge for State and

area agencies on aging will be not only to maintain necessary services, but also to assure the quality and accessibility of these services. Thus, continued broad support from Congress will be necessary if the OAA is to meet these new challenges.

FIGURE 1. Older Americans Act Appropriations, FY 1994



Total Appropriations - $1.4 billion

Chapter 15

SOCIAL, COMMUNITY, AND LEGAL SERVICES

OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health programs, legal services, education, transportation, and volunteer opportunities for older Americans.

In the 1980's, two basic themes emerged with respect to the delivery of social services for the elderly. States were given greater discretion in the administration of social services as part of "New Federalism" initiatives. This shift toward block grant funding was accompanied by a general trend toward fiscal restraint and retrenchment of the Federal role in human services. As a result, the competition for scarce resources accelerated between the elderly and other needy groups.

In addition to cuts accompanying the block grants, the 1980's brought reduced spending for education, transportation, and attempts to eliminate entirely legal services. Older Volunteer Programs, by contrast, enjoyed strong support.

More recently, following the war in the Persian Gulf and the continuing changes in Russia, advocates of human service programs were hopeful that the reduced pressures to finance large defense requirements would result in greater Federal resources being devoted to social service programs. Despite the changing political climate, the economy and the budget deficit have prevented significant policy changes in 1992 and 1993. Advocates, however, remain hopeful that the new administration's policies and goals will help revitalize important social programs.

A. BLOCK GRANTS

1. BACKGROUND

(A) SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, help them become self-sufficient, and reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a

dollar-for-dollar match of State social services funding; however, this matching rate was not sufficient incentive for many States and few chose to participate. Between 1962 and 1972, the Federal matching amount was increased and several program changes were made to encourage increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new Title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration. Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded.

In 1981, Congress created the Social Services Block Grant (SSBG) as part of the Omnibus Budget Reconciliation Act (OBRA). Non-Federal matching requirements were eliminated and Federal standards for services, particularly for child day care, also were dropped. The block grant allows States to design their own mix of services and to establish their own eligibility requirements. There is also no federally specified sub-State allocation formula.

The regular SSBG program is permanently authorized by Title XX of the Social Security Act as a "capped" entitlement to States. Additional funds are available for social services in enterprise communities and empowerment zones. This special SSBG program for enterprise communities and empowerment zones is authorized by the OBRA 93 (P.L. 103–66). Legislation amending Title XX is referred to the House Ways and Means Committee and the Senate Finance Committee. The program is administered by HHS.

SSBG provides supportive services for the elderly and others. States have wide discretion in the use of SSBG funds as long as they comply with the following broad guidelines set by Federal law. First, the funds must be directed toward the following federally established goals: (1) prevent, reduce, or eliminate dependency; (2) prevent neglect, abuse or exploitation of children and adults; (3) prevent or reduce inappropriate institutional care; (4) secure admission or referral for institutional care when other forms of care are not appropriate; and (5) provide services to individuals in institutions. Second, the SSBG funds may also be used for administration, planning, evaluation, and training of social services personnel. Finally, SSBG funds may not be used for capital purchases or improvements, cash payments to individuals, payment of wages to individuals as a social service, medical care, social services for residents of residential institutions, public education, child day care that does not meet State and local standards, or services provided by anyone excluded from participation in Medicare and other SSA programs. States may transfer up to 10 percent of their SSBG allotments to certain Federal block grants for health activities and for low-income home energy assistance.

Welfare reform legislation enacted in the 104th Congress (P.L. 104–193) established a new block grant, called Temporary Assistance for Needy Families (TANF), to replace a former Aid to Families with Dependent Children (AFDC) program. The welfare reform law allows States to transfer no more than 10 percent of their TANF allotments to the SSBG. However, these transferred funds may be used only for children and families whose income is less than 200 percent of the Federal poverty guidelines. Moreover, not-

withstanding the SSBG prohibition against use of funds for cash payments to individuals, these transferred funds may be used for vouchers for families who are denied cash assistance because of time limits under TANF, or for children who are denied cash assistance because they were born into families already receiving benefits for another child.

Some of the diverse activities that block grant funds are used for are: child and adult day-care, home-based services for the elderly, protective and emergency services for children and adults, family planning, transportation, staff training, employment services, meal preparation and delivery, and program planning.

(B) COMMUNITY SERVICES BLOCK GRANT

The Community Services Block Grant (CSBG) is the current version of the Community Action Program (CAP), which was the centerpiece of the war on poverty of the 1960's. This program originally was administered by the Office of Economic Opportunity within the Executive Office of the President. In 1975, the Office of Economic Opportunity was renamed the Community Services Administration (CSA) and reestablished as an independent agency of the Executive Branch.

As the cornerstone of the agency's antipoverty activities, the Community Action Program gave seed grants to local, private nonprofit or public organizations designated as the official antipoverty agency for a community. These community action agencies were directed to provide services and activities "having a measurable and potentially major" impact on the causes of poverty. During the agency's 17-year history, numerous antipoverty programs were initiated and spun off to other Federal agencies, including Head Start, legal services, low-income energy assistance and weatherization.

Under a mandate to assure greater self-sufficiency for the elderly poor, the CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. Programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at both the State level and the point of delivery.

In 1981, the Reagan Administration proposed elimination of the CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and a congressional oversight committee had criticized the agency as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97–35) abolished the CSA as a separate agency, but replaced it with the CSBG to be administered by the newly created Office of Community Services within the Administration for Children and Families, under the Department of Health and Human Services (HHS).

The CSBG Act requires States to submit an application to HHS, promising the State's compliance with certain requirements, and a plan showing how this promise will be carried out. States must guarantee that legislatures will hold hearings each year on the use of funds. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs, and to encourage the use of private-sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Head Start, and low-income energy assistance. No more than 5 percent of the funds, or $55,000, whichever is greater, may be used for administration.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act of 1981 offered States the option of not administering the new CSBG during fiscal year 1982. Instead, HHS would continue to fund existing grant recipients until the States were ready to take over the program. States which opted not to administer the block grants in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior grant recipients. In the Act, this 90-percent pass-through requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal years 1983 and 1984, Congress extended the grandfather provision to ensure program continuity and viability. The extension was viewed widely as an acknowledgement of the political stakes inherent to community action agencies and the programs they administer.

In 1984, Congress made the 90-percent pass-through requirement permanent and applicable to all States under Public Law 98–558. Currently, about 1,145 eligible service providers receive funds under the 90-percent pass-through. More than 80 percent of these entities are community action agencies and the remainder include limited purpose agencies, migrant or seasonal farmworker organizations, local governments or councils of government, and Indian tribes or councils.

The National Association for State Community Services Programs (NASCSP) has released a 50-State survey of programs funded by CSBG in 1993. Among the principal findings were: (1) 91 percent of CSBG funds are received by local agencies eligible for the congressionally mandated pass-through; (2) 81 percent of such eligible agencies are Community Action Agencies (CAA's); (3) approximately 70 percent of the funds received by CSBG-funded agencies come from Federal programs other than CSBG; (4) approximately 22 percent of funds received by CSBG-funded agencies come from State and local government sources; and (5) CSBG money constitutes only 9 percent of the total funds received by CSBG-funded agencies.

Local agencies from 52 States provided detailed information about their uses of CSBG funds. Those agencies used CSBG money in the following manner: emergency services (23 percent), linkages between and among programs (22 percent), nutrition programs (12 percent), education (11 percent), employment programs (9 percent),

income management programs (4 percent), and housing initiatives (11 percent).

2. Issues

(A) NEED FOR COMMUNITY SERVICES BLOCK GRANTS

After 2 years of existence, the Reagan Administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for antipoverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the Administration maintained that States would gain greater flexibility because the SSBG suggested fewer restrictions. According to the Administration, States then would be able to develop the mix of services and activities that were most appropriate to the unique social and economic needs of their residents.

However, a 1986 GAO report on the operation of CAA's which was funded by the CSBG refuted this claim. Specifically, the GAO addressed the Administration's position that: The type of programs operated under CSBG duplicated social service programs under the SSBG; CAA's can find other Federal and State funds to cover administrative activities; and funding under CSBG is not essential to the continued operation of CAA's.

The report found that, in general, CSBG-funded services often were short-term and did not duplicate those provided under SSBG. Primarily, CSBG funds are used to provide services that fulfill unmet local needs and to complement those services provided by other agencies. Unmet local needs cited by GAO include temporary housing, transportation, and services for the elderly. CSBG-funded agencies provided such complementary programs as the training of day care personnel for SSBG-funded day care programs and temporary shelter for clients awaiting more permanent housing financed by other sources. The most predominant CSBG-funded services found by GAO were information, outreach, and referral, as well as emergency and nutritional services.

GAO also found that CSBG funds often are used for administration of other social service programs, which may have limitations on the use of their own funds for administrative expenses. Consequently, CAAs are not in a position to find other Federal and State funds to cover administrative costs. According to GAO, the Federal Government in 1984 provided 89 percent of the total funds received by CAAs in 32 States. The remaining 11 percent of the 1984 budgets of reporting CAAs were provided by CSBG funds. Several other Federal programs including Head Start, the Community Development Block Grant, and Low Income Home Energy Assistance, provide substantial CAA funding.

The GAO report also did not support the Administration's claims that CSBG funding is nonessential to continued program operation. State and local governments are under such fiscal duress that they may not be able to replace lost CSBG funds.

In every budget package submitted to Congress since its inception, the Reagan and Bush Administrations proposed phasing out the CSBG. The Clinton Administration, however, has supported funding for the CSBG, and on May 18, 1994, President Clinton

signed into law the Human Services Amendments of 1994, which reauthorized the CSBG and several other programs through fiscal year 1998.

(B) ELDERLY SHARE OF SERVICES

(1) SSBG

The role that the Social Services Block Grant plays in providing services to the elderly had been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for groups such as the elderly. In addition, critics have noted that reductions in SSBG funding could trigger uncertainty and increase competition between the elderly and other needy groups for scarce social service resources.

Under Title XX, the extent of program participation on the part of the elderly was difficult to determine because programs were not age specific. In the past, States have had a great deal of flexibility in reporting under the program and, as a result, it has been hard to identify the number of elderly persons served, as well as the type of services they received. The elimination of many of the reporting requirements under SSBG made efforts to track services to the elderly very difficult. In the past, States had to submit pre-expenditure and post-expenditure reports to HHS on their intended and actual use of SSBG funds. These reports were not generally comparable across States, and their use for national data was limited. In 1988, Section 2006 of the SSA was amended to require that these reports be submitted annually rather than biennially. In addition, a new subsection 2006(c) was added to require that certain specified information be included in each State's annual report and that HHS establish uniform definitions of services for use by States in preparing these reports. HHS published final regulations to implement these requirements on November 15, 1993.

These regulations require that the following specific information be submitted as a part of each State's annual report: (1) The number of individuals who received services paid for in whole or in part with funds made available under Title XX, showing separately the number of children and adults who received such services, and broken down in each case to reflect the types of services and circumstances involved; (2) the amount spent in providing each type of service, showing separately the amount spent per child and adult; (3) the criteria applied in determining eligibility for services (such as income eligibility guidelines, sliding fee scales, the effect of public assistance benefits and any requirements for enrollment in school or training programs); and (4) the methods by which services were provided, showing separately the services provided by public agencies and those provided by private agencies, and broken down in each case to reflect the types of services and circumstances involved. The new reporting requirements also direct the Secretary to establish uniform definitions of services for the States to use in

their reports. All States now have submitted reports to HHS, but these reports have not been compiled or analyzed to provide national information on the SSBG.

In addition to these annual reports, another source of data on Title XX is from the Voluntary Cooperative Information System (VCIS) of the American Public Welfare Association (APWA) funded by HHS. This is a voluntary survey conducted by APWA to fill in the gap caused by the lack of Federal reporting requirements in the past. The most recent VCIS survey published in January 1994 covers information for fiscal year 1990. A total of 33 State or territorial agencies participated in this survey. It must be kept in mind that the VCIS data base is incomplete because a number of States were able to provide only partial data or their data could not be used due to lack of conformity with reporting guidelines. Data from 21 States shows that a total of five services accounted for more than half of all services provided to adults and the elderly. These services are—information and referral services, homemaker/home-management/chore services, family planning services, protective services, and counseling services. (It should be noted that not all States included in the analysis were able to provide data for every service category.) Data from 14 States shows that homemaker/home management/chore services accounted for three-quarters of all expenditures for adults and the elderly. Again not all 14 States were able to provide data for every service category.

In 1990, the American Association of Retired Persons released a survey of States regarding the amount of SSBG funds being used for services to the elderly. The survey showed that 44 States use some portion of their SSBG funds to provide services to older persons. The percentage of Federal funds used for seniors ranged from 0 to 90 percent in 39 States that were able to provide age-specific estimates. Most States indicated that they have held service levels relatively constant by a variety of devices, including appropriating their own funds, cutting staff, transferring programs to other funding sources, requiring local matching funds, or reducing the frequency of services to an individual. The most frequently provided services were home-based, adult protective, and case management/access. Other uses include family assistance, transportation, nutrition/meals, socialization and disabled services. All but 3 of the 47 States responding to the survey reported that services for older people have suffered from the absence of increases in Federal SSBG funding. As a result, States have raised the eligibility criteria so that they provide fewer and less comprehensive services to fewer people and, except with respect to protective services, they serve only the very low-income elderly. In addition, some States reported that shrinking funds make it necessary to consider the costs of services more than the quality of services.

It seems clear that there is a strong potential for fierce competition among competing recipient groups for SSBG dollars. Increasing social services needs along with declining support dollars portends a trend of continuing political struggle between the interests of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the Administra-

tion, and State governments as policymakers contend with issues of access and equity in the allocation of scarce resources.

(2) CSBG Funds

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant also remains unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of CSBG funds.

The report by NASCSP on State use of fiscal year 1993 CSBG funds, discussed above, provides some interesting clues. Although the survey was voluntary, all jurisdictions eligible for CSBG allotments answered all or part of the survey. Thus, NASCSP received data on CSBG expenditures broken down by program category and number of persons served which provides an indication of the impact of CSBG services on the elderly. For example, data from 52 States show expenditures for employment services, which includes job training and referral services for the elderly, accounted for 11 percent of total CSBG expenditures in those States. A catchall linkage program category supporting a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, legal services, homemaker and chore services, and information and referrals accounted for 22 percent of CSBG expenditures. Emergency services such as donations of clothing, food, and shelter, low-income energy assistance programs and weatherization are provided to the needy elderly through CSBG funds, accounting for 23 percent of CSBG expenditures in fiscal year 1993. Unfortunately, data related to the age, sex, race, and income levels of program participants were not reported in the survey. Until such data are available, a definitive picture of the role CSBG programs play in assisting the needy elderly is unclear.

3. Federal Response

(A) SOCIAL SERVICES BLOCK GRANT APPROPRIATIONS

The SSBG program is permanently authorized and States are entitled to receive a share of the total according to their population size. By fiscal year 1986, an authorization cap of $2.7 billion was reached.

Congress appropriated the full authorized amount of $2.7 billion for fiscal year 1989 (P.L. 100–436). Effective in fiscal year 1990, Congress increased the authorization level for the SSBG to $2.8 billion (P.L. 101–239). This full amount was appropriated for each fiscal year from 1990 through fiscal year 1995.

In fiscal year 1994, an additional $1 billion for temporary SSBG in empowerment zones and enterprise communities was appropriated. Each State is entitled to one SSBG grant for each qualified enterprise community and two SSBG grants for each qualified empowerment zone within the State. Grants to enterprise commu-

nities generally equal about $3 million while grants to empowerment zones generally equal $50 million for urban zones and $20 million for rural zones. States must use these funds for the first three of the five goals listed above. Program options include—skills training, job counseling, transportation, housing counseling, financial management and business counseling, emergency and transitional shelter and programs to promote self-sufficiency for low-income families and individuals. The limitations on the use of regular SSBG funds do not apply to these program options.

For fiscal year 1996, Congress appropriated $2.38 billion for the SSBG, which was lower than the entitlement ceiling. Under welfare reform legislation enacted in August 1996 (P.L. 104–193), Congress reduced the entitlement ceiling to $2.38 billion for fiscal years 1997 through 2002. After fiscal year 2002, the ceiling would return to the previous level of $2.8 billion. However, for fiscal year 1997, Congress actually appropriated $2.5 billion for the SSBG, which was higher than the entitlement ceiling established by the welfare reform legislation.

(B) COMMUNITY SERVICES BLOCK GRANT REAUTHORIZATION AND APPROPRIATIONS

The CSBG Act was established as part of OBRA 81 (P.L. 97–35), and has subsequently been reauthorized four times—in 1984 under (P.L. 98–558), in 1986 under (P.L. 99–425), in 1990 under (P.L. 101–501), and in 1994 under (P.L. 103–252). In addition to the CSBG itself, the Act authorizes various discretionary activities, not all of which are currently funded. Specifically, the Act currently authorizes community economic development activities, rural community development activities, development of interactive information technology systems, assistance for migrants and seasonal farmworkers, community food and nutrition programs, and the National Youth Sports Program. The 1994 amendments also authorize appropriations through fiscal year 1998 for emergency community services for the homeless, and demonstration partnership grants to test innovative approaches to combating poverty.

In fiscal year 1997, appropriations are as follows: $490 million for the CSBG (a $100 million increase over the previous year); $27 million for community economic development; $3 million for rural community facilities; $12 million for national youth sports; and $4 million for community food and nutrition.

B. EDUCATION

1. BACKGROUND

State and local governments have long had primary responsibility for the development, implementation, and administration of primary, secondary, and higher education, as well as continuing education programs that benefit students of all ages. The role of the Federal Government in education has been to ensure equal opportunity, to enhance the quality, and to address national priorities in training.

Federal and State interest in developing educational opportunities for older persons grew out of several White House Conferences on Aging which discussed the educational needs for older persons.

These educational needs range from the need to acquire the basic skills necessary to function in society, to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit other people. The White House Conferences on Aging pointed out that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons and assure a match between the needs of older adults and the training of those who serve them.

While many strong arguments exist for the importance of formal and informal educational opportunities for older persons, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily at the establishment and maintenance of programs for children and college age students. This is due largely to the perception that education is a foundation constructed in the early stages of human development.

Although learning continues throughout one's life in experiences with work, family, and friends, formal education has traditionally been viewed as a finite activity extending only through early adulthood. Thus, it is a relatively new notion that the elderly have a need for formal education extending beyond the informal, experiential environment. This need for structured learning may appeal to "returning students" who have not completed their formal education, older workers who require retraining to keep up with rapid technological change, or retirees who desire to expand their knowledge and personal development.

At the end of 1991, the Special Committee on Aging released a publication entitled "Lifelong Learning for An Aging Society." This report, which was updated for 1992 provides an introduction to the concept of lifelong learning as well as to the laws that affect education for the older adult.

2. Issues

(A) ADULT LITERACY

Conventional literacy means the ability to read and write. The Census Bureau estimated that the Nation's conventional illiteracy rate was 0.5 percent in 1980, which would place the estimated number at over 1 million. However, literacy means more than the ability to read and write. The term "functional illiteracy" began to be used during the 1940's and 1950's to describe persons who were incapable of understanding written instructions necessary to accomplish specific tasks or functions.

Definitions of functional literacy depend on the specific tasks, skills, or objectives at hand. As various experts have defined clusters of needed skills, definitions of functional literacy have proliferated. These definitions have become more complex as technological information has increased. For example, the National Literacy Act of 1991 defines literacy as "an individual's ability to read, write, and speak in English, and compute and solve the problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential."

According to a major literacy survey released in September 1993 by the Department of Education (ED), approximately 90 million adults (about 47 percent of the U.S. adult population) demonstrate low levels of literacy. However, most of these adults describe themselves as being able to read or write English "well" or "very well." Thus, a majority of Americans do not know that they do not have the skills necessary to earn a living in today's increasingly technological society. These findings are contained in a survey by the National Center for Education Statistics (NCES) that sampled the English literacy levels of 26,000 individuals in the United States over the age of 16.

The National Adult Literacy Survey (NALS) conducted in 1992, tested adults on three different literacy skills (prose, document, and quantitative). The study defines literacy as "using printed and written information to function in society, to achieve one's goals, and to develop one's knowledge and potential." The report found that adults performing in the lowest literacy level were more likely to have fewer years of education, to have a physical, mental, or other health problem, and to be older, in prison or born outside the United States. The survey also underscores low literacy skill's strong connection to low economic status. *Adult Literacy in America* provides an overview of the results of NALS. The Department of Education (ED) also published six additional reports concerning the results of NALS. These reports cover literacy and the elderly, literacy and welfare recipients, literacy and the prison population, literacy and job seekers, literacy and young adults, and literacy and state surveys.

