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106TH CONGRESS
2d Session

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Volume 1

DEVELOPMENTS IN AGING: 1997 and 1998
VOLUME 1

REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 54, SEC. 19(c), FEBRUARY 13, 1997

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

FEBRUARY 7, 2000.—Ordered to be printed

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(II)

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, 2000.

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

DEAR MR. PRESIDENT: Under authority of Senate Resolution 54, agreed to February 13, 1997, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 1997 and 1998, 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 1997 and 1998 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.*

(III)

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DEVELOPMENTS IN AGING: 1997 and 1998—VOLUME 1

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

REPORT

Chapter 1

SOCIAL SECURITY—OLD AGE, SURVIVORS AND DISABILITY

OVERVIEW

Social Security continues to be a topic of national debate. During the January 1998 State of the Union Address, President Clinton urged Congress to "Save Social Security First." The President recommended that Social Security's long-range financing problems be resolved before legislators commit Federal budget surpluses for other purposes. In addition, he called for a series of bipartisan forums on Social Security reform to be held around the country throughout the year, and a White House Conference on Social Security Reform in December 1998. Finally, the President called for bipartisan Social Security reform legislation in early 1999.

The 1994–1996 Advisory Council on Social Security issued a report in January 1997 on ways to solve the program's long-range financing problems. The Council could not reach a consensus on a single approach, so the report contains three different proposals that are intended to restore long-range solvency to the Social Security system. The first proposal, labeled the "maintain benefits" plan, keeps the program's benefit structure essentially the same by addressing most of the long-range deficit through revenue increases, including an eventual rise in the payroll tax, and minor benefit cuts. To close the remaining gap, it recommends that investing part of the Social Security trust funds in the stock market be considered. The second, labeled the "individual account" plan,

restores financial solvency mostly with reductions in benefits, and in addition imposes mandatory employee contributions to individual savings accounts. The third, labeled the "personal security account" plan, achieves long-range financial balance through a major redesign of the system that gradually replaces a major portion of the Social Security retirement benefit with individual private savings accounts.

Elements of the Council's recommendations were reflected in a number of bills introduced in the 105th Congress. More than 30 financing reform bills were introduced, most of which would permit or require the creation of personal savings accounts to supplement or replace Social Security benefits for future retirees. Some of the bills would allow or require the investment of Social Security trust funds in the financial markets. Although none of these measures were acted upon during the 105th Congress, similar proposals may be considered during the 106th Congress.

Other Social Security measures were taken up by lawmakers during the 105th Congress. In April 1998, the House of Representatives passed H.R. 3546 (the National Dialogue on Social Security Act of 1998). The measure would direct the President, the Speaker of the House of Representatives, and the Majority Leader of the Senate to convene a national dialogue on Social Security through regional conferences and Internet exchanges. The dialogue would serve both to educate the public regarding the Social Security program and generate comments and recommendations for reform. The measure also would establish the Bipartisan Panel to Design Long-Range Social Security Reform which would be required to report a single set of recommendations for restoring long-range solvency to the system. The Senate did not act on the measure prior to adjournment of the 105th Congress.

In September 1998, the House of Representatives passed H.R. 4578 which would create a "Protect Social Security Account" in the Treasury into which 90 percent of unified budget surpluses projected over the next 11 years would be deposited until the Social Security system is projected to be in long-term balance. Subsequently, the House inserted the language in H.R. 4578 into H.R. 4579 (the Taxpayer Relief Act of 1998) also passed by the House in September 1998. The Senate did not act on the measure prior to adjournment of the 105th Congress.

H.R. 4579 (the Taxpayer Relief Act of 1998) also included a provision that would have increased the Social Security earnings test exempt amount for recipients at or above the full retirement age according to a specified timetable through 2008 (the earnings test exempt amount is the amount of earnings Social Security recipients may earn before their benefits are reduced). After 2008, the exempt amount again would be indexed to wage growth. The provision was not included in any other legislation passed by the 105th Congress.

As Social Security's long-range financial picture has worsened, an increase in the retirement age has been the target of renewed interest. Two of the three sets of proposals put forth by the 1994–1996 Advisory Council on Social Security recommended that the increase in the full retirement age to 67 in current law be accelerated, so that it would be fully effective in 2016 (instead of 2027), and indexed thereafter to increases in longevity. One of these two

sets of proposals further recommended that the early retirement age be raised in tandem with the full retirement age until it reached age 65, where it would remain, but with increased actuarial reductions as the full retirement age continues to increase. A number of bills that would raise the early retirement age and the full retirement age were introduced during the 105th Congress.