Statistics on educational attainment have also revealed cause for concern. For 1995, the Census Bureau estimated that 166 million persons were 25 years old and over; of these 18.3 percent (30 million) less than 12 years of school. The use of these data to estimate functional literacy rates, however, has the drawback that the number of grades completed does not necessarily correspond to the actual level of skills of adult individuals.

In addition, today, almost 80 percent of 2- and 4-year institutions enrolling freshman offer remedial courses for some students. When the inherent problems associated with illiteracy are considered (unemployment, crime, homelessness, alcohol and drug abuse) the social consequences of widespread illiteracy in this country are particularly disturbing.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. As would be expected, there is a heavy concentration of older persons among the group of adults who have not graduated from high school. According to the Statistical Abstract of the United States for 1996, which contains information for 1993, 24.8 percent of all adults 25 years old and older did not graduate from high school while almost twice that many (54 percent) of those 55 years old and older did not graduate from high school. Of those 75 and older almost 50 percent (43.2 percent) did not graduate from high school.

In 1990 President Bush and the Nation's Governors adopted six national education goals to be achieved by the year 2000. One of the six goals is that every adult American will be literate and will possess the knowledge and skills necessary to compete in a global

economy and exercise the rights and responsibilities of citizenship. In order to accomplish these goals, the President proposed a new education strategy, entitled AMERICA 2000 and the 102nd Congress considered and passed a number of alternatives to implement this strategy. Because there was no final agreement on the various proposals, no legislation was enacted.

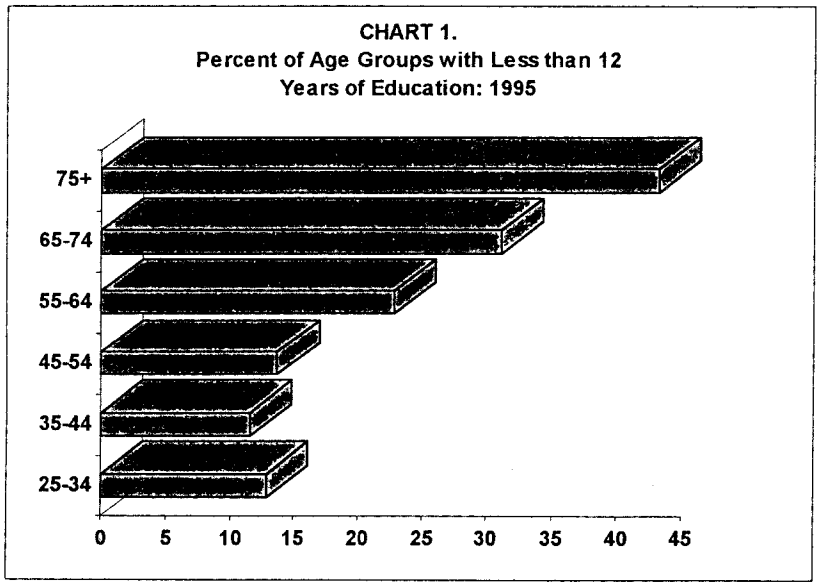
President Clinton signed the Goals 2000: Educate America Act into law (P.L. 103–227) on March 31, 1994. This Act enacted into law the national educational goals; created the National Education Goals Panel (NEGP) to monitor progress toward the Goals, and the National Education Standards and Improvement Council (NESIC) to certify national and State standards and assessments; established and certified voluntary national "opportunity-to-learn" (OTL) standards, and voluntary State standards and assessments; provided grants for implementation of State systemtic reform under which States would develop and implement reform plans, State content and performance standards, OTL standards or strategies, and assessments; gave the authority for waivers of requirements and regulations under designated Federal education programs; and created a national board to establish occupational skill standards.

The 104th Congress' fiscal year 1996 appropriations legislation (P.L. 104–134) repealed and modified different elements of the school reform framework established by the Goals 2000: Educate America Act. The appropriations legislation amended the authorizing statute to repeal the National Education Standards and Improvement Council; the requirement that States develop opportunity-to-learn standards or strategies; the need for States to have approval of their State reform plans by the Secretary of Education. Further, the legislation was amended to permit local educational agencies, in States that are not participating in Goals 2000, to apply directly to the Secretary of Education for funding, if they receive approval from their State educational agency.

In the 104th Congress, the Workforce and Career Development Act of 1996 (WCDA), H.R. 1617 was proposed which would have replaced most Federal vocational and adult education programs with a block grant to the States. After the conference committee reported H.R. 1617, the WCDA did not reach the House or Senate floor, and no further action took place on the proposal. Issues raised of concern to older adults during consideration of WCDA included the fragementation and multiplicity of existing Federal programs and specific funding provisions for dislocated worker training. Appropriations for existing vocational and adult programs are continued through fiscal year 1997.

In the 105th Congress, renewed action on vocational and adult education programs is anticipated, possible through consideration of: a modification of the WCDA proposal that was agreed to in the conference report on H.R. 1617; a streamlined and consolidated vocational and adult education program without any specific job training components; or a modification and extension of the current vocational and adult education programs. Specific adult education and literacy issues may include the extent of targeting services on those most in need; the extent of targeting services to meet workplace needs; state flexibility in required setasides and program administration; the impact of performance standards on the quality

of State and local services; and incentive programs for collaborative activities between employers and educators.



(B) PARTICIPATION IN ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (AEA) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to: (a) Establish adult education programs to help persons 16 years and older to acquire basic literacy skills necessary to function in society, (b) enable adults to complete a secondary school education, and (c) make available to adults the means to secure training and education that will enable them to become more employable, productive, and responsible citizens. Funds provided for adult education are distributed by a formula to States based on the number of adults in a State without high school diplomas who currently are not enrolled in school. The AEA served approximately 4 million participants in 1993.

Data from the Office of Vocational and Adult Education within the Department of Education (ED) shows that, in 1986, of the total eligible adult population receiving Adult Basic Education (ABE) services (basic literacy and English as a second language instruction), 7.4 percent or 217,488 were in the 60-plus age group, as compared to 185,000 the previous year, an 11.8-percent increase. By

1989, only 5 percent of participants (or 165,000) in these programs were over age 60. At the State level, the percentage of older adult participation in literacy instruction varied from less than 1 percent to 20 percent. The reasons for participation in literacy programs most often cited by this group were a desire: (1) to read to their grandchildren, (2) to read the Bible, (3) to read medicine labels, (4) to accomplish a lifetime goal of earning a General Education Development (GED) certificate, (5) to learn more about money and banking, and (6) to learn more about available community resources.

With less than 4 percent of the elderly population estimated to be enrolled in an educational institution or program, older Americans continue to be underrepresented in education programs in relation to the percentage of the total U.S. adult population they comprise. This is due partly to the fact that while the elderly certainly have the ability to learn, the desire to learn is a function of educational experience. A 1984 Department of Education report supports the correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most of the classes currently focus on self-enrichment and life-coping skills. However, they are gradually shifting the focus to educational programs on self-sufficiency. Few programs currently exist to meet the growing demand to acquire the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift emphasis from personal interest courses to courses on job-training skills.

Although States use various methods for reaching the eligible aging population, reports indicate that there are problems in carrying out this effort. The major problems most often mentioned by States are transportation and recruitment. Reaching older persons, especially in rural areas, is complicated because of distance, low population density, and lack of public transportation.

3. Federal and Private Response

(A) PROGRAMS

(1) Literacy

(a) *Public efforts.*—The Adult Education Act was enacted as part of the Elementary and Secondary Education Amendments of 1966 (P.L. 89–750). This Act was reauthorized under Section 6214 of the Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 (P.L. 100–297). The Act has been amended several times since 1966, but the basic purpose and structure have remained similar since its enactment.

Much of the public effort by States and localities to address literacy problems is organized under the AEA program, which is funded primarily by the States. Section 353 of the Adult Education Act requires States to set aside 15 percent of their Federal funds for special experimental demonstration and teacher training

projects. The section calls for coordinated approaches to the delivery of adult basic education services to promote effective programs and to develop innovative methods. Some of the States developed projects targeted to improve literacy services to the older population. For example, Louisiana developed a set of basic skills curricula for adults reading at the 0–4 grade levels and West Virginia used cable television to reach the disadvantaged who live in rural areas, as well as those who are institutionalized, homebound, or isolated.

Federal legislation has been critical in strengthening adult education during the past decade. The National Literacy Act of 1991, for example, represents the result of legislative efforts to expand the programs and resources available to address the country's literacy problem. Programs authorized by the Family Support Act and the Job Training Partnership Act amendments also highlight the importance placed on literacy and basic skills education. Both Acts encourage State and local entities to work with educational institutions in designing and implementing services for economically and educationally disadvantaged adults to promote job training and economic self-sufficiency.

In addition, the AEA amendments authorized several literacy projects including those for workplace literacy, English literacy, and literacy services for the homeless. The AEA also called for the National Adult Literacy Survey to be conducted in order to provide a definitional framework and comprehensive data on adult literacy in America.

The AEA amendments also required that the Secretary of Education, in conjunction with the Secretary of Labor and Secretary of HHS conduct an interagency study of Federal funding sources and services for adult education programs. Pursuant to this requirement, the Cosmos Corporation was commissioned by these three agencies to: (1) Collect and synthesize information about Federal adult education programs that support literacy, basic skills, English as a second language or, adult secondary education; and (2) provide recommendations about the necessity of program coordination and facilitation among Federal, State, and local levels. This report was done in two phases. Phase 1 examined the variety of Federal programs that authorized the expenditure of funds for adult education services by reviewing 85 programs in 12 Federal agencies. Phase 2 investigated effective efforts in State and local coordination of adult education services. Phase 1 of the study entitled "Federal Funding Sources and Services for Adult Education" was completed by Cosmos in 1992 and covers fiscal years 1986–89.

Among the principal findings of phase 1 are as follows: (1) the number of programs and amount of funding for Federal adult education programs increased gradually during the fiscal year period 1986–89; (2) the type of activity funded most frequently was the provision of instructional services; (3) because of the limited availability of data the amount of Federal funding spent on adult education for 1989 that can be reliably verified is a low-end estimate of $247,090,059. (This amount did not include funds from the JTPA, Job Opportunities and Basic Skills Program, and other such programs which would have made this number substantially higher. Most of these moneys came from Department of Education pro-

grams funded under the AEA); and (4) the support for adult education has been concentrated on the provision of direct educational services in basic skills and literacy. The report stated that support for other areas such as research, dissemination, and staff training is necessary because it is critical to the improvement of the overall system for adult education. The report concluded by stating that the lack of data and difficulty in retrieving data regarding adult education programs made assessing those programs very difficult.

(b) *Private efforts.*—Literacy programs are operated by a multitude of private groups including churches, local school districts, businesses, labor unions, civic and ethnic groups, community and neighborhood associations, community colleges, museums and galleries, and PTA groups. While many of these organizations have relied primarily on funding under the AEA for their adult education programs, they are increasingly relying on the JTPA, HHS Family Support Act and other programs.

Several national groups provide voluntary tutors and instructional materials for private literacy programs, the two primary ones are the Laubach Literacy Action (50,000 tutors) and Literacy Volunteers of America (30,000 tutors). At the instigation of the American Library Association, a group of 11 national organizations, including Laubach and Literacy Volunteers, created the Coalition for Literacy to deliver information and services at the national and local levels.

(2) Higher Education

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. One study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and enabled them to identify their older classmates as their peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

Some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years. Today over 100 colleges and universities participate in the College Centers for Older Learners (CCOL) program (also known as Institutes/Learning In Retirement Centers). The two most common variations of this program are either those curricula that are planned and implemented exclusively by older persons, or those that are designed and managed by the institution with involvement of older students in the program planning.

Other colleges recognize experience as credit hours. At American University in Washington, D.C., for example, the Assessment of Prior Experiential Learning (APEL) program allows older students to translate their years of work or life experience into as many as 30 credits toward a bachelor's degree.

For those older students who cannot afford the cost of a private college, some States are beginning to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer a full tuition waiver and allow participants to take regular courses for credit in State-supported institutions. The Older Americans Act (OAA) Amendments of 1987 (P.L. 100–175) included a provision which requires area agencies on aging to conduct a survey on the availability of tuition-free postsecondary education in their area, supplement the data where necessary, and disseminate this information through senior centers, congregate nutrition sites, and other appropriate locations. Providing access to such information aimed at increasing the enrollment of older persons in higher education programs.

(3) Intergenerational Programs

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward providing the support, teaching, and caring that would enhance the learning and development of school children. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. There are now more than 100 intergenerational school programs nationwide. More than 250,000 volunteers participate in grades kindergarten through 12.

Intergenerational school programs range from informal and haphazard to large, centrally organized projects spanning several school districts. One example of a successful intergenerational program is the Teaching Learning Community, established by an elementary art teacher in 1971 in Ann Arbor, MI. The Teaching Learning Community links older persons with a small group of student-apprentices. They work together on joint activities on a regular, weekly basis. The focus is to teach the student a new skill and create a product, while communicating with and developing respect for others. The program has spread to many States, including Florida, Pennsylvania, Idaho, Texas, and New York.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children and to better cope with their own personal traumas, such as the death of a spouse or friend. These programs also allow school children to develop a more positive view of the elderly while benefiting from the social, academic, and life experience of their older tutors.

The OAA Amendments of 1987 included a provision that allows the Assistant Secretary on Aging to award demonstration grants to provide expanded, innovative volunteer opportunities to older persons and to fulfill unmet community needs. These projects may include intergenerational services by older persons to meet the needs of children in day care and school settings. The 1992 OAA Amendments also promote intergenerational programs. More specifically, the amended Act includes provisions which require the Assistant

Secretary on Aging to establish a program for making grants to States for establishing projects in public schools which, among other things, provide hot meals to older individuals and provide multigenerational activities in which volunteer older individuals and students interact. This program, however, has not been funded to date.

In addition, pursuant to Sections 406 and 409 of the 1992 OAA Amendments, AOA solicited grant applications to develop and implement intergenerational and multigenerational programs designed to assist families at-risk. Seven projects intended to increase the commitment of organizations to incorporate intergenerational and/or multigenerational programs into their agendas were funded for a 17-month period. These projects encourage the organizations to focus on the role of older family members when developing solutions to the problems facing American families. The AOA also funded a national training and technical assistance project to take place at the same time as the intergenerational projects.

Two of the projects which have to do specifically with education are as follows: First, the Teaching-Learning Communities Multigenerational Family Empowerment Project of Eastern Michigan University links three programs together ((1) Senior aides participating in DOL's Senior Community Service Employment Program, (2) youth and their parents receiving Section 8 housing support, and (3) local school districts) in order to demonstrate how interorganizational collaboration can work to better meet the respective goals of each organization and those served by them. Second, the Hand in Hand: Multigenerational Assistance Exchange project will employ minority college students as outreach aides to inform and assist older people in applying for public benefits and obtaining aging services. In exchange, elders will be invited to volunteer as mentors, tutors, and companions for at-risk children in the Head Start and Youth Enrichment Experience Programs.

In November 1992, the Special Committee on Aging convened a roundtable on intergenerational mentoring in order to study the direction that mentoring programs might take. This roundtable was the first step in exploring possible legislation for a National Mentor Corps, a public-private partnership that can provide mentors in our public school system.

(B) LEGISLATION

The 102d Congress considered and passed a number of comprehensive proposals to improve the Nation's literacy which were enacted into law. The most significant for older adults was the National Literacy Act of 1991 (P.L. 102–73) which was signed into law in July 1991. This legislation, which extends the AEA for an additional 2 years to 1995, contains a comprehensive set of amendments to assist State and local programs in providing literacy skills to adults. This legislation also establishes an interagency National Institute for Literacy, together with a National Institute Board, to conduct basic and applied research.

The 103d Congress amended and enacted the Clinton Administration's proposed Goals 2000: Educate America Act. This legislation provides a framework for moving the Nation toward the national education goals. These goals seek to achieve substantial im-

provement in U.S. education, primarily at the precollege level, by the year 2000. The legislation enacts the Goals into Federal law, and supports development of National and State education standards and assessments to help meet these goals. It would also fund systemwide State and local education reform aligned with State standards and assessments. One of the goals of this legislation is that all adults will be literate by the year 2000.

C. ACTION PROGRAMS

1. Background

ACTION was established in 1971 through a Presidential reorganization plan that brought together under one independent agency several existing volunteer programs. The programs transferred to ACTION in 1971 include Volunteers in Service to America (VISTA) and the National Student Volunteer Program, both previously administered by the Office of Economic Opportunity; the Foster Grandparent Program (FGP); and the Retired Senior Volunteer Program (RSVP), which had been part of the Administration on Aging.

ACTION was given statutory authority under the Domestic Volunteer Service Act of 1973, which placed all domestic volunteer programs under a single authorizing statute. The act was reauthorized in 1989 through fiscal year 1993.

Today, programs administered by ACTION include the Title I–A VISTA program, the Title I–B Student Community Service Programs, the Title I–C Special Volunteer Programs, and the Title II Older American Volunteer Programs (FGP, RSVP, and the Senior Companion Program (SCP)). ACTION programs are directed toward reducing poverty and poverty-related problems, helping the physically and mentally disabled, and assisting in a variety of other community service activities. ACTION also supports demonstration projects for testing new initiatives in voluntarism, and advocacy and promotes voluntarism in the public and private sectors.

On September 21, 1993, President Clinton signed into law major new national service legislation entitled The National and Community Service Trust Act of 1993 (P.L. 103–82). The conference agreement on this legislation (H.R. 2010) was passed by the Senate on September 8, 1993, and by the House on August 6, 1993. Public Law 103–82 establishes a new Federal Corporation for National Service that will be created by combining the Commission on National and Community Service and ACTION. The Corporation will be responsible for administering: the new National Service Trust Program; programs authorized under the National Community Service Act of 1990; the Domestic Volunteer Service Act; the Civilian Community Corps; and funding training and technical assistance, service clearinghouses and other activities.

The Corporation can solicit and accept private funds. A bipartisan 15-member board of directors appointed by the President and confirmed by the Senate will administer the Corporation and an Inspector General will oversee the programs. Programs can arrange for independent audits and evaluations, and can also be required to participate in national or State evaluations. The Corporation is

required to retain the ACTION field office structure, and the transfer of ACTION into the Corporation cannot take place sooner than 12 months after enactment of authorizing legislation.

To receive a grant, States must establish a commission on national service. Commissions are to have 15–25 members, and be comprised of representatives from a variety of fields including: local government, existing national service programs, local labor organizations, and community-based organizations. A representative of the Federal corporation must be a voting member of every State commission. State commissions will select programs to be funded, design strategic plans for service in the States, recruit participants, disseminate information about service opportunities, and support clearinghouses. They cannot operate national service programs, but can support programs administered by State agencies. For approximately 2 transitional years, existing State agencies can assume the responsibility of the State commissions.

(A) OLDER AMERICAN VOLUNTEER PROGRAMS

The Older American Volunteer Programs (OAVP), which includes the RSVP, the FGP, and the SCP, is the largest of the ACTION program components. The various programs provide opportunities for persons 60 years and older to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies that recruit, place, supervise, and support older volunteers.

The programs within ACTION were amended and extended through fiscal year 1993 by the Domestic Volunteer Service Act Amendments of 1989 (P.L. 100–204). The 1989 amendments increased the authorized funding levels and numbers of volunteers for several programs and increased the volunteer stipend amounts for the VISTA, FGP, and SCP. For both the VISTA and OAVP, the 1989 amendments included language requiring ACTION to spend a certain portion of appropriated funds on recruitment and placement.

Pursuant to Public Law 103–82, the OAVP will be renamed the National Senior Volunteer Corps. Public Law 103–82 clarifies that Foster Grandparents can work with children with special needs in Head Start programs, schools, and daycare centers. It also authorizes a new demonstration program for innovative older American projects, and increases stipend amounts for low-income foster grandparents and senior companions over the next 5 years to account for inflation.

(1) Retired Senior Volunteer Program

The Retired Senior Volunteer Program (RSVP) was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on Aging to ACTION and in 1973 the program was incorporated under Title II of the Domestic Volunteer Service Act. Pursuant to Public Law 103–82, RSVP will now be a part of the new Federal Corporation for National Service. RSVP is designed to provide a variety of volunteer opportunities for persons 60 years and older. In fiscal year 1993, 423,500 volunteers served in 746 projects. Volunteers serve in such areas as youth

counseling, literacy enhancement, long-term care, refugee assistance, drug abuse prevention, consumer education, crime prevention, and housing rehabilitation. Current RSVP projects emphasize prescription drug abuse, education, latchkey children in after-school library programs, and respite care for frail elderly. Program sponsors include State and local governments, universities and colleges, community organizations, and senior service groups.

Each project is locally planned, operated, and controlled. Although volunteers do not receive hourly stipends as under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses, such as transportation costs.

(2) Foster Grandparent Program

The Foster Grandparent Program (FGP) originated in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration on Aging to ACTION. In 1973, the FGP was incorporated under Title II of the Domestic Volunteer Service Act. Pursuant to Public Law 103–82, FGP will now be a part of the new Federal Corporation for National Service.

The FGP provides part-time volunteer opportunities for primarily low-income volunteers aged 60 and older. These volunteers provide supportive services to children with physical, mental, emotional, or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day-care centers, and institutions for the mentally or physically disabled. Volunteers serve 20 hours a week and provide care on a one-to-one basis to three or four children. A foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming age 21.

The FGP was originally intended for low-income volunteers who receive an hourly stipend. The Domestic Volunteer Service Act exempts stipends from taxation and from being treated as wages or compensation. Foster grandparent volunteers must have an income below the higher of 125 percent of the Department of Health and Human Services poverty guidelines or 100 percent of those guidelines plus the amount each State supplements the Federal Supplemental Security Income payment. In 1992, this annual income level was $6,810 for an individual in most States, and $9,190 for a two-person family.

In an effort to expand volunteer opportunities to all older Americans, Congress added an amendment to the 1986 Amendments (P.L. 99–551) which permitted non-low-income persons to become foster grandparents. The non-low-income volunteers are reimbursed for out-of-pocket expenses only.

(3) Senior Companion Program

The Senior Companion Program (SCP) was authorized in 1973 by Public Law 93–113 and incorporated under Title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The OBRA amended

section 211 of the Act to create a separate Part C containing the authorization for the Senior Companion Program. Pursuant to the National and Community Services Trust Act of 1993 SCP will now be a part of the new Federal Corporation for National Service.

This program is designed to provide part-time volunteer opportunities for primarily low-income volunteers aged 60 years and older. These volunteers provide supportive services to vulnerable, frail older persons in homes or institutions. Like the FGP, the 1986 Amendments (P.L. 99–551) amended SCP to permit non-low-income volunteers to participate without a stipend, but reimbursed for out-of-pocket expenses. The volunteers help homebound, chronically disabled older persons to maintain independent living arrangements in their own residences. Volunteers also provide services to institutionalized older persons and seniors enrolled in community health care programs. Senior companions serve 20 hours a week and receive the same stipend and benefits as foster grandparents. To participate in the program, low-income volunteers must meet the same income test as for the Foster Grandparent Program.

(B) VOLUNTEERS IN SERVICE TO AMERICA

Volunteers in Service to America (VISTA) was originally authorized in 1964, conceived as a domestic peace corps for volunteers to serve full-time in projects to reduce poverty. Today, VISTA still holds this mandate. Volunteers 18 years and older serve in community activities to reduce or eliminate poverty and poverty-related problems. Activities include assisting persons with disabilities, the homeless, the jobless, the hungry, and the illiterate or functionally illiterate. Other activities include addressing problems related to alcohol abuse and drug abuse, and assisting in economic development, remedial education, legal and employment counseling, and other activities that help communities and individuals become self-sufficient. Volunteers also serve on Indian reservations, in federally assisted migrant worker programs, and in federally assisted institutions for the mentally ill and mentally retarded.

Volunteers are expected to work full-time for a minimum of 1 year, but they may serve for up to 5 years. To the maximum extent possible, they live among and at the economic level of the people they serve. Volunteers are reimbursed for certain travel expenses and receive a subsistence allowance for food, lodging, and incidental expenses. The subsistence allowance may not be less than 95 percent of the poverty line for the area in which the volunteer is serving. They also receive health insurance and a monthly stipend of $95 that is paid in a lump sum at the end of their service. The 1989 reauthorization legislation requires that at least 20 percent of the volunteers fall into each of two age categories: (a) persons 55 years and older, and (b) persons 18–27 years old.

Public Law 103–82 makes several changes to the VISTA program. These changes include: increasing the number of VISTA volunteers; creating a new VISTA summer associate program; increasing post-service stipends; and restoring the practice of allowing VISTA service to be credited toward Federal pensions. In addition, the authority under the Special Volunteers Program will be broadened to support demonstration programs, provide technical assistance and promote entrepreneurial activities. Finally, Public Law

103–82 eliminates specific authority for student community service and drug programs.

2. Issues

In recent years, there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in society. Historically, voluntarism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools, churches, and other social service agencies. More recently, volunteer service has included activities for grassroots political advocacy and community improvement programs. In many communities, the need to address the problems of poverty and to utilize the skills and experiences of elderly volunteers continues. Despite the interest among volunteer programs to utilize elderly volunteers, there has been relatively little structured evaluation of ways to achieve this goal.

In the Domestic Volunteer Service Act Amendments of 1984 (P.L. 98–288), Congress authorized senior companion demonstration projects to explore ways in which the Senior Companion Program could serve the growing population of frail homebound older persons at high risk of institutionalization. To accomplish this, SCP was authorized to recruit unpaid community volunteers to train senior companions and to use senior companion volunteer leaders (SCVLs) to assist other older persons in need. Grants were awarded to 19 new SCP projects and 17 new components of existing SCP projects at the beginning of fiscal year 1986.

In a search for public policy to meet the long-term care needs of the rapidly increasing older population, Congress mandated an evaluation of the demonstration projects, identifying five issues:

(1) The extent to which the costs of providing long-term care are reduced by using SCP volunteer companions, who receive modest stipends, to assist the frail elderly living at home;

(2) The effectiveness of long-term care services provided by volunteers;

(3) The extent to which the health care needs and health-related costs of the volunteer companions are affected by their participation in SCP;

(4) The extent of SCP project coordination with other Federal and State efforts aimed at enabling older individuals to receive care in their own homes; and

(5) The effectiveness of using Senior Companion Volunteer leaders and volunteer trainers.

The evaluation of the new projects, completed in 1988, points out that SCP services supplement and augment long-term care services from other sources, rather than replace them. Nevertheless, the projects proved to be a relatively low-cost means of providing needed services to frail older persons who generally could not afford to purchase them. However, cost containment is not the only rationale for developing long-term care policy. Improving the quality of life and well-being of the elderly are also major long-term care goals.

The value of the program to the senior companions is demonstrated by the economic benefit of the stipend and the senior companions' high degree of social integration and well-being. Senior companions generally benefit from training by volunteers. Pre-service as well as in-service training is already a requirement of the Senior Companion Program. It is unclear whether the benefits of utilizing volunteer trainers differ significantly from paid staff trainers.

The position of Senior Companion Volunteer Leaders (SCVL) was not successfully implemented in many of the projects due to a concern among project staffs that the position created a hierarchy among the volunteers, that jeopardized senior companion relationships. Senior companions were generally found to provide informal support services for each other regardless of the presence of SCVLs. The evaluation also found that the most significant impediment to matching companions and clients in the projects, urban or rural, was the lack of access to transportation, another issue to be addressed in implementing long-term care policy.

A major concern for successful continuation of the programs is the need for increased funding support for administration of the projects. Due to administrative restrictions, past cost-of-living increases for the Senior Volunteer Corps have resulted in an expansion of volunteer services without a corresponding increase for administrative costs. Consequently, for over 10 years, project directors have been faced with the increasingly difficult task of supervising a greater number of volunteers without additional support. Public Law 103–82 states that 18 percent of the total amount appropriated for ACTION agency programs shall be appropriated for administration.

3. Federal Response

Programs contained in Public Law 103–82 are authorized through fiscal year 1996. Of amounts appropriated under the trust program, one-third will go to the States based on State population. The remaining two-thirds will be allocated on a competitive basis—half awarded to States and half awarded by the Corporation to various entities. (Federal agencies can only receive 30 percent of funds awarded competitively by the Corporation, and must match every dollar awarded with a dollar of matching funds.) Fifty percent of appropriated funding must be spent on programs in areas of economic distress that recruit participants from their own areas.

For fiscal year 1994, Public Law 103–82 authorizes a total of $621.6 million for all of its programs. Of this amount, $370 million is authorized for the new Corporation for National and Community Service. Funding for the ACTION agency programs is part of the Departments of Labor, Health and Human Services, and related agencies appropriations bill (P.L. 103–112).

Fiscal year 1994 authorization levels and appropriations for the National Senior Volunteer Corps programs are as follows: VISTA (authorization—$56 million, appropriation—$35.9 million); RSVP (authorization—$45 million, appropriation—$34.4 million); FGP (authorization—$85 million, appropriation—$66.1 million); and SCP (authorization—$40 million, appropriation—$29.8 million). Fiscal year 1994 appropriations for administration for the ACTION

programs is $31.8 million (this figure includes Inspector General and program support).

D. TRANSPORTATION

1. BACKGROUND

Transportation is a vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs—maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need.

Transportation serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support an individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

Three strategies have marked the Federal Government's role in providing transportation services to the elderly:

(1) Direct provision (funding capital and operating costs for transit systems);

(2) Reimbursement for transportation costs; and

(3) Fare reduction.

In fiscal years 1981–89, the Reagan Administration proposed to eliminate or substantially reduce Federal operating subsidies to States for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems. The Bush Administration continued to substantially reduce operating subsidies in its annual budgets.

The major federally sponsored transportation programs that provide assistance to the elderly and persons with disabilities are administered by HHS and DOT. Under HHS, a number of programs provide specialized transportation services for the elderly, including Title III of the Older Americans Act (OAA), the Social Services Block Grant Program (SSBG), the Community Services Block Grant Program (CSBG) and Medicaid, which will to a limited extent reimburse elderly poor for transportation costs to medical facilities. Under CSBG, more dollars (approximately 32 percent) have been spent on so-called linkages with other programs—including transportation for the elderly and persons with disabilities to senior centers, and community and medical services—than on any other program category.

The passage of the OAA of 1965 has had a major impact on the development of transportation for older persons. Under Title III of the Act, States are required to spend an adequate proportion of their Title III–B funds on three categories: access services (transportation and other supportive services); in-home, and legal services. According to an Administration on Aging report, in fiscal year 1991, 1,067,480 persons were recipients of transportation services under the OAA. Approximately 10 percent of OAA funds are used

for transportation services. However, this funding level does not take into consideration the mix of State and local resources which also fund transportation support services. Nonetheless, these levels of participation and funding indicate the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage of the 1970 amendments to the Urban Mass Transit Act (UMTA) of 1964 (P.L. 98–453) now called the Federal Transit Act, which added Section 16, marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities to improve access for the elderly and people with disabilities. Section 16 of UMTA declares a national policy that elderly and people with disabilities have the same rights as other persons to utilize mass transportation facilities and services. Section 16 also states that special efforts shall be made in the planning and design of mass transportation facilities and services to assure the availability of mass transportation to the elderly and people with disabilities, and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. The goal of Section 16 programs is to provide assistance in meeting the transportation needs of elderly and people with disabilities where public transportation services are unavailable, insufficient, or inappropriate. It is unfortunate that Section 16 has never been fully funded. Funding levels have primarily supported the purchase of capital equipment for nonprofit and public entities.

Another significant initiative was the enactment of the National Mass Transportation Assistance Act of 1974 (P.L. 93–503) which amended UMTA to provide block grants for mass transit funding in urban and nonurban areas nationwide. Under the program, block grant money can be used for capital operating purchases at the localities' discretion. The Act also requires transit authorities to reduce fares by 50 percent for the elderly and persons with disabilities during offpeak hours.

In addition, passage of the Surface Transportation Assistance Act (STAA) of 1978 (P.L. 95—549) amended UMTA to provide Federal funding under Section 18 which supports public transportation program costs, both operating and capital, for nonurban areas. The elderly and people with disabilities in rural areas benefit significantly from Section 18 projects due to their social and geographical isolation and thus greater need for transportation assistance. Section 18 has received annual appropriations of approximately $65 to $75 million through 1991. Section 18 appropriations have increased significantly for 1992 through 1994, averaging $109 million annually.

The STAA of 1982 (P.L. 97–424) established Section 9 in its amendments to the UMTA Act. Section 9 provides assistance to the public in general, but two of its provisions are especially important to the elderly and persons with disabilities. Section 9 continues the requirement that recipients of Federal mass transit assistance offer half-fares to the elderly and people with disabilities during nonpeak hours. In addition, every State can choose to transfer funds from Section 9 to the Section 18 program. Each year, be-

tween $10 million and $20 million of Section 9 funds have been transferred to the Section 18 program.

The Rural Transit Assistance Program (RTAP) was set up to provide training, technical assistance, research, and related support service for providers of rural public transportation. The Federal Transit Administration allocates 85 percent of the funds to the States to be used to develop State rural training and technical assistance programs. By the end of fiscal year 1989, all States had approved programs underway. The remaining 15 percent of the annual appropriation supports a national program, which is administered by a consortium led by the American Public Works Association and directed by an advisory board made up of local providers and State program administrators.

In July 1990 the Americans With Disabilities Act (ADA) was enacted. The ADA is a piece of civil rights legislation which outlaws discrimination against people with disabilities in almost all aspects of American life. The ADA does not create any new programs nor does it fund any services. The Act has two sections which address transportation issues relevant to the elderly. Both sections stress that people with disabilities should have the same rights and options as the general nondisabled public. There will be a discussion of the implications of the ADA's implementation on the elderly in a later discussion in this chapter.

The programs administered by HHS have proven to be highly successful in providing limited supportive transportation services necessary to link needy elderly and persons with disabilities to social services in urban, rural, and suburban areas. The DOT programs have been the major force behind mass transit construction nationwide and are an important ingredient in providing transportation services for older Americans. Recognizing the overlapping of funding and services provided by the two departments and the need for increased coordination, HHS and DOT established an interdepartmental Coordinating Council on Human Services Transportation in 1986. The Council is charged with coordinating related programs at the Federal level and promoting coordination at the State and local levels. As part of this effort, a regional demonstration project has been funded, and transportation and social services programs in all States are being encouraged to develop better mechanisms for working together to meet their transportation needs.

Despite these program initiatives, Federal strategy in transportation has been essentially limited to providing seed money for local communities to design, implement, and administer transportation systems to meet their individual needs. In the future, the increasing need for specialized services for the elderly and persons with disabilities will dictate the range of services available and the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

With the reauthorization of the STAA (renamed the Intermodal Surface Transportation Efficiency Act of 1991, ISTEA) in 1991, the importance of transportation was brought to the forefront of congressional and aging advocates' agendas. ISTEA created the Transit Cooperative Research Program (TCRP), the first federally fund-

ed cooperative research program exclusively for transit. The program is governed by a 25-member TCRP Oversight and Project Selection (TOPS) committee jointly selected by the Federal Transit Administration, the Transportation Research Board (TRB), and the American Public Transit Association (APTA). To date, the TOPS Committee has selected 32 issues to be researched among which include ADA transit service and delivery systems for rural transit, and demand forecasting for rural transit.

The ISTEA reauthorization made changes in the Federal Transit Act's Section 16 program which will benefit older people. Funds may now go to private, nonprofit organizations or to public bodies which coordinate services. Additionally, funds can continue to be used for capital costs or for capital costs of contracting for services. Equally important, both sections 16 and 18 have been amended to allow for the provision of home delivered meals if the meal delivery services do not conflict with the provision of transit services or result in the reduction of services to transit passengers. Moreover, both sections require local coordination of all federally funded services including transportation, similar to language in the reauthorized Older Americans Act.

The Omnibus Transportation Employee Testing Act of 1991 gives the Federal Transit Administration (FTA) the statutory authority to impose testing as a condition of financial assistance. It can also require the programs providing transportation to the elderly to be covered by Federal testing requirements even if they do not receive transit funding. The Act requires drug testing of covered employees such as drivers, dispatchers, maintenance workers, and supervisors. Alcohol tests are to be administered prior to, during, or just after the employee performs out-of-service safety-sensitive functions. Post accident testing is also required. The Act requires employers to report their data annually developing a national database of experience with drug and alcohol testing.

In July 1991, AARP and the National Association of Area Agencies on Aging released findings of a survey of area agencies regarding transportation services. The report revealed that a lack of financing compounded by the high cost of operating transportation systems is the largest barrier to meeting elderly transportation needs. Other barriers reported included high service provider costs, lack of client funds, high insurance costs, lack of client awareness, and area agency reporting requirements.

In addition, the AOA awarded a 3-year cooperative agreement to the Community Transportation Association of America to establish a National Eldercare Institute on Transportation. This initiative is a part of a National Eldercare Campaign initiated by AOA to help older persons maintain their independence and dignity. The Institute serves as a national resource institute to the aging community on transportation issues and resources. It also serves to link the interests of the aging community with those of the community transportation providers.

HHS also funds the Community Transportation Assistance Project (CTAP). The project is targeted at State and local human service agencies, planning entities and government decisionmakers. The project goals are: To help improve coordination of human services transportation and public transit resources; to help human

service transit providers meet their obligations under the ADA; to encourage coordination of HHS funded transportation with other community public transit services; and to provide a coordinated program of information, technical assistance and training to human services and community transportation providers and planners.

In 1992, dominant topics in public transportation were accessibility and mobility. At the 6th International Conference on Mobility and Transport for Elderly and Disabled Persons (June, Lyon, France), participants agreed that mobility for the elderly and disabled is a basic civil right. The challenge remains to maximize scarce public resources and thereby increase the overall level of transit service.

2. Issues

(A) TRANSPORTATION AS ACCESS SERVICE

Medicare's Prospective Payment System (PPS) has placed increasing demands on transportation services. Under PPS, predetermined fixed payment rates are set for each Medicare hospital inpatient administration, based on the diagnosis-related group (DRG) into which the admission falls. This fixed payment is an incentive for hospitals to limit costs spent on Medicare patients either by reducing lengths of stay or the intensity of care provided. As a result, many older persons are being released from the hospital earlier and in need of more follow-up care than before the introduction of PPS. One State, Kentucky, characterizes transportation as its top priority. This State conducted a survey which found that lack of transportation is a major barrier to mental health and social support services. Of those who had difficulty attending social activity programs, 52 percent cited the lack of transportation as the reason. This barrier results in less socialization and less satisfaction with life in general. It is anticipated that the demand for transportation services will increase as our population ages.

TABLE 1.—LATENT DEMAND FOR TRANSPORTATION SERVICES OF POPULATION 65 AND OVER IN 2000

	Number of nondrivers	Trips per capita per year	Total annual trips
Urban		1,734.4	
Activity limitation:			
Unable to conduct major activity	821,730		1,425,208,582
Limited in major activity	986,592		1,711,145,388
Limited but not in major activity	297,116		515,317,417
Unlimited	1,753,335		3,040,984,073
Suburban		1,734.4	
Activity limitation:			
Unable to conduct major activity	1,211,704		2,101,578,756
Limited in major activity	1,454,805		2,523,214,312
Limited but not in major activity	438,120		759,874,935
Unlimited	2,585,426		4,484,162,956
Rural		1,679.3	
Activity limitation:			
Unable to conduct major activity	1,058,500		1,777,538,568
Limited in major activity	1,270,864		2,134,162,587
Limited but not in major activity	382,725		642,710,544
Unlimited	2,258,533		3,792,754,649
Total number of trips taken because of lack of transportation			24,908,652,616

The lack of adequate transportation to social activities, the grocery store, and the doctor can have serious consequences for the well-being and independence of many elderly. It also may set back some of the advancements in health that have been achieved through better access to services.

In addition, requirements under the ADA may create some potential difficulties for elderly travelers. Title II of the ADA mandates that public transit systems which provide fixed-route services (i.e., transit services where vehicles run on regular, predesignated routes with no deviation) must furnish both accessible fixed-route services and complementary paratransit service for persons who cannot use fixed-route transit. Paratransit services accommodate any passenger unable to access the fixed-route system because of a physical, mental, or sensory disability. This section of the ADA has resulted in some displacement of elderly passengers because not all elders who need assistance are ADA-eligible for special services. Age alone is not a factor in determining ADA eligibility. Thus, public transit operators may refuse paratransit services to elderly riders in order to have the funds and capacity to meet their many ADA obligations. On the other hand, the reverse may also occur if providers of social services should view the ADA's mandates for public paratransit services as an opportunity to withdraw from providing transportation to their clients for cost-savings.