Legislators also addressed concerns over the small number of disability recipients who leave the benefit rolls and return to work. In June 1998, the House of Representatives passed H.R. 3433 (the Ticket to Work and Self-Sufficiency Act of 1998). Under the legislation, a disabled beneficiary would be given a "ticket" which could be used to obtain employment, vocational rehabilitation, or other support services from approved providers. The service provider would be entitled to a share of the cash benefit savings that result from the beneficiary's return to work. The Senate did not take up the measure prior to adjournment of the 105th Congress.

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 1998, $31.3 billion in monthly benefits were paid to Social Security beneficiaries, with payments to retired workers averaging $768 and those to disabled workers averaging $723. In 1998, administrative expenses were $3.4 billion, representing less than 1 percent of total revenues.

The Social Security program touches the lives of nearly every American. In November 1998, there were 44.2 million Social Security beneficiaries. Retired workers numbered 27.5 million, accounting for 62 percent of all beneficiaries. Disabled workers and dependent family members numbered 6.3 million, comprising 14 percent of the total, while surviving family members of deceased workers totaled 7.1 million or 16 percent of all beneficiaries. In 1999, there are an estimated 149.9 million workers in Social Security-covered employment, representing over 95 percent of the total American work force.

In 1999, Social Security contributions are paid on earnings up to $72,600, a wage cap that is annually indexed to keep pace with inflation. Workers and employees alike each pay Social Security taxes of 6.2 percent on earnings. In addition, workers and their employers pay 1.45 percent on all earnings for the Hospital Insurance (HI) part of Medicare. For the self-employed, the payroll tax is doubled, or 15.3 percent of earnings, counting Medicare.

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 currently exceeding the outflow of benefit

payments. At the end of 1997, the Social Security trust funds held assets totaling $656 billion.

(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.

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 approaches the 21st century.

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 1974–1975 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 Commission 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 Secu-

rity 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 154 percent by 1997. Under the Social Security trustees' intermediate assumptions, the contingency fund ratio in 1999 is an estimated 191 percent (188 percent under pessimistic assumptions).

(D) OASDI NEAR-TERM FINANCING

Combined Social Security trust fund assets are expected to increase over the next 5 years. According to the 1998 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 payroll tax increases—from 6.06 percent in 1989 to 6.2 percent in 1990. The OASDI reserves are expected to steadily build for the next 20 years peaking at $3.8 trillion in 2020.

(E) OASDI LONG-TERM FINANCING

In the long run, the Social Security trust funds will experience two decades of rapid growth, followed by declining fund balances thereafter (annual deficits are projected to occur starting in 2013). Under intermediate assumptions, the program's cost is expected to exceed its income by 16 percent on average over the next 75 years.

It should be emphasized that the OASDI trust fund experience in each of the three 25-year periods between 1998 and 2072 varies considerably. In the first 25-year period (1998 to 2022) revenues are expected to exceed costs on average by 1.4 percent. Annual balances are projected to remain positive through 2012, with negative balances occurring thereafter. By 2007, the contingency fund ratio is projected to be 301 percent. In the second 25-year period (2023 to 2047) the financial condition of OASDI deteriorates and the trust funds are projected to become insolvent early in the period (2032) under intermediate projections. On average, program costs are expected to exceed revenues by 35 percent. The third 25-year period (2048 to 2072) is expected to be one of continuous deficits. As annual deficits persist, program costs are expected to exceed revenues on average by 42 percent.

(1) Midterm Reserves

In the years between 1999 and 2012, it is projected that Social Security will receive 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 (beginning in 2013). 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 in the future. The growing trust fund reserves enable Congress to spend more money on other government activities 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 "baby-boom" generation which will begin to retire in 2008 (at age 62). 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 4.6 percent of GDP. Under intermediate assumptions, Social Security is expected to rise to 6.9 percent of GDP by 2072.

(F) SOCIAL SECURITY'S RELATION TO THE BUDGET

Over the years, Social Security has been entangled in debates over the Federal budget. 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. More recently, it

was argued that growing reserves served to mask the true size of the deficit. In fact, many Members of Congress contended that the inclusion of the surpluses disguised the Nation's fiscal problems. As budget shortfalls grew, concern persisted over the temptation to cut Social Security benefits to reduce budget deficits.

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 stated 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

Congress created new rules in 1990, as part of OBRA 90 (P.L. 101–508), known as "firewall" 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 7-year period. These firewall 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. 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 deemed necessary. Given the focus of Congress on the paring back of spending, and the hostile environment toward expanding entitlement programs, proposals for benefit improvements have made little progress.

(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 was the Senior Citizens Equity Act which included a measure that would roll back the 85 percent tax on Social Security benefits for beneficiaries with higher incomes.