These ADA requirements affect both current and future users of paratransit services. Studies suggest that only 40 percent of all elderly may have disabilities severe enough to make them ADA eligible though many more elderly have trouble in driving or walking. Recent research conducted by the AARP, suggests that on average, 10 to 25 percent of the elderly currently using public paratransit services are not ADA eligible. At the State and national level, the aging network must help generate funds which will permit transit operators to meet their ADA obligations and also provide services for the elderly who are not ADA eligible.

In order to help alleviate these potential problems advocates for the elderly should work with transit operators to implement travel training programs to train the elderly to become regular public transit riders. Aging advocates can also: Develop transit services targeted to serve the origins and destinations needed by the elderly; evaluate implementing low entry, low floor buses; and work to coordinate social service agency transportation which is too fragmented and disjoined to benefit the elderly; and work with the local planning entities for transit and aging services to assure that the elderly's interests are not ignored in the communitywide planning process. Advocacy for community transportation should be a priority at the local, State, and national level.

(B) RURAL TRANSPORTATION NEEDS

Generally, Federal transportation policy has not recognized the special needs of rural elderly. Specific recommendations were made during the 1971 White House Conference on Aging directed at improving transportation for the rural elderly. A mini-conference on transportation for the aging, which preceded the general conference, recommended that State transportation agencies play a central role in developing responsible rural systems, and that im-

plementation of such systems be initiated at the local level. The conference also recommended greater citizen participation at the policymaking level, as well as at the advisory and implementation levels of transportation programs.

Transportation was cited as one of the major barriers facing the rural elderly in a 1984 report published by the Senate Special Committee on Aging. According to the report, an estimated 7 million to 9 million rural elderly lack adequate transportation, and as a result, are severely limited in their ability to reach needed services. Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas complicates the design of a cost-effective, efficient public transit system. Second, the incomes of the rural elderly generally are insufficient to afford the high fares necessary to support a rural transit system. Third, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Fourth, the physical design and services features of public transportation, such as high steps, narrow seating, and unreliable scheduling, discourage elders' participation. Fifth, the rural transit emphasis on general public access and employment transportation may adversely affect the elderly. If rural transit concentrates on transporting workers to jobs, less emphasis may be placed on senior transportation to nonessential services. Finally, the elderly are being displaced in some areas because they are not eligible for services under the ADA.

Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessibility rather than program design.

In August 1990, the Special Committee on Aging conducted a field hearing in Little Rock, AR. The hearing, chaired by Senator Pryor, addressed a number of long-term care issues, including the transportation programs under Title III of the Older Americans Act. The hearing further highlighted the need for senior transportation services, particularly in rural communities.

(C) SUBURBAN TRANSPORTATION NEEDS

The graying of the suburbs is a phenomenon that has only recently received attention from policymakers in the aging field. Since their growth following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have since elapsed have changed entirely the profile of the average American suburb, resulting in profound implications for social service design and delivery. In 1980, for the first time, a greater number of persons over age 65 lived in the suburbs (10.1 million) than in central cities (8.1 million).

This aging of suburbia can be attributed to two major factors. First, migration has contributed to the growth of the older suburban population. It is estimated that for every person age 65 and older who moves back to the central city, three move from the central city to the suburbs. Second, many older persons desire to

remain in the homes and neighborhoods in which they have grown old, i.e., "aging in place." The growth of the suburban elderly population is expected to continue to increase at an even more rapid rate in the future due to the large number of so-called pre-elderly (ages 50–64) living in the suburbs.

A 1988 national study of 260 metropolitan statistical areas conducted by the U.S. Conference of Mayors (USCM) and the National Association of Counties (NAOC) identified three priority concerns of the suburban elderly: home and community-based care, housing, and transportation. The availability of transportation services for the elderly suburban dweller is limited. Unlike large cities where dense population patterns can facilitate central transit systems, the lack of a central downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Private taxi companies, if they operate in the outlying suburban areas at all, are usually very expensive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services. Consequently, Federal support for private transit systems designed especially for the elderly suburban dweller is almost nonexistent. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Alternative revenue sources, such as user fees, are insufficient alone to support suburbanwide services, and are generally viewed as penalizing those most in need of transportation services in the community—the elderly poor.

The aging of the suburbs has several implications for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from services and/or service providers is a critical need. Community programs that serve the needs of elderly persons, such as hospitals, senior centers, and convenience stores, must be designed with supportive transportation services in mind. In addition, service providers must assist in coordinating transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community to adequately serve the dispersed elderly population. All too often, public transit serves commuters' needs primarily. If accessibility for the entire community is not possible, then service route models should be considered. Service routes are deviated fixed-routes that provide transportation between the constituents' homes and the services that they need to access to maintain their independence.

The demand for transportation services should be measured to determine the feasibility of alternative systems, such as dial-a-ride and van pools. Alternative funding mechanisms, such as reduced fares, user fees, and the local tax base, need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the extent that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand re-examination.

(D) SAFETY

The automobile remains the primary means of transportation for the entire country, including older persons. More than 80 percent of trips by persons age 65 and over are made in automobiles and that percentage is increasing.

A study by the Transportation Research Board (TRB) on the mobility and safety of older drivers found that up through age 75, most older drivers have good driving records and appear to perform as well as middle-aged drivers. However, although they are involved in a small number of crashes, after age 75, older drivers are about twice as likely to be involved in a crash per mile driven. In addition, older persons are among the most vulnerable to injury in motor vehicle crashes. Automobile occupants age 65 and older are more than three times as likely to die than a 20-year-old occupant from serious injuries of equal severity. The study emphasizes that because it is not a predictor of performance, age alone should not be the basis for restricting or withholding driver's licenses.

The TRB report does recommend changes in roadway design and operation to improve the safety of not only older, but all drivers. For example, current sign legibility standards assume a level of visual ability that many older persons cannot meet. Safety could be enhanced by larger and brighter road signs. In addition, vehicles could be made safer to offer better crash protection and the elderly should be made aware of the current safety features which are available such as anti-locking braking systems, airbags, and larger mirrors.

More recently, the National Institute on Aging reported that the accident rate for older drivers fell during the 1980's. Automobile deaths, however, have increased significantly suggesting that older drivers may be particularly vulnerable when crashes do occur.

With the increasing number of older drivers on the roads, several States are examining ways to improve the automobile traffic system. In 1990, the California Department of Motor Vehicles (DMV) began planning for new night and peripheral vision tests, video simulation exercises and longer, more complex written examinations. Although couched as the State's effort to assure competence of all drivers, and not just the elderly, aging advocates carefully monitored the proposed changes for signs of illegal age discrimination.

In order to increase the safety of older drivers, the 103d Congress introduced The High Risk Drivers Act of 1993 (S. 738). This bill directs the Secretary of Transportation to develop and implement effective and comprehensive policies and programs to promote safe driving behavior by younger drivers, older drivers, and repeat violators of traffic safety regulations and laws, including specified safety promotion and driver training research activities. Title II of the bill is entitled Older Driver Programs and directs the Secretary

to engage in specified activities regarding: (1) research on predictability of high risk driving by older drivers; (2) specialized training for license examiners; (3) counseling procedures and consultation methods; (4) alternative transportation means; (5) State licensing practices; (6) improvement of medical screenings; (7) intelligent vehicle-highway systems; and (8) technical evaluations under the Intermodal Surface Transportation Efficiency Act of 1991. It also authorizes appropriations. This bill was passed by the Senate and is currently being considered by the House.

Walking is second in importance to driving as a mode of transportation for older persons who are able and live in safe communities. For those older persons without driver licenses, between 20 and 40 percent of all their trips are made by walking. Yet many suburban environments do not provide for safe walking—pedestrian crossings are frequently not available and signals are often set to maintain a high volume of auto traffic. In addition, signal timing assumes a walking speed faster than that of many older pedestrians.

3. Federal and State Response

(A) FEDERAL

Significant developments in transportation programs affecting the elderly and disabled include the passage of the ADA placed additional responsibilities on Section 18 agencies, both private, nonprofit, and public. These agencies are now required to accommodate the needs of the disabled. In addition, the regulation includes private for-profit companies under contract from a public body to provide Section 18 services. Under the final rule published, however, most transit providers will be exempt from the paratransit requirement unless they are providing public, fixed-route transit services.

The 102nd Congress enacted a number of significant initiatives pertaining to senior transportation. The reauthorization of the Surface Transportation Act through 1997 (H.R. 2950, P.L. 102–240) provided a number of important changes for the elderly and disabled. The law, which renames UMTA the Federal Transit Administration, includes a substantial increase in funding for programs benefiting elderly and disabled persons. Specifically, the new law authorizes the Section 16 programs at $55 million for fiscal year 1992; $70.1 million for fiscal year 1993; $68.7 million for each of the fiscal years from 1994 through 1996; and $97.2 million for fiscal year 1997. For Section 18, the bill authorizes $106.1 million for fiscal year 1992; $151.5 million for fiscal year 1993; $153.8 million for each of the fiscal years from 1994 through 1996; and $217.7 million for fiscal year 1997. For the Rural Transit Assistance Program, the bill authorizes $5 million for fiscal year 1992; $7.9 million for fiscal year 1993; $7.7 million for each of the fiscal years 1994 through 1996; and $10.9 million for fiscal year 1997.

Key provisions of Public Law 102–240 included: (1) Allowing paratransit agencies to apply for Section 3 capital funding for transportation projects that specifically address the needs of elderly and disabled persons; (2) establishing a rural transit setaside of 5.5 percent of Section 3 funds allocated for replacement, rehabilitation, purchase of buses and related equipment, and the construction of

business related facilities; and (3) allowing transit service providers receiving assistance under Section 16(b) or Section 18 to use vehicles—under certain restrictions—for meal delivery service for homebound persons.

The Older Americans Act 1992 amendments (H.R. 2967, P.L. 102–375) also propose changes dealing with transportation services. The reauthorization required area plans under Title III to identify the needs and describe methods to be used to coordinate planning and delivery of transportation services. It also required State plans to assure that the State will coordinate public services within the State to assist older individuals to obtain transportation services. In addition, Public Law 102–375 included provisions initiated by Chairman Pryor, which would: (1) Provide grants to States for developing comprehensive and coordinated senior transportation systems; and (2) provide grants to area agencies on aging for leveraging additional resources to deliver transportation services and coordinating the resources available for such services.

In September 1993, the AOA funded grants for five demonstration projects on senior transportation. All of these programs have a project period of 2 years. Three of the projects have to do with improving rural transportation services and two of the projects are concerned with coordination of services.

The transportation appropriations bill for fiscal year 1994 (P.L. 103–122) provided the Federal Transit Administration with its highest funding level since 1985 for the transit system as a whole and for Section 16(b)(2) and 18. For fiscal year 1994, the appropriation for Sections 16(b)(2) is $58.7 million and the appropriation for Section 18 is $129.6 million. Both of these appropriation levels show a substantial increase over the 1993 funding level for Sections 16(b)(2) and 18.

(B) STATES

As an indication of concern about transportation issues, the Council of State Governments created the Center for Transportation in 1986 to function as a State policy research think-tank. A survey by the Center reveals that at least 40 States have responded to the issue of coordination of locally designed services by creating either voluntary or legislatively mandated interagency coordination committees. In addition, 9 States impose mandatory coordination on local providers. It is hoped that provisions in Public Law 102–375 initiated by Senator Pryor are assisting State and local efforts toward coordination of services.

Montana, for example, has developed a coordinated interagency approach for purchasing vehicles. As the lead agency, the Department of Commerce works to ensure that vehicles are shared by those agencies that need them at the local level. Local technical advisory committees also review and recommend transportation providers and purchasers of services in the community, including the area agencies on aging. In Florida, the Coordinating Council for the Transportation Disadvantaged oversees and develops transportation policy affecting about 4 million elderly, low-income and disabled residents who need transportation assistance. Approximately $41 million is being spent for these services in all of Florida's 67

counties. Each county has designated a single provider to coordinate these services.

More recently, Kansas passed the Kansas Coordinated Transit Act to organize the State's numerous agencies, reducing duplicative service and maximizing vehicle usage.

E. LEGAL SERVICES

1. BACKGROUND

(A) THE LEGAL SERVICES CORPORATION

Legislation establishing the Legal Services Corporation (LSC) was enacted in 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. Because litigation initiated by legal services attorneys often involves local and State governments or controversial social issues, legal services programs can be subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, the Nixon Administration developed legislation creating a separate, independently housed corporation. The LSC was then established as a private, nonprofit corporation headed by an 11 member board of directors, nominated by the President and confirmed by the Senate. No more than 6 of the 11 board members, as directed in the Corporation's incorporating legislation, may be members of the same political party as the President.

The Corporation does not provide legal services directly. Rather, it funds local legal aid programs which are referred to by LSC as "grantees." Each local legal service program is headed by a board of directors, of whom 60 percent are lawyers admitted to a State bar. LSC annually awards grants to 323 legal services programs in each of the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam.

Legal services provided through Corporation funds are available only in civil matters and to individuals with incomes less than 125 percent of the Office of Management and Budget poverty line. The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. Legal services cases deal with a variety of issues including: family related issues (divorce, separation, child custody, support, and adoption); housing issues (primarily landlord-tenant disputes in nongovernment subsidized housing); welfare or other income maintenance program issues; consumer and finance issues; and individual rights (employment, health, juvenile, and education). Most cases are resolved outside the courtroom. The majority of issues involving the elderly concern government benefit programs such as Social Security and Medicare.

The Corporation funds 23 national and State support centers, which provide specialized expertise in various aspects of poverty law. Three of these centers are specifically involved in issues that confront older people—the National Senior Citizens Law Centers, in Los Angeles and Washington, D.C.; Legal Counsel for the Elderly, in Washington, D.C.; and Legal Services for New York City

(branch office of Legal Services for the Elderly). LSC also provides funding for law school clinics. For the academic year 1992–93, LSC awarded $1,228,850 to a total of 22 law school clinics, two of which deal primarily with legal issues affecting the elderly. For the academic year 1993–94, LSC awarded $1,253,000 to a total of 17 law school clinics. One of the clinics noted elderly issues as a particular area of service.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several other restrictions have since been added in appropriations measures. These include, among others, limitations on lobbying, class actions, political activities, and prohibitions on the use of Corporation funds to provide legal assistance in proceedings that seek nontherapeutic abortions or that relate to school desegregation. In addition, if a recipient of Corporation funds also receives funds from private sources, the latter funds may not be expended for any purpose prohibited by the Act. Funds received from public sources, however, may be spent "in accordance with the purposes for which they are provided."

The appropriations statute for fiscal year 1994 (P.L. 103–121) provided that "none of the funds appropriated by this Act for the Legal Services Corporation shall be expended for any purpose prohibited or limited by or contrary to any of the provisions of * * *" the appropriations statute for fiscal year 1991 (P.L. 101–515). Public Law 101–515 prohibited the use of Federal funds "to participate in any litigation with respect to abortion." It also limited the use of Federal funds for class actions, lobbying, representing illegal aliens, and other matters. However, limitations on the actions of the LSC board of directors which were contained in Public Law 101–515, have been eliminated in Public Law 103–121.

(B) OLDER AMERICANS ACT

Support for legal services under the Older Americans Act (OAA) was a subject of interest to both the Congress and the Administration on Aging (AOA) for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were made at the 1971 White House Conference on Aging. Regulations promulgated by the AOA in 1973 made legal services eligible for funding under Title III of the OAA. Subsequent reauthorizations of the OAA contained provisions relating to legal services. In 1975, amendments granted legal services priority status. The 1978 Amendments to the OAA established a funding mechanism and a program structure for legal services. The 1981 amendment required that area agencies on aging spend "an adequate proportion" of social service funding for three categories, including legal services, as well as access and in-home services, and that "some funds" be expended for each service. The 1984 amendments to the Act retained the priority, but changed the term to "legal assistance", and required that an "adequate proportion" be spent on "each" priority service. In addition, area agencies were to annually document funds expended for this assistance. The 1987 amendments specified that each State unit on aging must designate a "minimum percentage" of Title III social services funds

that area agencies on aging must devote to legal assistance and the other two priority services. If an area agency expends at least the minimum percentage set by the State, it will fulfill the adequate proportion requirement. Congress intended the minimum percentage to be a floor, not a ceiling, and has encouraged area agencies to devote additional funds to each of these service areas to meet local needs.

The 1992 amendments modified the structure of the Title III program through a series of changes designed to promote services that protect the rights, autonomy, and independence of older persons. One of these changes was the shifting of some of the separate Title III service components to a newly authorized Title VII, Vulnerable Elder Rights Protection Activities. State legal assistance development services was one of the programs shifted from Title III to Title VII.

In order to be eligible for Title VII elder rights and legal assistance development funds, State agencies must establish a program that provides leadership for improving the quality and quantity of legal and advocacy assistance as part of a comprehensive elder rights system. State agencies are required to provide assistance to area agencies on aging and other entities in the State that assist older persons in understanding their rights and benefiting from services available to them. Among other things, State agencies are required to establish a focal point for elder rights policy review, analysis, and advocacy; develop statewide standards for legal service delivery, provide technical assistance to AAAs and other legal service providers, provide education and training of guardians and representative payees; and promote pro bono programs. State agencies are also required to establish a position for a State legal assistance developer who will provide leadership and coordinate legal assistance activities within the State.

The OAA also requires area agencies to contract with legal services providers experienced in delivering legal assistance and to involve the private bar in their efforts. If the legal assistance grant recipient is not a LSC grantee, coordination with LSC-funded programs is required.

Another mandate under the OAA requires State agencies on aging to establish and operate a long-term care ombudsman program to investigate and resolve complaints made by, or on behalf of, residents of long-term care facilities. The 1981 amendment to the OAA expanded the scope of the ombudsman program to include board and care facilities. The OAA requires State agencies to assure that ombudsmen will have adequate legal counsel in the implementation of the program and that legal representation will be provided. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AOA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal, and protective services activities for older people and to assure coordination of these activities. State ombudsman reports and a survey by the AARP conducted in 1987 indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to the records of resi-

dents and facilities, provide consultation to ombudsmen on law and regulations affecting institutionalized persons, represent clients referred by ombudsman programs, and work with ombudsmen and others to change policies, laws, and regulations that benefit older persons in institutions.

In other initiatives under the OAA, the AOA began in 1976 to fund State legal services developer positions—attorneys, paralegals, or lay advocates—through each State unit on aging. These specialists work in each State to identify interested participants, locate funding, initiate training programs, and assist in designing projects. They work with legal services offices, bar associations, private attorneys, paralegals, elderly organizations, law firms, attorneys general, and law schools.

In addition, the 1984 amendments also mandated that AOA fund national legal support centers. In fiscal year 1992, AOA awarded funds for legal services to support the following organizations: the National Senior Citizens Law Center; Legal Counsel for the Elderly (sponsored by the AARP); the ABA's Commission on Legal Problems of the Elderly; the Center for Social Gerontology; the Pension Rights Center; the National Clearinghouse for Legal Services, Inc.; the Mental Health Law Project; and the National Consumer Law Center. These projects received continuation awards in 1993. Continuation funding was also awarded to three demonstrations of statewide legal hotlines. Another demonstration grant, to determine the efficacy of background checks on potential Social Security representative payees, was active throughout the year.

Today, OAA funds support over 600 legal programs for the elderly in greatest social and economic need. The 1987 amendments to OAA required that beginning in fiscal year 1989, the Assistant Secretary collect data on the funds expended on each type of service, the number of persons who receive such services, and the number of units of services provided.

In 1990, the Special Committee on Aging surveyed all State offices on aging regarding Title III funded legal assistance. Key findings of the survey include: (1) 18 percent of States contract with law school programs to provide legal assistance under Title III–B of the Act and 35 percent contract with nonattorney advocacy programs to provide counseling services; (2) a majority of States polled (34) designated less than 3 percent of their Title III–B funds to legal assistance; (3) minimum percentage of Title III–B funds allocated by area agencies on aging to legal assistance ranged from 11 percent down to 1 percent; and (4) only 65 percent of legal services developers are employed on a full-time basis and only 38 percent hold a law degree.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, either provide services directly or contract with public and nonprofit social service agencies to provide social services to individuals and families. In general, States determine the type of social services to provide and for whom they shall be provided. Services may include legal aid. Because the Omnibus Budget Reconciliation Act of 1981 eliminated much of the reporting requirements included in the Title XX program, little information

has been available on how States have responded to both funding reductions and changes in the legislation. As a result, little data have been available on the number and age groups of persons being served. In 1993, however, Title XX was amended to require that certain specified information be included in each State's annual report and that HHS establish uniform definitions of services for use by States in preparing these reports. The specified information required includes the number and ages of persons being served and the types of services provided. Therefore, in the future it should be easier to determine the amount of SSBG funding for legal services to the elderly.

2. Issues

(A) NEED AND AVAILABILITY OF LEGAL SERVICES

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. This is partially due to the complex nature of the programs under which the elderly are dependent. After retirement, most older Americans rely on government-administered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security program for income security and on the Medicare and Medicaid programs to meet their health care needs. These benefit programs are extremely complicated and often difficult to understand.

In addition to problems with government benefits, older persons' legal problems typically include consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to institutions, nursing home and probate matters. Legal representation is often necessary to help the elderly obtain basic necessities and to assure that they receive benefits and services to which they are entitled.

Due to the increasing victimization of seniors by consumer fraud artists, on September 24, 1992, the Special Committee on Aging convened a hearing entitled "Consumer Fraud and the Elderly: Easy Prey?" The Committee sought to determine whether senior citizens are easy prey for persons that seek to take their money. The evidence suggests that seniors are often the target of unscrupulous people that will sell just about anything to make a dollar. It matters little that the services or products that these individuals sell are of little value, unnecessary, or at times nonexistent.

The purpose of the hearing was to provide a forum for discussion of what various States are doing to combat consumer fraud that targets the elderly, and to examine what the Federal Government might do to support these efforts. The hearing focused not only on the broad issue of consumer fraud that targets older Americans, but more specifically, the areas of living trusts, home repair fraud, mail order fraud, and guaranteed giveaway scams. The States have generally taken the lead in addressing this kind of fraud through law enforcement and prosecution. The hearing illustrated, however, that the Federal Government needs to do more. The Legal Services Corporation is one of the weapons in the Federal arsenal that could be used to combat this type of fraud.

Legal Services Corporation programs do not necessarily specialize in serving older clients but attempt to meet the legal needs of

the poor, many of whom are elderly. It is estimated that approximately 9 million persons over 60 are LSC-eligible.

There is no precise way to determine eligibility for legal services under the Older Americans Act because, although services are to be targeted on those in economic and social need, means testing for eligibility is prohibited. Nevertheless, a paper developed by several legal support centers in 1987 concluded that, in spite of advances in the previous 10 years, the need for legal assistance among older persons is much greater than available OAA resources can meet.

The availability of legal representation for low-income older persons is determined, in part, by the availability of funding for legal services programs. In recent years, there has been a trend to cut Federal dollars to local programs that provide legal services to the elderly. There is no doubt that older persons are finding it more difficult to obtain legal assistance. When the Legal Services Corporation was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of two legal services attorneys for every 10,000 poor people. The goal of minimum access was achieved in fiscal year 1980 with an appropriation of $300 million, and in fiscal year 1981, with $321 million. This level of funding met only an estimated 20 percent of the poor's legal needs. Currently, the LSC is not even funded to provide minimum access. In most States, there is only 1 attorney for every 10,000 poor persons. In contrast, there are approximately 28 lawyers for every 10,000 persons above the Federal poverty line.

The Private Attorney Involvement (PAI) project under LSC requires each LSC grantee to spend at least 12.5 percent of its basic field grant to promote the direct delivery of legal services by private attorneys, as opposed to LSC staff attorneys. The funds have been primarily used to develop pro bono panels, with joint sponsorship between a local bar association and a LSC grantee. Over 350 programs currently exist throughout the country. Data indicates that the PAI requirement is an effective means of leveraging funds. A higher percentage of cases were closed per $10,000 of PAI dollars than with dollars spent supporting staff attorneys.

It should be noted, however, that these programs have been criticized by Legal Services staff attorneys. They claim that these programs have been unjustifiably cited to support less LSC funding and to the diversion of cases from LSC field offices. Cuts in funding have decreased the LSC's ability to meet clients' legal needs. Legal services field offices report that they have had to scale down their operations and narrow their priorities to focus attention on emergency cases, such as evictions or loss of means of support. Legal services offices must now make hard choices about whom they serve.

The private bar is an essential component of the legal services delivery system for the elderly. The expertise of the private bar is considered especially important in areas such as will and estates as well as real estate and tax planning. Many elderly persons, however, cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stem from their dependence on public benefit programs. The private bar generally is unable to undertake rep-

resentation in these matters because it requires familiarity with a complex body of law and regulations, and there is a little chance of collecting a fee for services provided. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee basis, the potential of the private bar has yet to be fully realized.

(B) LEGAL SERVICES CORPORATION

(1) Board Appointments

The Legal Services Corporation Act provides that "[t]he Corporation shall have a Board of Directors consisting of 11 voting members appointed by the President, by and with the advice and consent of the Senate, no more than 6 of whom shall be of the same political party." President Clinton nominated 11 new Board members, all of whom were confirmed on October 21, 1993.

(2) Status of Legal Services Corporation

Few people disagree that provision of legal services to the elderly is important and necessary. However, people continue to debate how to best provide these services. President Reagan repeatedly proposed termination of the federally funded Legal Services Corporation and the inclusion of legal services activities in a social services block grant. Funds then provided to the Corporation, however, were not included in this proposal. This block grant approach was consistent with the Reagan Administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and allowing States to make funding decisions regarding legal services would make the program accountable to elected officials.

The Reagan Administration also revived earlier charges that legal services attorneys are more devoted to social activism and to seeking collective solutions and reform than to routine legal assistance for low-income individuals. These charges resparked a controversy surrounding the program at the time of its inception as to whether Federal legal aid is being misused to promote liberal political causes. The poor often share common interests as a class, and many of their problems are institutional in nature, requiring institutional change. Because legal resources for the poor are a scarce commodity, legal services programs have often taken group-oriented case selection and litigation strategies as the most efficient way to vindicate rights. The use of class action suits against the government and businesses to enforce poor peoples' rights has angered some officials. Others protest the use of class action suits on the basis that the poor can be protected only by procedures that treat each poor person as a unique individual, not by procedures which weigh group impact. As a result of these charges, the ability of legal services attorneys to bring class action suits has been severely restricted.

The Reagan Administration justified proposals to terminate the Legal Services Corporation by stating that added pro bono efforts by private attorneys could substantially augment legal services

funding provided by the block grant. It was believed that this approach would allow States to choose among a variety of service delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the Corporation.

Supporters of federally funded legal services programs argue that neither State nor local governments nor the private bar would be able to fill the gap in services that would be created by the abolition of the LSC. They cite the inherent conflict of interest and the State's traditional nonrole in civil legal services which, they say, makes it unlikely that States will provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. They believe that private lawyers have limited desire and ability to do volunteer work. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are less likely to have this experience or the interest in dealing with the types of problems that poor people encounter.

Defenders of LSC believe that the need among low-income people for civil legal assistance exceeds the level of services currently provided by both the Corporation and the private bar. Elimination of the Corporation and its funding could further impair the need and the right of poor people to have access to their government and the justice system. They also contend that it is inconsistent to assure low-income people representation in criminal matters, but not in civil cases.

3. Federal and Private Sector Response

(A) LEGISLATION

(1) The Legal Services Corporation

The 1974 LSC Act was reauthorized for the first and only time in 1977 for an additional 3 years. Although the legislation authorizing the LSC expired at the end of fiscal year 1980, the agency has operated under a series of continuing resolutions and appropriations bills, which have served both as authorizing and funding legislation. The Corporation is allowed to submit its own funding requests to Congress. In fiscal year 1985, Congress began to earmark the funding levels for certain activities to ensure that congressional recommendations were carried out. In addition to original restrictions, the legislation for fiscal year 1987 included language that provided that the legislative and administrative advocacy provisions in previous appropriations bills and the Legal Services Corporation Act of 1974, as amended, shall be the only valid law governing lobbying and shall be enforced without regulations. This language was included because the Corporation published proposed regulations that were believed to go far beyond the restrictions on lobbying which are contained in the LSC statute.

For fiscal year 1988, Congress appropriated $305.5 million for the LSC. Congress also directed the Corporation to submit plans and proposals for the use of funding at the same time it submits its budget request to Congress. This was deemed necessary because the appropriations committees had encountered great difficulty in

tracing the funding activities of the Corporation and received very little detail from the Corporation about its proposed use of the funding request, despite repeated requests for this information. The Corporation is prohibited from imposing requirements on the governing bodies of recipients of LSC grants that are additional to, or more restrictive than, provisions already in the LSC statute. This provision applies to the procedures of appointment, including the political affiliation and length of terms of office, and the size, quorum requirements, and committee operations of the governing bodies.

(2) Older Americans Act

In response to prior conflict between legal assistance providers and area agency staff over confidentiality and reporting, the 1987 amendments to the Older Americans Act (OAA) (P.L. 100–175) specifically provided that State and area agencies may not require Title III legal providers to reveal information that is protected by the attorney-client privilege.

The OAA 1987 amendments also required the State agency to establish a minimum percentage of Title III–B funds that each area agency must spend on legal services. In addition, prior to granting a waiver of this requirement, the State agency must provide a 30-day notice period during which individuals or providers may request a hearing, and must offer the opportunity for a hearing to any individual or provider who makes such a request. Area agencies on aging are encouraged to devote additional funds to legal services, as well as access and in-home services, to meet local needs.

The OAA was reauthorized in 1992. In preparation for the reauthorization, the Special Committee on Aging convened a series of workshops, one of which focused on legal assistance. Based on the findings from an Aging Committee workshop series, Chairman Pryor introduced legislation (S. 974) which included provisions to strengthen legal assistance services authorized by the Act. Key provisions which were incorporated into the final reauthorization package (P.L. 102–375) include: (1) A requirement that AOA develop guidelines for area agencies to follow in choosing and evaluating legal assistance providers, and (2) a requirement that area agencies develop a model job description for the legal services developer position. The 1992 amendments also transferred State legal assistance development services from Title III to a newly authorized Title VII entitled Vulnerable Elder Rights Protection Activities. Title VII authorizes support for legal assistance programs administered by State agencies on aging.

(B) ACTIVITIES OF THE PRIVATE BAR

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments began to devote more of their time to the poor on a pro bono basis. Such programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provisions of legal services to the disadvantaged. Although pro bono programs are gaining

momentum, there is no precise way to determine the number of lawyers actually involved in the volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys.

A relatively recent development in the delivery of legal services by the private bar has been the introduction of the Interest on Lawyers' Trust Accounts (IOLTA) program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts is then channeled to federally funded, bar affiliated, and private and nonprofit legal services providers. IOLTA programs have grown rapidly. There was one operational program in 1983. Today 47 States and the District of Columbia have adopted IOLTA programs that are bringing in funds at a rate of $42 million per year. An American Bar Association study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. The California IOLTA program specifically allocates funds to those programs serving the elderly. Although many of the IOLTA programs are voluntary, the ABA passed a resolution at its February 1988 meeting suggesting that IOLTA programs be mandatory to raise funds for charitable purposes.

Supporters of the IOLTA concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of a paying client who is not ordinarily apprised of how the money is spent. Supporters point out that attorneys and law firms have traditionally pooled their client trust funds, and it is difficult to attribute interest to any given client. Prior to IOLTA, the banks have been the primary beneficiaries of the income. While there is no unanimity at this time among lawyers regarding IOLTA, the program appears to have value as a funding alternative.

In 1977, the president of the American Bar Association was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the ABA in 1979. The Commission is charged with examining six priority areas: the delivery of legal services to the elderly; age discrimination; simplification of administrative procedures affecting the elderly; long-term care; Social Security; and housing. In addition, since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The Commission on Legal Problems of the Elderly has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs of the aged. One such activity was a national bar activation project, which provided technical assistance to State and local bar associations, law firms, corporate counsel, legal service

projects, the aging network, and others in developing projects for older persons.

The private bar has also responded to the needs of elderly persons in new ways on the State and local levels. A number of State and local bar association committees on the elderly have been formed. Their activities range from legislative advocacy on behalf of seniors and sponsoring pro bono legal services for elderly people to providing community legal education for seniors. Other State and local projects utilize private attorneys to represent elderly clients on a reduced fee or pro bono basis. In more than 38 States, handbooks that detail seniors' legal rights have been produced either by State and area agencies on aging, legal services offices, or bar committees. In addition, some bar associations sponsor telephone legal advice lines. Since 1982, attorneys in more than half the States have had an opportunity to attend continuing legal education seminars regarding issues affecting elderly people. The emergence of training options for attorneys that focus on financial planning for disability and long-term care are particularly noteworthy.

In 1987, the Academy of Elder Law Attorneys was formed. The purpose of this organization is to assist attorneys advising elderly clients, to promote high technical and ethical standards, and to develop awareness of issues affecting the elderly.

A few corporate law departments also have begun to provide legal assistance to the elderly. For example, Aetna Life and Casualty developed a pro bono legal assistance to the elderly program in 1981 through which its attorneys are granted up to 4 hours a week of time to provide legal help for eligible older persons. The Ford Motor Company Office of the General Counsel also began a project in 1986 to provide pro bono representation to clients referred by the Detroit Senior Citizens Legal Aid Project.

As recognized by the American Bar Association, private bar efforts alone fall far short in providing for the legal needs of older Americans. The ABA has consistently maintained that the most effective approach for providing adequate legal representation and advice to needy older persons is through the combined efforts of a continuing Legal Services Corporation, an effective Older Americans Act program, and the private bar. With increased emphasis on private bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal services programs for the elderly exists.

F. PROGNOSIS

Despite Federal funding cutbacks, States will continue to spend as much of their block grant funds on social services for older persons as feasible. However, these expenditures will focus increasingly on emergency services rather than on coordinated long-term services. States will find it increasingly necessary to utilize multiple funding sources to support their programs for the elderly. The new reporting laws which require more specified information will help to determine how the funds are used and how many elderly are served by them.

The National Adult Literacy Survey conducted in 1992 should help to better determine the actual size and scope of the literacy

problem amongst the elderly in this country. Additional funding could be used to encourage research into programs that work and provide seed money for promising techniques. The complexity of the issue—and its relation to national productivity, security, and welfare—suggests the need for a Federal concern beyond program funding or public awareness campaigns.

The Older Americans Volunteer Programs and VISTA will continue to receive broad bipartisan support because these programs have proven to be cost-effective, with measurable human benefits as well.

In view of increasingly limited Federal participation in transportation services, the role of State and local governments in the transportation area will become of major significance to needy elderly and persons with disabilities. States will need to reassess priorities and focus attention on replacing Federal funding through increased State or local taxes or simply eliminating certain services. Although private sector contributions have played a significant role in social service delivery, it is unlikely that this revenue source will be adequate to close the gaps opened by Federal budget cuts in the area of specialized transportation services. Another resource—volunteer activities—has always been important in providing transportation services to older Americans. A report for the Administration on Aging on the transportation problems of older Americans indicated that many agencies serving the elderly already use volunteers extensively in their programs. Given the limited resources which may be anticipated over the next decade, efforts to increase the role of volunteers are likely to become increasingly important.

It is a basic tenet in our society that those who live under the law should also have an opportunity to use the law. Access to the legal system for all persons is basic to our democratic system of government and the fundamental purpose of the Legal Services Corporation Act. The federally funded legal services program represents a significant improvement in the system of dispensing justice in this country and has gone a long way to alleviate the harsh consequences of being poor and unable to afford legal services. If we are to continue to make progress in the goal of equal justice and access for all, adequate funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

While all of the Nation's social services programs provide a vital role in linking persons to needed services, there remains the difficulty of effectively tying the programs together. Despite the current trend toward coordinating various funding sources for programs, separate reporting requirements and other administrative obstacles continue to hinder these efforts. Advocates, however, remain hopeful that the new administration and an invigorated economy will provide the support necessary to stimulate further efforts in this direction.

Chapter 16

CRIME AND THE ELDERLY

A. VIOLENT CRIME

1. BACKGROUND

Violence is increasing dramatically in the United States. Americans are concerned, angry, and fearful for their personal safety. In fact, a May 1993 poll conducted by Mellman, Lazarus, and Lake reports that 29 percent of Americans have been a victim or had a family member be a victim of crime in the last 3 years; 55 percent of Americans believe that they will be a victim of crime; and 86 percent of Americans list crime as an important personal fear.

The latest crime statistics released by the Federal Bureau of Investigation, in October 1995, proves that the fears of these Americans are not unfounded. The Uniform Crime Reports (UCR) show that violent crimes reported in 1994 exceeded 1.7 million offenses. According to the UCR, in the United States there is one violent crime every 18 seconds, one murder every 24 minutes, one forcible rape every 5 minutes, one robbery every 54 seconds, and one aggravated assault every 29 seconds.

Although recent evidence suggests that older Americans are less likely than younger Americans to be a victim of crime, they are more likely when victimized to be harmed by strangers and to sustain grievous injuries.

In October 1992, the Bureau of Justice Statistics (BJS) released a report, entitled *Elderly Victims,* which presents some of the most recent information on crime and the elderly. According to the BJS, violent crime victimization rates among the elderly were the highest in 1974 when the rate was 9 victimizations per 1,000 people age 65 and older, compared to 3.5 per 1,000 in 1990, a 61-percent decline.

Some of the major findings in the report include:

> The elderly were significantly less likely than younger age groups to become a victim of virtually any type of crime. People who are 65 years old or more comprise about 14 percent of the U.S. population, but make up less than 2 percent of the victims;
>
> Elderly robbery victims were more likely than younger victims to face multiple offenders and offenders armed with guns;
>
> Elderly victims of violent crime were more likely than other victims to be harmed by strangers. Among homicide victims, the elderly were also more likely to be killed by a stranger during the commission of a felony;

Elderly victims of violent crime were significantly more likely to be victimized at or near their home than victims under the age of 65;

Elderly victims of all forms of crime, including crimes of violence, crimes of theft, and household crime, were significantly more likely to report their victimizations to the police compared to victims under the age of 65;

When the elderly were divided into two groups, age 65 to 74 and age 75 or older, the older group was generally found to have lower rates of crime victimization;

Among the elderly, certain groups were generally more likely to experience crime than others—males, African-Americans, divorced or separated persons, urban residents, and renters. Those elderly in the lowest income categories were more likely to experience a crime of violence, but less likely to experience a crime of theft than those with higher household incomes.

The BJS report also found that the lifestyle of older persons may affect their vulnerability to certain crimes. When compared to other age groups, the report found that, "the elderly are more likely to live alone and to stay at home because they are less likely to work full time or regularly participate in activities after dark." Further, the report found that "these characteristics or routines may contribute to the elderly having a lower likelihood of assault or robbery by a relative or acquaintance." Thus, elderly victims of violent crime are proportionately more likely than victims in other age groups to be victimized by strangers.

While this seems to be encouraging news, there are special considerations that arise when an older person falls victim to crime. The impact of crime on the lives of older adults is likely to be greater than on other population groups given their special vulnerabilities. They are more likely to be injured, take longer to recover, and incur greater proportional losses to income. About 60 percent live in urban areas, where crime is more prevalent. Often, the elderly live in social isolation and in many instances, they are unable to defend themselves against their attackers. Because they rarely have insurance or coverage through their place of employment, the financial impact of crime can be devastating to older victims. Seniors often have to carry the full burden of the cost of the crime since many live on income from Social Security or some other form of fixed income.

Emotionally, crime victimization of the elderly can be traumatic, having a devastating effect on older Americans.

2. Congressional Response

During 1993, several bills were introduced in both Houses of Congress that focused on crime and the elderly. Some bills introduced early in the year were later included in H.R. 3355, the Violent Crime Control and Law Enforcement Act of 1993 (crime bill), which passed both houses.

On January 5, 1993, Representative Gerald Solomon introduced H.R. 388, a bill to amend the Federal criminal code to impose mandatory sentences for violent felonies committed against individuals age 65 and over. The bill would prohibit suspended, probationary, and concurrent sentences. Further, H.R. 388 would prohibit parole

and any plea bargaining agreements that would result in the defendant serving less than the minimum sentence. H.R. 388 was referred to the House Committee on the Judiciary.

Two related bills were introduced on November 10, 1993. H.R. 3494, Let's Protect Our Seniors Act of 1993, was introduced by Representative Bob Franks. This bill would amend the Federal criminal code to double the imprisonment penalty for crimes committed against the elderly. It was referred to the House Committee on the Judiciary. Also, H.R. 3501, the Senior Citizen Protection Act of 1993, was introduced by Representative Thomas J. Manton. H.R. 3501 would impose mandatory sentences for crimes of violence and fraud against senior citizens. It was referred to the Committees on Banking, Finance, and Urban Affairs, Energy and Commerce, Ways and Means, and the Judiciary.

On June 8, 1995, Representative Chrysler introduced H.R. 1794, the Crimes Against Youth and Elderly Double Penalty Act. Senator Helms introduced a related bill on May 8, 1996. S. 1733 is the Crimes Against Children and Elderly Persons Increased Punishment Act, which proposed to stiffen the punishment, by an average of 50 percent, for criminals who prey on the vulnerable in society by committing violent crimes—including carjacking, assault, rape, and robbery. More specifically, the bill directs the U.S. Sentencing Commission to increase sentences by five levels above the offense level otherwise provided if a Federal violent crime is committed against an elderly person. The measure passed the House on May 7, 1996 and was referred to the Senate Committee on the Judiciary.

On November 19, 1993, the Senate passed omnibus crime legislation, S. 1607, the Violent Crime Control and Law Enforcement Act. This bill contains several provisions that focus on violent crime toward the elderly.

(A) TITLE VIII—SEXUAL VIOLENCE AND ABUSE OF CHILDREN, THE ELDERLY, AND INDIVIDUALS WITH DISABILITIES

As introduced, S. 1607 included provisions to develop a national background check procedure to ensure that persons working or volunteering with children do not have criminal histories of child abuse or other crimes against children. Specifically, the bill establishes national guidelines on the format, accuracy, content, and timeliness of information provided by States to the FBI on child abuse crimes, and promotes cooperation among States and national child abuse prevention organizations in developing a nationwide system through which background checks can be performed.

The bill does not mandate States to require background checks for individuals working with children, but does encourage such checks by making the information from other States through the FBI National Crime Information Center (NCIC) system more accurate and available. Because current FBI information on child abuse is deficient, States are often unable to get complete nationwide information on whether a potential employee has ever been convicted of child abuse offenses or similar offenses in another State.

The provisions of S. 1607 include standard information that can be requested for background checks and procedural due process rights for the job applicant whose records are being checked (such

as right to obtain the report and to challenge the accuracy of the information found). The bill also includes privacy protections on the use and reuse of the information obtained through the background checks.

During Senate consideration of the crime bill, Senator William Cohen (R–ME), Ranking Member of the Special Committee on Aging, offered an amendment to extend these provisions to allow background checks of job applicants for home care workers and others who work with the elderly and the disabled. While elder abuse does not raise precisely the same issues as child abuse, many of the same opportunities for exploitation exist with these populations.

Current statistics state that 6.3 percent of all elder abuse cases in the home are caused by a service provider. Senator Cohen's amendment recognizes that the growing trend toward home care, as well as the significant growth in the size of the aging population, makes it important to ensure that individuals needing home care, as well as their families, have confidence in the individuals they hire to provide services. Senator Cohen's amendment was adopted by the Senate by voice vote.

Subsequent to passage of the Senate crime bill, the Senate and House passed separate legislation, H.R. 1237, the National Child Protection Act of 1993, which allows access to NCIC information to child care providers. This legislation, however, did not extend access to such data to those providing care to the elderly or individuals with disabilities. Extension of these provisions to these populations will be considered during the conference on the omnibus crime legislation.

(B) TITLE IX—CRIME VICTIMS, SUBTITLE C—SENIOR CITIZENS

This subtitle would establish the National Triad Program Act, requiring the Director of the National Institute of Justice (NIJ) to conduct a qualitative and quantitative national assessment of: (1) The nature and extent of crimes committed against senior citizens and the effect of such crimes on the victims; (2) the numbers, extent, and impact of violent and nonviolent crimes against senior citizens and the extent of unreported crime; (3) the collaborative needs of law enforcement, health, and social service organizations focused on crime prevention against senior citizens, to identify, investigate, and provide assistance to crime victims; and (4) the development and growth of strategies to respond effectively to such matters.

Subtitle C would direct the Director of NIJ to make grants to coalitions of local law enforcement agencies and senior citizens to assist in the development of programs and to execute field tests of particularly promising strategies for crime prevention and related services, using the Triad model, which generally calls for the participation of the sheriff, at least one police chief, and a representative of at least one senior citizens' organization within a county. The programs and strategies would then be evaluated and serve as the basis for further demonstration and education projects.

Subtitle C would require the Director to make awards to: (1) Organizations with demonstrated ability to provide training and technical assistance in establishing crime prevention programs based on the Triad model for purposes of aiding in the establishment and

expansion of pilot programs; (2) research organizations to evaluate the effectiveness of selected pilot programs, and to conduct research and development identified as being critical; and (3) public service advertising coalitions to increase public awareness and promote ideas or programs to prevent crimes against senior citizens.

Earlier in the year three bills were introduced to establish a National Triad Program, H.R. 1161, S. 205, and S. 451, sponsored by Representative Charles H. Taylor, Senators William V. Roth, and J. Bennett Johnston, respectively. Senator Johnston's bill was included in S. 1607.

(C) TITLE XX—PROTECTIONS FOR THE ELDERLY

This title would establish the Missing Alzheimer's Disease Patient Alert Program. It directs the Attorney General to make grants in support of programs to protect and locate missing patients with Alzheimer's disease and related dementias. Additionally, it directs the U.S. Sentencing Commission to amend the sentencing guidelines to ensure that the sentences for those convicted of crimes of violence against elderly victims are sufficiently stringent to deter such crimes, protect the public from additional crimes by a convicted criminal, and provide stiffer penalties. The criteria for enhanced penalties require that the guidelines provide increasingly severe punishment for a defendant commensurate with the degree of physical harm caused to the elderly victim; take into account the vulnerability of the victim; and provide enhanced punishment for a defendant (who has previously been convicted more than once of a crime of violence against an elderly victim, regardless of whether the conviction occurred in Federal or State court) convicted of a crime of violence against an elderly victim.

In the House of Representatives, H.R. 3355 was introduced and referred to the Committee on the Judiciary on October 10, 1993. The Judiciary Committee considered the bill and held a markup session; and thereafter ordered the measure to be reported out of committee as amended on October 28, 1993. The bill was reported to the full House as amended on November 3, 1993. On that same day, H.R. 3355 passed by voice vote, under suspension of the rules (two-thirds vote required). The measure was sent to the Senate on November 4, 1993.

On November 19, 1993, the Senate struck all language after the enacting clause of H.R. 3355 and inserted in lieu thereof the text of S. 1607, as amended, by the Senate. S. 1607 was introduced by Senator Joseph Biden on November 1, 1993. H.R. 3355, as amended, passed the Senate by a margin of 95–4 on November 19, 1993. The Senate insisted on its amendment and requested a conference with the House on the same day.

B. ELDER ABUSE

1. BACKGROUND

An issue of family violence that continues to cause concern within the aging community is elder abuse. State law definitions of elder abuse vary considerably. Federal definitions of elder abuse, neglect, and exploitation appeared for the first time in the 1987 amendments to the Older Americans Act. However, these defini-

tions were provided in the law only as guidelines for identifying the problems and not for enforcement purposes. The American Medical Association describes elder abuse as acts of commission or omission that result in harm or threatened harm to the health or welfare of an older adult.

In order to address the issue of elder abuse, the Senate Special Committee on Aging hosted a roundtable discussion entitled *Elder Abuse and Violence Against Midlife and Older Women.* The discussion focused particularly on addressing the concerns of women as they age, particularly looking at what can be done in local communities and at the State and national levels to reduce the incidence of crime against older women. Senators Pryor and Cohen focused on how the Senate might address the issue in legislation, urging better reporting of elder abuse, prevention of violence and abuse, crime reform, and increased education and training.

The National Center on Elder Abuse (NCEA) identifies three basic categories of elder abuse. These definitions are based on an analysis of existing State and Federal definitions of elder abuse, neglect, and exploitation conducted by the Center in 1995.

(1) *Domestic elder abuse.*—Refers to any of several forms of mistreatment of an older person by someone who has a special relationship with the elder in their home or in the home of a caregiver. For example, a spouse, sibling, child, friend, or caregiver. There are five types of domestic abuse.

Physical abuse, the intentional use of physical force that results in bodily injury, pain, or impairment.

Sexual abuse, the nonconsensual sexual contact of any kind with an older person.

Emotional or psychological abuse, the willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal abusive conduct.

Neglect, the willful or nonwillful failure by the caregiver to fulfill his/her care-taking obligation or duty.

Financial or material exploitation, the unauthorized use of funds, property, or resources of an older person.

(2) *Institutional abuse.*—Refers to any of the above-mentioned forms of abuse that occur in institutional or residential facilities that provide board and care for the elderly. Perpetrators of institutional abuse usually are persons who have a legal or contractual obligation to provide elder victims with care and protection.

(3) *Self-neglect or self-abuse.*—Refers to the neglectful or abusive conduct of an older person directed at himself/herself that threatens the person's safety. Self-neglect usually occurs as a result of the older person's physical or mental impairment or in a situation where the older person is socially isolated.

Whether or not elder abuse is considered a crime depends on State law. Generally, physical, sexual, and financial/material abuses are considered crimes. In some instances, emotional abuse and neglect are crimes. However, self-neglect is not a crime in any State.

It is difficult to obtain accurate information on the extent of elder abuse and neglect in the United States. According to NCEA, elder abuse is far less likely to be reported than child abuse, which has

gained greater public awareness. Too often cases go unreported because victims may be embarrassed, intimidated, or overwhelmed by the situation, and many may be unaware of the availability of help. In 1994 the NCEA conducted a national study of domestic elder abuse.[1] Data on elder abuse reports were collected from state adult protective service agencies and state units on aging across the Nation. Presented below are selected findings from that survey:

- From 1986 to 1994 there has been a steady increase in the reporting of domestic elder abuse nationwide: 117,000 reports in 1986, 128,000 reports in 1987, 140,000 reports in 1988, 211,000 reports in 1990, 213,000 reports in 1991, 227,000 reports in 1993, and 241,000 reports in 1994. This 1994 figure represents an increase of 106.0 percent since 1986.
- It is estimated that approximately 820,000 elders became victims of various types of domestic elder abuse in 1994. This figure, however, excludes self-neglecting elders. If self-neglecting elders are added, the total number of elder abuse victims would be 1.86 million individuals in the same year.
- The median age of elder abuse victims was 76.5 years, according to 1994 data that excluded self-neglecting elders. The median age of self-neglecting elders was 77.2 years in 1994.
- In 1994, 65.4 percent of the victims of domestic elder abuse were white, while 21.4 percent were black. In addition, Hispanic elders accounted for 9.6 percent of the domestic elder abuse victims in the same year, but the proportions of Native Americans and Asian Americans/Pacific Islanders were each less than 1 percent.

The number of elder abuse reports will continue to increase as the public and professionals gain greater awareness of the problem and as the elder population continues to grow.

The NCEA, together with its subcontractor Westat, has launched the Nation's first elder abuse incidence study, with funding from the Administration for Children and Families (ACF) and the Administration on Aging (AOA) of the U.S. Department of Health and Human Services (HHS). The study, scheduled for completion in the summer of 1997, will provide estimates of the national incidence of the abuse, neglect and exploitation of older people in domestic settings and information about the characteristics of domestic elder abuse victims, including self-neglecting elders. The American Public Welfare Association (APWA) will serve as the lead organization for the study, while Westat, Inc. will direct many of the technical tasks as APWA's subcontractor.

There are a number of Federal funding sources for elder abuse prevention services, including the Social Services Block Grant (SSBG) and the Older Americans Act (OAA). There are no Federal data on the amounts States use of their SSBG funds for these services. Elder abuse prevention services were, until recently, funded through Title VII of the OAA. Beginning in fiscal year 1995, Congress provided specific earmarks of funding for elder abuse prevention and long-term care ombudsman as part of the supportive services allotment under Title III. For fiscal year 1995–1997 these

[1] Source: http://interinc.com/NCEA/Statistics

amounts are for elder abuse prevention, $4.7 million; and for long-term care ombudsman, $4.4 million each year.

In fiscal year 1996, Federal funding for the National Elder Abuse Resource Center was $350,000; the Ombudsman Resource Center was funded at $100,000. In fiscal year 1997, the Elder Abuse Center and the Ombudsman Resource Center will both receive Federal grants of $200,000.

2. Congressional Response

H.R. 3355, discussed earlier, has two Titles addressing the problem of elder abuse, namely, Title VIII—Sexual Violence and Abuse of Children, the Elderly, and Individuals With Disabilities, and Title IX—Crime Victims, Subtitle C—Senior Citizens.

C. CONSUMER FRAUDS AND DECEPTIONS

1. Background

The age 65 and over market is a lucrative source of consumers, spending over $60 billion annually. This fact, combined with a number of age-related factors such as fixed income levels and chronic health conditions, contribute to making the elderly prime targets of consumer frauds and deceptions.

The 103rd and 104th Congresses held numerous hearings addressing consumer fraud and deception among the elderly. In 1993 the Senate Special Committee on Aging held a hearing entitled *Health Care Fraud as it Affects the Aging*. The hearing discussed how health care fraud puts our national health care system in a critical condition. The committee cited to a GAO report which estimated that 10 percent of the dollars we spend on health care in America are stolen through waste, fraud, and abuse. In 1993 it was estimated that $900 billion would be spent on medical care in the United States. That means that $90 billion, or 10 percent, would be lost through illegal or unethical activities.

In March 1996 the Senate Special Committee on Aging held a hearing entitled *Telescams Exposed: How Telemarketers Target the Elderly*. The hearing examined the dramatic increase in telemarketing fraud targeting senior citizens and what law enforcement is doing to crack down on these schemes. Telemarketing scams cost Americans about $40 billion a year, and they run the gamut from small fly by-night operators to sophisticated organized crime rings. In 1993 the FBI unveiled "Operation Disconnect", a national covert investigation targeting telephone boiler rooms that made millions of deceptive calls to consumers. Congress and the Federal Trade Commission also moved to crack down on telemarketing fraud by placing restrictions on when telemarketers can make calls and what can and cannot be included in their sales pitch. Based on the findings made by the committee and others, Congress also imposed tougher penalties on telemarketers who intentionally target senior citizens. At the hearing, the results of "Senior Sentinel"—a major covert investigation led by the FBI and using the cooperation and resources of many law enforcement agencies. Senior Sentinel used senior citizen volunteers to receive calls

by telemarketers who believed they were soliciting innocent victims. The taped conversations were then used as evidence of the outrageous and deceptive promises made by the callers. The tapes and transcripts of these conversations vividly illustrate how unscrupulous callers engage in what amounts to be "teleterrism by verbally abusing, insulting, and berating senior citizens when they call.

Ironically, as older Americans grow as a cumulative market with increasing consumer purchasing power, many elderly live close to the poverty line and have little disposable income. Consequently, crimes aimed at the pocketbooks of the elderly frequently have devastating effects on their victims.

There is little doubt that the older consumer is frequently targeted by unscrupulous marketeers who will sell just about anything to make a dollar. It matters little that the services or products they market are of little value, unnecessary, or at times nonexistent.

While there are several reasons why the elderly are disproportionately victimized, the older victims' accessibility is a major factor. Since they often spend most of their days at home, older consumers are easier to contact by telephone, mail, and in person. Additionally, many elderly consumers are homebound due to physical illness or disabilities. The dishonest telemarketer usually gets an answer when he or she telephones an older person. Door-to-door salespeople hawking worthless goods are more likely to find someone at home when they ring the doorbell of a retired person. Deceptive or fraudulent mass mailings are likely to be given more attention by retired individuals with more leisure time.

Unfortunately, the "con artists" who prey on the elderly, are extremely effective at defrauding their victims. To the poor, they make "get rich quick" offers; to the rich, they offer investment properties; to the sick, they offer health gimmicks and new discoveries to cure ailments; to the healthy, they offer attractive vacation tours; and to those who are fearful of the future, they offer a confusing array of useless insurance plans.

Con artists are well organized, sophisticated, and effective. Police authorities report that it is not uncommon for a con, upon leaving one successful location, to exchange the addresses of his easiest victims with another con who is just moving into the area. To avoid being caught, cons usually avoid leaving a paper trail. Whenever possible they deal in cash. They avoid written estimates, avoid properly drawn contracts, and insist on haste to take advantage of a "today only" special price. Increasingly, there are con artists who operate on a very sophisticated level. New technology provides a variety of new ways to defraud consumers. Now, schemes exist which victimize even the most cautious and skeptical among us.

One scheme brought to the attention of the Senate Special Committee On Aging by Arkansas Attorney General Winston Bryant, was the so-called "sweepstakes" or "free giveaways." A consumer receives a postcard which announces that she is entitled to claim one or more prizes. The award notice is professionally designed to appear legitimate. The postcard bears a toll-free telephone number and the consumer is instructed that he or she must simply call to claim the prizes. Once the toll-free number is accessed, a recording

instructs the consumer to touch numbers on the telephone which correspond with a "claim number" which appears on the postcard. Ultimately, the consumer receives no prize. What is received is a "telephone bill" which reflects a substantial charge for the call just as if a 900 number had been called. The entry of the sequence of numbers that matched the "claim number" engaged an automated information service for which the consumer is charged.

Consumer fraud that targets the elderly is widespread and is increasing. Nationwide, law enforcement and consumer specialists report frauds against the elderly. No area of the country, whether rural, or urban, is immune. Consumer fraud pervades nearly every aspect of an elderly person's life from health care to housing, from investment programs to travel promotions.

Like violent crime, consumer oriented crime has a devastating effect on the lives of older victims. Living on fixed incomes makes the financial loss to consumer fraud extremely difficult to recoup. Elderly consumers are more likely to be approached by the perpetrators of consumer fraud, and they are the least able to rebound from being victimized.

This problem is best attacked in two ways: (1) Interdiction, to put these criminals out of business, through detection, enforcement, and prosecution; and (2) a continuing education program to inform and educate seniors of the scams and deceptive practices to which they may be exposed. It is paramount that seniors learn they can fight consumer fraud by simply tossing out junk mail, hanging up the phone, or closing the front door.

SUPPLEMENT 1

BRIEF SYNOPSIS OF HEARINGS AND WORKSHOPS HELD IN 1994, 1995 AND 1996

The Senate Special Committee on Aging, convened three hearings and five field hearings during the 2nd Session of the 103rd Congress and in the 104th Congress the Committee convened 15 hearings, one field hearing, and two forums.

HEARINGS

April 12, 1994—Health Care Reform: The Long-Term Care Factor
May 4, 1994—Elder Abuse and Violence Against Midlife and Older Women
September 29, 1994—Uninsured Bank Products: Risky Business for Seniors
March 2, 1995—Problems in the Social Security Disability Programs: The Disabling of America
March 21, 1995—Gaming the Health Care System: Trends in Health Care Fraud
May 11, 1995—Planning Ahead Future Directions in Private Financing of Long-Term Care
June 27, 1995—Breakthroughs in Brain Research: A National Strategy to Save Billions in Health Care Costs
August 3, 1995—Federal Oversight of Medicare HMOS: Assuring Beneficiary Protection
October 26, 1995—Medicaid Reform: Quality of Care in Nursing Homes at Risk
November 2, 1995—Health Care Fraud: Milking Medicare and Medicaid
February 28, 1996—Hearing on Mental Illness Among the Elderly
March 6, 1996—Telescams Exposed: How Telemarketers Target the Elderly
March 28, 1996—Hearing on Adverse Drug Reactions in the Elderly
April 23, 1996—Alzheimer's Disease in a Changing Health Care System: Falling Through the Cracks
June 5, 1996—Stranded on Disability: Federal Disability Programs Failing Disabled Workers
July 30, 1996—Suicide and the Elderly: A Population At Risk
September 24, 1996—Social Security Reform Options: Preparing for the 21st Century
September 26, 1996—Investing in Medical Research: Saving Health Care and Human Costs

FIELD HEARINGS

March 30, 1994—Home Care and Community-Based Services: Overcoming Barriers to Access, Kalispell, MT

April 11, 1994—Medicare Fraud: An Abuse, Miami, FL
May 9, 1994—Long Term Care, Milwaukee, WI
May 18, 1994—Health Care Reform: Implications for Seniors, Lansing, MI
June 20, 1994—Fighting Family Violence: Response of the Health Care System, Bangor, ME
April 11, 1995—Society's Secret Shame: Elder Abuse and Family Violence, Portland, ME

FORUMS

May 14, 1996—The National Shortage of Geriatricians: Meeting the Needs of our Aging Population,
June 20, 1996—Forum on Nutrition and the Elderly: Savings for Medicare,

HOME CARE AND COMMUNITY-BASED SERVICES: OVERCOMING BARRIERS TO ACCESS, KALISPELL, MT, MARCH 30, 1994, THE HONORABLE CONRAD BURNS, PRESIDING

WITNESSES

Nancy Heyer, RN, director of Clinical Services, Partners in Home Care, Inc.
Ann F. Cook, director, Foster Grandparent and Senior Companion Programs, Missoula Aging Services
Bridget McGregor, director of Clinical Services, West Mont Home Health
Linda Iverson, manager, Kalispell Medical Equipment
Jerry Stoick, registered pharmacist, Stoick Drug
Robert J. Grady, registered pharmacist, Option Care
Joyce DeCunzo, supervisor, Home and Community Services Section, Montana Medicaid Services Division
Casey Blumenthal, director, Flathead County Home Health Agency
Judy Graham, health care provider, Kalispell Regional Hospital Home Care Agency

SYNOPSIS

This field hearing examined how cost-effective services are financed and looked at some of the barriers associated with these services. The hearing helped educate and train the public on these services.

MEDICARE FRAUD: AN ABUSE, MIAMI, FL, APRIL 11, 1994, THE HONORABLE BOB GRAHAM, PRESIDING

WITNESSES

Sharon Rager, family member of Fraud Victim, West Palm Beach
Luz E. Gual, family member of Fraud Victim, Fort Lauderdale
Ariela Rodriguez, Ph.D., A.C.S.W., Little Havana Activities and Nutrition Centers of Dade County, Inc.
Kendall Coffey, U.S. Attorney, Southern District of Florida
Albert Hallmark, Office of the Inspector General, Department of Health and Human Services, Atlanta, GA
George B. Clow III, special agent in charge, Miami Division, Federal Bureau of Investigation

John G. Morris, Jr., director, Florida Medicaid Fraud Control Unit

SYNOPSIS

This field hearing addressed the enforcement and prosecution of individuals who participated in fraudulent Medicare activities.

HEALTH CARE REFORM: THE LONG-TERM CARE FACTOR, WASHINGTON, DC, APRIL 12, 1994, THE HONORABLE DAVID PRYOR, PRESIDING

WITNESSES

Hon. Fernando Torres-Gil, assistant secretary for Aging, Administration on Aging, HHS, accompanied by Dr. Robyn Stone, deputy assistant secretary, Family, Community, and Long-Term Care Policy, and William Benson, deputy assistant secretary, Administration on Aging, HHS
Jane L. Ross, associate director, Income Security Issues, U.S. General Accounting Office
Hazel Chapman, Virginia Beach, VA, accompanied by Angela Chapman
Shirley Reed, caregiver, Washington, DC
Diane Rowland, executive director, Kaiser Commission on the Future of Medicaid
Gail Shearer, manager, Policy Analysis, Consumers Union
James Firman, president and CEO, United Seniors Health Cooperative
Mark Meiners, director, Robert Wood Johnson Foundation National Program Office, partnership for long-term care insurance

SYNOPSIS

This hearing examined the critical role long-term care plays in health care reform. The hearing explored how long-term care can affect several generations at a time.

ELDER ABUSE AND VIOLENCE AGAINST MIDLIFE AND OLDER WOMEN, WASHINGTON, DC, MAY 4, 1994, THE HONORABLE DAVID PRYOR, PRESIDING

WITNESSES

Lou Glasse, President, Older Women's League
Joan Kuriansky, Esq., executive director, Older Women's League
Sara C. Aravanis, moderator, institute director, National Association of State Units on Aging
Tom Carluccio, Esq., director, Medicaid Fraud Control Unit, Office of the Attorney General
Elma Holder, executive director, National Citizens Coalition for Nursing Home Reform
Pat Reuss, senior policy analyst, NOW Legal Defense and Education Fund
Toshio Tatara, Ph.D., director, National Center for Elder Abuse
Terry T. Fulmer, Ph.D., associate dean for research, Columbia University School of Nursing
Maria Brown, planner, Philadelphia Corporation for Aging

Handy Brandenburg, program manager, Adult Protective Services, representing the National Association of Adult Protective Service Administrators
Rosalie S. Wolf, Ph.D., president, National Committee for the Prevention of Elder Abuse
Lori A. Stiegel, Esq. associate staff director, Commission on Legal Problems of the Elderly, American Bar Association

SYNOPSIS

This round table discussion focused on the severity of elder abuse on streets as well as violence against middle-aged and older women.

LONG TERM CARE, MILWAUKEE, WI, MAY 9, 1994, THE HONORABLE RUSSELL D. FEINGOLD

WITNESSES

Eugene Lehrmann, president, American Association of Retired Persons
John Cram, Milwaukee, WI
Susan Olson and John Olson
Linda Rowley, accompanied by her son Mitchell
Sharon Dobrzynski
Ann Hauser, Milwaukee, WI
Dorothy Freund, Milwaukee, WI
Stephanie Sue Stein, Milwaukee County Department of Aging
Tom Hlaveck, Wisconsin Commission on Aging
Bev Young, founder, National Alliance for the Mentally Ill

SYNOPSIS

This hearing educated the public and policy makers on the fundamental need for long-term care reform.

HEALTH CARE REFORM: IMPLICATIONS FOR SENIORS, LANSING, MI, MAY 18, 1994, THE HONORABLE DONALD W. RIEGLE, JR., PRESIDING

WITNESSES

Carol Chapman, Rogers City, MI
Orville "Al" LaGuire, Lansing, MI
Lisa Minott, Kalamazoo, MI
Debbie Arnold and Rick Arnold, Pontiac, MI
Joyce Gallant, chair, Michigan American Association of Retired Persons, Health and Long-Term Action Team
Robert Dolsen, executive director, Area Agency on Aging Region IV
James O'Brien, M.D., professor and associate chair, Department of Family Practice, Michigan State University; medical director, Geriatrics, St. Lawrence Hospital; and chair, Committee on Aging, Michigan State Medical Society

SYNOPSIS

This field hearing discussed the potential impact of health care reform on seniors.

FIGHTING FAMILY VIOLENCE: RESPONSES OF THE HEALTH CARE SYSTEM, BANGOR, ME, JUNE 20, 1994, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Roberta, victim of Aroostook County, ME
Grace, victim of Penobscot County, ME
Sharon, victim of Penobscot County, ME
Robert McAfee, M.D., president, American Medical Association
Eric R. Brown, M.D., faculty physician, Family Practice Residency Center, Eastern Maine Medical Center
Nancy Fishwick, family nurse practitioner and assistant professor, University of Maine School of Nursing
Robert McLaughlin, counselor and chairman, Health Care Response Committee, Maine Commission on Domestic Abuse
Francine Stark, community response coordinator, Spruce Run Association
Peggy Dumond, deputy director, Eastern Area Agency on Aging
Lieutenant Don Winslow, Bangor Police Department
Alice Clifford, assistant district attorney, Penobscot County

SYNOPSIS

This field hearing helped establish what health care providers need to explore in treating and preventing family violence.

UNINSURED BANK PRODUCTS: RISKY BUSINESS FOR SENIORS, WASHINGTON, DC, SEPTEMBER 29, 1994, THE HONORABLE DAVID PRYOR, PRESIDING

WITNESSES

Leilani J. DeMint, Investor
Max L. Wells, Investor
Laura A. Park, broker, certified financial planner and chartered financial analyst
Catherine B. Hovis, broker
Denise Voigt Crawford, Texas Securities Commissioner, and chair, Bank Securities Activities Committee, North American Securities Administrators Association
Alfred M. Pollard, senior director, the Bankers Roundtable
Scott Galloway, co-founder, Prophet Market Research and Consulting

SYNOPSIS

This hearing addressed the bank sales of uninsured products to older Americans. The information from this hearing suggested that some banks are encouraging older Americans as well as other Americans to take their money out of insured investments and put them in uninsured securities.

PROBLEMS IN THE SOCIAL SECURITY DISABILITY PROGRAMS: THE DISABLING OF AMERICA? WASHINGTON, DC, MARCH 2, 1995, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Mary Jane Owen, executive director, National Catholic Office for Persons With Disabilities
Bob Cote, director, Step 13 Homeless Shelter
Jane L. Ross, director, Income Security Issues, General Accounting Office, accompanied by Cynthia Bascetta, assistant director
Carolyn L. Weaver, Ph.D., the American Enterprise Institute
Sally L. Satel, M.D., Department of Psychiatry, Yale University School of Medicine
Gerben DeJong, Ph.D., director, National Rehabilitation Hospital Research Center
Edward A. Eckenhoff, president, National Rehabilitation Hospital
Ann DeWitt, director, Maine Disability Determination Services

SYNOPSIS

This hearing focused on ways to preserve disability programs and to help those who need assistance.

GAMING THE HEALTH CARE SYSTEM: TRENDS IN HEALTH CARE FRAUD, WASHINGTON, DC, MARCH 21, 1995, THE HONORABLE WILLIAM J. COHEN, PRESIDING

WITNESSES

Hon. Louis J. Freeh, director, Federal Bureau of Investigation, Washington, DC
Dr. "A", health care provider, testifying anonymously
Agent "B", testifying anonymously
Hon. June Gibbs Brown, inspector general, U.S. Department of Health and Human Services
Hon. Charles C. Masten, inspector general, U.S. Department of Labor, Washington, DC
Thomas A. Temmerman, director, Bureau of Medi-Cal Fraud, Washington, DC
Hon. William Gradison, president, Health Insurance Association of America
William Mahon, executive director, National Health Care Anti-Fraud Association, Washington, DC

SYNOPSIS

This hearing looked at the major trends in health care fraud and abuse that affect Federal, State and private health care plans.

SOCIETY'S SECRET SHAME: ELDER ABUSE AND FAMILY VIOLENCE, PORTLAND, ME, APRIL 11, 1995, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

"Florence," Victim of Abuse
"Grace," Victim of Abuse

Joann Wiles, representative of Holy Innocents Catholic Charities, Portland, ME, accompanied by Amy Jensen
Ricker Hamilton, regional manager of Adult Protective Services, Maine Department of Human Services
Lois Reckitt, executive director, Family Crisis Center, Portland, ME
Leo j. Delicata, Esquire, Managing Attorney of the Portland Office of Legal Services for the Elderly
Emmy Hunt, Head Nurse, Emergency Department, Maine Medical Center
Rosalie Wolf, Institute on Aging at the Medical Center in Central Massachusetts, and President, National Committee for the Prevention of Elder Abuse

SYNOPSIS

This field hearing heard testimony from people who experienced different forms of elder abuse and family violence in Maine communities.

PLANNING AHEAD: FUTURE DIRECTIONS IN PRIVATE FINANCING OF LONG-TERM CARE, WASHINGTON, DC, MAY 11, 1995, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

John Spear, PFL Life Insurance Co. policyholder, Champaign, IL, accompanied by Sarah Spear
Jean Heintz, Portland, OR
Ellen Friedman, manager of Benefits Planning, Ameritech
Stanley Wallack, chairman of the Coalition on Long Term Care Financing
Marilyn Moon, senior fellow, the Urban Institute, Washington, DC
Mark E. Battista, M.D., vice president, Long Term Care, UNUM Life Insurance Co. of America
Gail Holubinka, director, New York State Partnership for Long Term Care, New York, NY
Paul Willging, executive vice president, American Health Care Association
Val J. Halamandaris, president, National Association for Home Care, Washington, DC
Stephen McConnell, chair, Long Term Care Campaign, and Senior Vice President for Public Policy, Alzheimer's Association

SYNOPSIS

This hearing examined the private market and how it can assist families in planning their own future needs.

BREAKTHROUGHS IN BRAIN RESEARCH: A NATIONAL STRATEGY TO SAVE BILLIONS IN HEALTH CARE COSTS, WASHINGTON, DC, JUNE 27, 1995, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Frances Powers, Lebanon, PA
Millicent and Morton Kondracke, Washington, DC
Benjamin Reeve, Boston, MA

Arthur Ullian, Boston, MA
Richard W. Besdine, M.D., director of the Travelers Center on Aging, University of Connecticut Health Center representing the Alliance for Aging Research, Farmington, CT
Guy M. McKhann, M.D., director of the Zanvyl Krieger Mind/Brain Institute, Johns Hopkins University, representing the Dana Alliance for Brain Initiatives, Baltimore, MD
Jerry Avorn, M.D., associate professor of Medicine, Harvard Medical School Director, Program for the Analysis of Clinical Strategies, Brigham and Women's Hospital, Boston, MA
Robert M. Goldberg, senior research fellow, Gordon Public Policy Center, Brandeis University, Waltham, MA
Allen D. Roses, M.D., Jefferson Point Professor of Neurobiology and Neurology, Chief of Neurology, Duke University Medical Center, Durham, NC
Dennis J. Selkoe, M.D., professor of Neurology and Neuroscience, Harvard Medical School, codirector, Center for Neurologic Diseases, Brigham and Women's Hospital, Boston, MA
Ole Isacson, M.D., director, Neurogeneration Laboratory, McLean Hospital associate professor in the Program of Neuroscience, Harvard Medical School, Boston, MA
Dennis W. Choi, M.D., Jones Professor and head, Department of Neurology, Washington, University School of Medicine, St. Louis, MO

SYNOPSIS

This hearing explored savings, breakthroughs, personal experiences and trends in the study of brain research.

FEDERAL OVERSIGHT OF MEDICARE HMOS: ASSURING BENEFICIARY PROTECTION, WASHINGTON, DC, AUGUST 3, 1995, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Sarah Jaggar, director, Health Financing and Policy Issues, General Accounting Office accompanied by Ed Stropko, Lourdes Cho, Charles Walter
Hon. June Gibbs Brown, inspector general, Department of Health and Human Services accompanied by George Grob
Hon. Bruce Vladeck, administrator, Health Care Financing Administration
Geraldine Dallek, executive director, Center for Health Care Rights
Dr. Jesse Jampol, M.D., medical director, Health Insurance Plan of Greater New York, representing the Group Health Association of America
Helen Imbernino, assistant vice president, National Committee for Quality Assurance
Suzanne Mercure, manager, Benefits Administration, Southern California Edison

SYNOPSIS

This hearing examined the role of Medicare Health Maintenance Organizations and what needs to be done in order to establish

quality care assurance for Medicare beneficiaries who enroll in these HMOs.

MEDICAID REFORM: QUALITY OF CARE IN NURSING HOMES AT RISK, WASHINGTON, DC, OCTOBER 26, 1995, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Dorothy Garrison, Mobile, AL
Mildred Manning, New Market, VA
Gloria Messerley, Harrisonburg, VA, accompanied by Anne S. See, Blue Ridge Legal Services
Scott Severns, Esquire, president, National Citizens' Coalition for Nursing Home Reform
John Willis, president, National Association of State Ombudsman Program and Texas Long-Term Care Ombudsman
Ellen Reap, president, Association of Health Facility Survey Agencies
Catherine Hawes, senior policy analyst and co-director, Program and Long-Term Care, Research Triangle Institute
M. Keith Weikel, senior executive vice president and chief operating office, HCR Corporation, representing the American Health Care Association
Sheldon L. Goldberg, president and chief executive officer, American Association of Homes and Services for the Aging
Dr. William Russell, M.D., director of Medical Services, St. Mary's Nursing Home

SYNOPSIS

This hearing addressed the need for strong Federal quality care standards in nursing homes, especially in regards to reforming Medicaid.

HEALTH CARE FRAUD: MILKING MEDICARE AND MEDICAID. WASHINGTON, DC, NOVEMBER 2, 1995, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

"Mister A", Health Care Fraud Violator
"Doctor B", Health Care Fraud Violator, accompanied by: Hardy Gold, California Department of Justice, Bureau of Medi-Cal Fraud
Kristina Rowland Brambila, Health Care Fraud Violator
Hon. Dennis C. Vacco, New York State Attorney General, State of New York, Albany, NY
Sarah Jaggar, director, Health Finacing and Public Health Issues, U.S. General Accounting Office, Washington, DC, accompanied by Thomas Dowdal, assistant director

SYNOPSIS

This investigative hearing focused on the increase of fraud and abuse in the health care system specifically against Medicare and Medicaid.

HEARING ON MENTAL ILLNESS AMONG THE ELDERLY, WASHINGTON, DC, FEBRUARY 28, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

June Silverberg, Washington, DC
Mike Wallace, New York, NY
Anne O. Emery, Baltimore, MD
Dr. Gene D. Cohen, M.D., director, George Washington University Center on Aging, Health and Humanities, George Washington University Medical School
Dr. Ira R. Katz, M.D., professor of Psychiatry and director, Section on Geriatric Psychiatry, University of Pennsylvania School of Medicine
Dr. Barry Lebowitz, M.D., branch chief, Mental Disorders of the Aging, Division of Clinical and Treatment Research, National Institutes of Mental Health
Dorothy P. Rice, professor emeritus, Department of Social and Behavioral Sciences, School of Nursing, University of California at San Francisco
Dr. Gary Gottlieb, M.D, director and CEO, Friends Hospital, professor of Clinical Psychiatry, University of Pennsylvania Medical School
Dr. Frederick Goodwin, M.D., director, Center for Neuroscience, Medical Progress, and Society; and professor of Psychiatry, George Washington University Medical Center

SYNOPSIS

This hearing identified the many myths and misinformation regarding mental disorders in the elderly and the lack of vital mental health services in the current health care system. Also discussed were the savings in the health care system through timely diagnosis and appropriate treatments of mental disorders.

TELESCAMS EXPOSED: HOW TELEMARKETERS TARGET THE ELDERLY, WASHINGTON, DC, MARCH 6, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Edward Gould, Las Vegas, NY
Mary Ann Downs, Raleigh, NC
Peder Anderson, Washington, DC
Kathryn Landreth, United States Attorney, District of Nevada, Las Vegas, NV
Jodie Bernstein, director of the Bureau of Consumer Protection, Federal Trade Commission, Washington, DC
Chuck Owens, chief, White Collar Crime Section, Federal Bureau of Investigation, Washington, DC
Agnes Johnson, American Association of Retired Persons, Biddeford, ME
John Barker, director, National Fraud Information Center, Washington, DC

SYNOPSIS

This hearing discussed the tactics of the telephone scam artists, law enforcement efforts and the victims who tend to be targeted for this sort of abuse.

HEARING ON ADVERSE DRUG REACTIONS IN THE ELDERLY, WASHINGTON, DC, MARCH 28, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Sarah Jaggar, director of Health Financing and Public Health Issues, Health, Education and Human Services Division, U.S. General Accounting Office, Washington, DC, accompanied by John Hansen, assistant director and Frank Putallaz, Evaluator
Colleen O'Brien-Thorpe, Prescription Drug Consulting Services, Inc.
Calvin H. Knowlton, president, American Pharmaceutical Association; Chair, Department of Pharmacy Practice and Pharmacy Administration, Philadelphia College of Pharmacy and Science
Linda F. Golodner, president, National Consumers League
Robert E. Vestal, M.D., president-elect, American Society for Clinical Pharmacology and Therapeutics
Lynn Williams, chairman, Board of Directors, American Society of Consultant Pharmacists
Margaret G. McGlynn, senior vice president, Merck-Medco Managed Care, Inc.
Matthew Shimoda, president, Health Care Professionals

SYNOPSIS

This hearing looked at the growing problem of misuse of prescription medication.

ALZHEIMER'S DISEASE IN A CHANGING HEALTH CARE SYSTEM: FALLING THROUGH THE CRACKS, WASHINGTON, DC, APRIL 23, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Tim Ryan, Kethcum, ID
Lois Rockhold, Mobile, AL
Dr. Deborah Marin, M.D., chief of Geriatric Psychiatry, Mt. Sinai School of Medicine, New York, NY
Jessie Jacques, R.N., consultant, Alzheimer's Care Center of Gardiner, ME, Union, ME
Denise Reehl, Gardiner, ME
Stanley B. Jones, director, Health Insurance Reform Project, The George Washington University, Washington, DC
Griff Steinke Healy, chairman, Alzheimer's Association, Washington, DC
Edith Eddleman Robinson, LCSW, director of Social Medicine, Kaiser Permanente Medical Care Program, Los Angelese, CA
Dr. Cheryl Phillips-Harris M.D., clinical resource director, Continuing Care Division, Sutter/CHS, Sacramento, CA

SYNOPSIS

This hearing examined the quality and availability of care for Alzheimer's patients in both government and private health care managed care programs.

THE NATIONAL SHORTAGE OF GERIATRICIANS: MEETING THE NEEDS OF OUR AGING POPULATION, WASHINGTON, DC, MAY 14, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Dr. Gene Cohen, M.D., director, Washington, DC, Center on Aging
Dr. Jerome Kowal, M.D., director, Pepper Centers, Geriatric Care Center, Case Western Reserve University, Cleveland, OH
Dr. Mark S. Lachs, M.D., chief, Geriatric Unit, Division of General Internal Medicine, The New York Hospital-Cornell University Medical College, New York, NY
Dr. Mary Tinetti, M.D., associate professor of Medicine, Yale University, and director, Yale Claude D. Pepper Older Americans Independence Center, New Haven, CT
Donna Regenstreif, senior program officer, The John A. Hartford Foundation, New York, NY
Dr. David B. Reuben, M.D., division chief in Geriatrics, UCLA Medical School and chairman, Education Committee, American Geriatrics Society, Los Angeles, CA

SYNOPSIS

This was a joint forum between the Special Committee on Aging and the Alliance for Aging Research which discussed the lack of physician personnel, especially geriatricians, to train and prepare the physician work force for an aging America.

STRANDED ON DISABILITY: FEDERAL DISABILITY PROGRAMS FAILING DISABLED WORKERS, WASHINGTON, DC, JUNE 5, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Jane Ross, director, Income Security Division, General Accounting Office, accompanied by Cynthis Bascetta
Mary Ridgely, executive director, Employment Resources, Inc., Madison, WI
Barbara Otto, executive director, SSI Coalition, Chicago, IL
Admiral David Cooney, (USN Ret.), Former president and CEO, Goodwill Industries, Washington, DC
Dr. Susan Miller, M.D., director of Physical Medicine & Rehabilitation, National Rehabilitation Hospital, Washington, DC, accompanied by William Peterson, director, Assistive Technology and Rehabilitative Engineering
John Mazzuchi, deputy assistant for Clinical Services, U.S. Department of Defense, accompanied by Dinah Cohen, director, Computer Electronic Accommodation Program
Virgina Reno, project director, National Academy of Social Insurance, Washington, DC, on behalf of Jerry Mashaw, chairman, Disability Policy Panel

Tony Young, co-chairman, "Return-to-Work" Group, Washington, DC

SYNOPSIS

At this hearing experts discussed ways to improve the Social Security Administration's rehabilitation and work assistance programs.

NUTRITION AND THE ELDERLY: SAVINGS FOR MEDICARE, WASHINGTON, DC, JUNE 20, 1996

WITNESSES

Ronnie Chernoff, president American Dietetic Association
Kathryn Langwell, director of Health Economics Barents Group, LLC
Judy Fish, nutrition support dietitian, Geisinger Medical Center
Valerie Langbein, director, Nutrition Services, Eastern Maine Medical Center, and president, Maine Dietetic Association
Laura Matarese, manager of Nutrition Support Dietetics, Cleveland Clinic Foundation
Daniel Thurz, president emeritus, National Council on Aging
Barbara Fleming, clinical advisor for the HCFA Health Standards and Quality Bureau
Dr. Bruce Bagley, M.D., board member and chairman of the Commission on Public Health of the American Academy of Family Physicians
Nancy Wellman, past president of the American Dietetic Association and director of the National Resource and Policy Center on Nutrition and Aging

SYNOPSIS

This forum addressed the need for nutrition therapy among Medicare patients, which improves the quality of life and increases recovery time.

SUICIDE AND THE ELDERLY: A POPULATION AT RISK, WASHINGTON, DC, JULY 30, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Daryl Workman, Richmond, VA
Paige Garber, Kensington, MD
Hy Nelson and Esther Nelson, Spokane, WA
David C. Clark, director, Center for Suicide Research and Prevention, Rush Presbyterian Saint Luke's Medical Center, Chicago, IL
Dr. Eric Caine, M.D., professor of Psychiatry, University of Rochester Medical Center, Rochester, NY
Jane Pearson, chief, Clinical and Developmental Psychopathology Program, Mental Disorders of the Aging Research Branch, National Institute of Mental Health, Rockville, MD
Dr. Mark L. Rosenberg, M.D., director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA
Dr. Ira Katz, M.D., professor of Psychiatry, University of Pennsylvania Medical School, Philadelphia, PA

Joseph Richman, professor emeritus of Psychiatry, Albert Einstein College of Medicine, Bronx, NY
Ray Raschko, director of Elder Services, Spokane Community Mental Health Center, Spokane, WA
Betty Munley, coordinator, The Senior Connection Program, Crisis Call Center, Reno, NV

SYNOPSIS

The hearing discussed the stigma of mental illness, how to identify its symptoms and how to treat depression.

SOCIAL SECURITY REFORM OPTIONS: PREPARING FOR THE 21ST CENTURY, WASHINGTON, DC, SEPTEMBER 24, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

Hon. Alan Simpson, A United States Senator from the State of Wyoming
Michael Tanner, director of Health and Welfare Studies, Cato Industries
Paul S. Hewitt, executive director, National Taxpayers Union Foundation
Robert J. Myers, former chief actuary of the Social Security Administration
C. Eugene Steuerle, senior fellow, The Urban Institute
Martha H. Phillips, executive director, The Concord Coalition
Estelle James, lead economist, World Bank
Paul Yakoboski, research associate, Employee Benefit Research Institute

SYNOPSIS

This hearing considered the serious problems facing Social Security: aging of the Baby Boomers and the increase life expectancy of individuals.

INVESTING IN MEDICAL RESEARCH: SAVING HEALTH CARE AND HUMAN COSTS, WASHINGTON, DC, SEPTEMBER 26, 1996, THE HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

General Norman Schwarzkopf, USA (Ret.), Tampa, FL
Rod Carew, Los Angeles, CA
Joan Samuelson, Santa Rosa, CA
Travis Roy, Yarmouth, ME
Zenia Kim, Beaverton, OR
Dr. Tadataka Yamada, M.D., president, SB Healthcare and Services, Philadelphia, PA
Dr. Jess G. Theone, M.D., Pediatrics/Biochemistry Genetics, University of Michigan, Ann Arbor, MI
Richard J. Hodes, M.D., director, National Institute on Aging, Bethesda, MD
Dr. Robert Lindsay, M.D., chief of Internal Medicine, Helen Hayes Hospital, and president, National Osteoporosis Foundation, New York, NY

SYNOPSIS

This hearing was jointly sponsored by the Special Committee on Aging and the Committee on Appropriations. The hearing addressed the need for continued funding for medical research.

SUPPLEMENT 2

Committee Staff Members

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Patricia Hameister, *Chief Clerk*

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SUPPLEMENT 3

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REPORTS

Developments in Aging, 1959 to 1963, Report No. 8, February 1963.*
Developments in Aging, 1963 and 1964, Report No. 124, March 1965.*
Developments in Aging, 1965, Report No. 1073, March 1966.*
Developments in Aging, 1966, Report No. 169, April 1967.*
Developments in Aging, 1967, Report No. 1098, April 1968.*
Developments in Aging, 1968, Report No. 91–119, April 1969.*
Developments in Aging, 1969, Report No. 91–875, May 1970.*
Developments in Aging, 1970, Report No. 92–46, March 1971.*
Developments in Aging: 1971 and January–March 1972, Report No. 92–784, May 1972.*
Developments in Aging: 1972 and January–March 1973, Report No. 93–147, May 1973.*
Developments in Aging: 1973 and January–March 1974, Report No. 93–846, May 1974.*
Developments in Aging: 1974 and January–April 1975, Report No. 94–250, June 1975.*
Developments in Aging: 1975 and January–May 1976—Part 1, Report No. 94–998, June 1976.*
Developments in Aging: 1975 and January–May 1976—Part 2, Report No. 94–998, June 1976.*
Developments in Aging: 1976—Part 1, Report No. 95–88, April 1977.*
Developments in Aging: 1976—Part 2, Report No. 95–88, April 1977.*
Developments in Aging: 1977—Part 1, Report No. 95–771, April 1978.*
Developments in Aging: 1977—Part 2, Report No. 95–771, April 1978.*
Developments in Aging: 1978—Part 1, Report No. 96–55, March 1979.*
Developments in Aging: 1978—Part 2, Report No. 96–55, March 1979.*
Developments in Aging: 1979—Part 1, Report No. 96–613, February 1980.*
Developments in Aging: 1979—Part 2, Report No. 96–613, February 1980.*
Developments in Aging: 1980—Part 1, Report No. 97–62, May 1981.*
Developments in Aging: 1980—Part 2, Report No. 97–62, May 1981.*
Developments in Aging: 1981—Volume 1, Report No. 97–314, March 1982.*
Developments in Aging: 1981—Volume 2, Report No. 97–314, March 1982.*
Developments in Aging: 1982—Volume 1, Report No. 98–13, February 1983.*
Developments in Aging: 1982—Volume 2, Report No. 98–13, February 1983.*

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Developments in Aging: 1983—Volume 1, Report No. 98–360, February 1984—$13.*
Developments in Aging: 1983—Volume 2, Report No. 98–360, February 1984—$8.*
Developments in Aging: 1984—Volume 1, Report No. 99–5, February 1985.—$9.*
Developments in Aging: 1984—Volume 2, Report No. 99–5, February 1985—$8.*
Developments in Aging: 1985—Volume 1, Report No. 99–242, February 1986.
Developments in Aging: 1985—Volume 2—Appendixes, Report No. 99–242, February 1986.*
Developments in Aging: 1985—Volume 3—America in Transition: An Aging Society.*
Developments in Aging: 1986—Volume 1, Report No. 100–9, February 1987.*
Developments in Aging: 1986—Volume 2, Appendixes, Report No. 100–9, February 1987.*
Developments in Aging: 1986—Volume 3—America in Transition: An Aging Society, Report No. 100–9, February 1987.*
Developments in Aging: 1987—Volume 1, Report No. 100–291, February 1988.
Developments in Aging: 1987—Volume 2—Appendixes, Report No. 100–291, February 1988.*
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Developments in Aging: 1988—Volume 1—Report No. 101–4, February 1989.*
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Developments in Aging: 1989—Volume 2—Appendixes, Report No. 101–249, February 1990.*
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Developments in Aging: 1990—Volume 2—Appendixes, Report No. 102–28, February 1991.*
Developments in Aging: 1991—Volume 1—Report No. 102–261, February 1992.*
Developments in Aging: 1991—Volume 2—Appendixes, Report No. 102–261.*
Developments in Aging: 1992—Volume 1—Report No. 103–40, April 1993.*
Developments in Aging: 1992—Volume 2—Appendixes, Report No. 103–40, April 1993.*
Developments in Aging: 1993—Volume 1—Report No. 103–403, September 1994.
Developments in Aging: 1993—Volume 2—Appendixes, Report No. 103–403, September 1994.

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COMMITTEE PRINTS

1961

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 1961.*

The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 1961.*

New Population Facts on Older Americans, 1960, committee print, May 1961.*

Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 1961.*

Health and Economic Conditions of the American Aged, committee print, June 1961.*

State Action To Implement Medical Programs for the Aged, committee print, June 1961.*

A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.*

Mental Illness Among Older Americans, committee print, September 1961.*

1962

Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 1962.*

Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 1962.*

Statistics on Older People: Some Current Facts About the Nation's Older People, June 1962.*

Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print, June 1962.*

Housing for the Elderly, committee print, August 1962.*

Some Current Facts About the Nation's Older People, October 1962.*

1963

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.*

Medical Assistance for the Aged: The Kerr-Mills Program, 1960–63, committee print, October 1963.*

1964

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print, July 1964.*

Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print, August 1964.*

Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.*

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Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963–64, committee print, October 1964.*

1965

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations: 1964, committee print, January 1965.*

Extending Private Pension Coverage, committee print, June 1965.*

Health Insurance and Related Provisions of Public Law 89–97, The Social Security Amendments of 1965, committee print, October 1965.*

Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, committee print, November 1965.*

1966

Services to the Elderly on Public Assistance, committee print, March 1966.*

The War on Poverty As It Affects Older Americans, Report No. 1287, June 1966.*

Needs for Services Revealed by Operation Medicare Alert, committee print, October 1966.*

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 1966.*

Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print, December 1966.*

1967

Reduction of Retirement Benefits Due to Social Security Increases, committee print, August 1967.*

1969

Economics of Aging: Toward a Full Share in Abundance, committee print, March 1969.* [1]

Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.* [1]

Health Aspects of the Economics of Aging, committee print, July 1969 (revised).* [1]

Social Security for the Aged: International Perspectives, committee print, August 1969.* [1]

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1970

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- Part 1. Washington, D.C., July 12 and 13, 1961.
- Part 2. St. Petersburg, Fla., November 6, 1961.
- Part 3. Port Charlotte, Fla., November 7, 1961.
- Part 4. Sarasota, Fla., November 8, 1961.
- Part 5. Springfield, Mass., November 29, 1961.
- Part 6. St. Joseph, Mo., December 11, 1961.
- Part 7. Hannibal, Mo., December 13, 1961.
- Part 8. Cape Girardeau, Mo., December 15, 1961.
- Part 9. Daytona Beach, Fla., February 14, 1962.
- Part 10. Fort Lauderdale, Fla., February 15, 1962.

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- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

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- Part 2. Trenton, N.J., October 23, 1961.
- Part 3. Los Angeles, Calif., October 24, 1961.
- Part 4. Las Vegas, Nev., October 25, 1961.
- Part 5. Eugene, Oreg., November 8, 1961.
- Part 6. Pocatello, Idaho, November 13, 1961.
- Part 7. Boise, Idaho, November 15, 1961.
- Part 8. Spokane, Wash., November 17, 1961.
- Part 9. Honolulu, Hawaii, November 27, 1961.
- Part 10. Lihue, Hawaii, November 29, 1961.
- Part 11. Wailuku, Hawaii, November 30, 1961.
- Part 12. Hilo, Hawaii, December 1, 1961.
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- Part 2. Walla Walla, Wash., November 10, 1961.
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- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
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- Part 5. Los Angeles, Calif., December 5, 1962.
- Part 6. San Francisco, Calif., December 7, 1962.

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Part 5. New York, N.Y., August 2 and 3, 1965.
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Part 5. Paramus, N.J., central suburban area, August 14, 1969.
Part 6. Cape May, N.J., retirement community, August 15, 1969.
Part 7. Washington, D.C., international perspectives, August 25, 1969.
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Part 1. Washington, D.C., July 30, 1969.
Part 2. St. Petersburg, Fla., January 9, 1970.
Part 3. Hartford, Conn., January 15, 1970.
Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.
Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.
Part 6. San Francisco, Calif., February 12, 1970.
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Part 12. Chicago, Ill., April 2, 1971.
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Trends in Long-Term Care—Continued
Part 18. Washington, D.C., October 28, 1971.
Part 19A. Minneapolis-St. Paul, Minn., November 29, 1971.
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Part 24. New York, N.Y., February 4, 1975.
Part 25. Washington, D.C., February 19, 1975.
Part 26. Washington, D.C., December 9, 1975.
Part 27. New York, N.Y., March 19, 1976.

Older Americans in Rural Areas:*
Part 1. Des Moines, Iowa, September 8, 1969.
Part 2. Majestic-Freeburn, Ky., September 12, 1969.
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Part 5. Greenwood, Miss., October 9, 1969.
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Part 11. Dogbone-Charleston, W. Va., October 27, 1970.
Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.

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Part 1. Ocean Grove, N.J., April 18, 1970.
Part 2. Washington, D.C., June 8 and 9, 1970.

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Part 1. St. Louis, Mo., August 11, 1970.
Part 2. Boston, Mass., April 30, 1971.

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Part 2. Washington, D.C., March 29, 1971.
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Part 9. Casper, Wyo., August 13, 1971.
Part 10. Washington, D.C., February 3, 1972.

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Part 3. Providence, R.I., September 20, 1971.

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Part 2. Roanoke, Ala., August 10, 1971.
Part 3. Miami, Fla., August 11, 1971.
Part 4. Pocatello, Idaho, August 27, 1971.

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Part 3. Washington, D.C., August 4, 1971.
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Part 9. Boston, Mass., October 2, 1972.
Part 10. Trenton, N.J., January 17, 1974.
Part 11. Atlantic City, N.J., January 18, 1974.
Part 12. East Orange, N.J., January 19, 1974.
Part 13. Washington, D.C., October 7, 1975.
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Part 2. Washington, D.C., October 19, 1971.
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Part 1. Washington, D.C., August 7, 1972.
Part 2. Washington, D.C., August 8, 1972.
Part 3. Washington, D.C., August 9, 1972.

Future Directions in Social Security:*
Part 1. Washington, D.C., January 15, 1973.
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Future Directions in Social Security—Continued
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Part 2. Washington, D.C., February 28, 1973.
Barriers to Health Care for Older Americans:*
Part 1. Washington, D.C., March 5, 1973.
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Part 3. Livermore Falls, Maine, April 23, 1973.
Part 4. Springfield, Ill., May 16, 1973.
Part 5. Washington, D.C., July 11, 1973.
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Part 2. Washington, D.C., June 21, 1973.
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Part 2. Washington, D.C., February 27, 1974.
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Part 1. Los Angeles, Calif., June 14, 1974.
Part 2. Boston, Mass., August 30, 1976.
Part 3. Washington, D.C., September 28, 1976.
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Part 2. Washington, D.C., September 25, 1974.
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Part 7. Missoula, Mont., February 14, 1979.
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- Part 1. Washington, D.C., June 6, 1975.
- Part 2. Washington, D.C., June 26, 1975.

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- Part 1. Washington, D.C., September 26, 1975.
- Part 2. Washington, D.C., November 13, 1975.
- Part 3. Washington, D.C., December 5, 1975.
- Part 4. Washington, D.C., February 16, 1976.
- Part 5. Washington, D.C., August 30, 1976.
- Part 6. Washington, D.C., August 31, 1976.
- Part 7. Washington, D.C., November 17, 1976.
- Part 8. Washington, D.C., March 8, 1977.
- Part 9. Washington, D.C., March 9, 1977.

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- Part 1. Winterset, Iowa, August 16, 1976.
- Part 2. Ottumwa, Iowa, August 16, 1976.
- Part 3. Gretna, Nebr., August 17, 1976.
- Part 4. Ida Grove, Iowa, August 17, 1976.
- Part 5. Sioux Falls, S. Dak., August 18, 1976.
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- Part 12. Roswell, N. Mex., November 18, 1977.
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- Part 14. Albuquerque, N. Mex., November 21, 1977.
- Part 15. Pensacola, Fla., November 21, 1977.
- Part 16. Gainesville, Fla., November 22, 1977.
- Part 17. Champaign, Ill., December 13, 1977.

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- Part 1. Washington, D.C., April 18, 1977.
- Part 2. Washington, D.C., April 19, 1977.

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- Part 1. Washington, D.C., May 16, 1977.
- Part 2. Washington, D.C., May 17, 1977.
- Part 3. Washington, D.C., June 15, 1977.

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Part 4. Cleveland, Ohio, July 6, 1977.
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Part 6. Holyoke, Mass., October 12, 1977.
Part 7. Tallahassee, Fla., November 23, 1977.
Part 8. Washington, D.C., April 17, 1978.

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Part 1. Akron, Ohio, August 30, 1979.
Part 2. Washington, D.C., September 13, 1979.
Part 3. Pennsauken, N.J., May 23, 1980.
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Part 1. Washington, D.C., October 18, 1979.
Part 2. Washington, D.C., March 24, 1980.
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Part 3. Orlando, Fla., July 9, 1980.
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Part 4. Washington, D.C., December 4, 1980.
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Continuum of Health Care for Indian Elders, Santa Fe, NM, September 3, 1986, Serial No. 99–27.*
Catastrophic Health Care Costs, Washington, DC, January 26, 1987, Serial No. 100–1.*
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Long-Term Care in Rural America: A Family and Health Policy Challenge, August 22, 1989, Little Rock, AR (joint with Pepper Commission), Serial No. 101–8.*

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Medicare Coverage of Catastrophic Health Care Costs: What Do Seniors Need, and What Do Seniors Want? Las Vegas, NV, October 10, 1989, Serial No. 101–11.*

The Shadow Caregivers: American Families and Long-Term Care, November 13, 1989, Philadelphia, PA, Serial No. 101–12.*

Our Nation's Elderly: Hidden Victims of the Drug War? Washington, DC, November 15, 1989, Serial No. 101–13.*

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Part 2—Turning a Bad Deal Into a Fair Deal, November 16, 1989, Washington, DC, Serial No. 101–14.*

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Health Care Reform: The Time Has Come, Serial No. 102–16.

- February 10, Fort Smith, AR, Long-Term Care and Prescription Drug Costs.
- February 11, 1992, Jonesboro, AR, Skyrocketing Health Care Costs and the Impact on Individuals and Businesses.
- February 12, El Dorado, AR, Answers to the Health Care Dilemma.

Continuing Long-Term Care Services, February 10, 1992, Lauderhill, FL, Serial No. 102–17.*

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Controlling Health Care Costs: The Long-Term Care Factor, April 20, 1993, Washington, DC, Serial No. 103–4.
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