In 1993, as part of the budget reconciliation process, 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 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) 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. Under the law, in 1999, the earnings test reduces benefits for Social Security beneficiaries under age 65 by $1 for every $2 earned above $9,600. Beneficiaries age 65 to 69 will have benefits reduced $1 for each $3 earned above $15,500. 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 earnings test is among the least popular features of the Social Security program. Consequently, proposals to liberalize or eliminate the earnings test are perennial. 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. 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 (the Contract with America Advancement Act, P.L. 104–121), 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 cost of the provision (an estimated $5.6 billion) was 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. An estimated 1 million recipients aged 65–69 are affected by the new earnings test. Their incomes could increase by more than $5,000 in 2002 depending on the level of annual earnings.

In September 1998, Congress took up legislation making further changes to the Social Security earnings test. The House of Representatives approved H.R. 4579 (the Taxpayer Relief Act of 1998) which included a provision that would have increased the earnings test exempt amount for recipients at or above the full retirement age according to the following timetable:

1998	$14,500
1999	17,000
2000	18,500
2001	26,000
2002	30,000
2003	31,300
2004	34,000

2005	35,400
2006	36,800
2007	38,350
2008	39,750

After 2008, the exempt amount again would be indexed to wage growth. The Senate did not take up the bill, and the measure was not included in any legislation passed by the 105th Congress.

(C) 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 surrounding 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 cost-of-living adjustments (or COLAs). 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 1970's and early 1980's 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 form 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.

(D) FINANCING OF SOCIAL SECURITY TRUST FUNDS

Focus on the long-term solvency of the Social Security trust funds has nullified proposals to increase benefits or cut payroll taxes. Despite the emergence of Federal budget surpluses for the first time in three decades, concern persists over expected future growth in expenditures for entitlement programs, including Social Security. Recent congressional proposals to shore up the financing of the Social Security trust funds range from relatively conservative adjustments within the current program to wholesale restructuring of the system.

(1) Raising the Retirement Age

To help solve Social Security's long-range financing problems, proposals have been made to increase the retirement age. Bills introduced in the 105th Congress would accelerate the phase-in of the increase to age 67, raise the early retirement age to 65 or 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 January 1997, the 1994–1996 Advisory Council on Social Security issued a report on recommendations to solve Social Security's long-range financial problems. Although it split into three factions because it could not

agree on a single set of proposals, two of the factions recommended that the increase in the full retirement age to 67 in current law be accelerated, so that it would be fully effective in 2016 (instead of 2027), and indexed thereafter to increases in longevity. One of these two factions also recommended that the early retirement age be raised in tandem with the full retirement age until it reached age 65, where it would remain, but with increased actuarial reductions as the full retirement age continues to increase. During the 105th Congress, a number of proposals to raise the retirement age were introduced.

Senator Gregg introduced a bill (S. 321) that would raise the full retirement age and the early retirement age to 70 and 65, respectively, by 2037, and by ½ month per year thereafter.

Representative Sanford introduced a bill (H.R. 2768) that would gradually increase the age for full retirement, aged spouses and widow(er)s benefits to 70. The full retirement age would increase by 2 months for each year that a person was born after 1937 (i.e., who attain age 62 after 1999), until it reached age 70 for those born in 1967 (i.e., 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 increase (e.g., the reduction for retirement at age 62 would be 40 percent). Similarly, H.R. 2929 introduced by Representative Porter would raise the full retirement age to 70 by 2037 in the same manner as H.R. 2768.

Another bill introduced by Representative Sanford (H.R. 2782) would raise the full retirement age to age 70 by 2037 and by one-half month per year thereafter. The early retirement age would be raised to 65 by 2020, and by one-half month per year beginning in 2033.

Representative Nick Smith introduced a bill (H.R. 3082) that would raise the full retirement and early retirement ages by raising the full retirement age by 3 months per year that a person is born after 1937 (who attains age 62 after 1999) until it reaches age 69 for those born in 1953 (age 62 in 2015). The early retirement age would also rise by 3 months per year , until it reaches age 65 for those born in 1949 (age 62 in 2011). The earliest age for eligibility for widow and widower benefits likewise would rise, to age 63 for those born in 1949. After 2015, the full retirement age would be adjusted so as to maintain a constant ratio of projected life expectancy at the full retirement age to potential working years, defined as the full retirement age minus 20, and the early retirement age would be adjusted to be 4 years (6 years for widows and widowers) lower than the full retirement age.

Senator Moynihan introduced a bill (S. 1972) that would raise the full retirement age to 68 by 2017, and would raise it thereafter by 1 month every 2 years until it reaches age 70.

Senator Gregg and Representative Kolbe introduced legislation (S. 2313 and H.R. 4256, respectively) that would raise the full retirement age to 70 by 2037 in the same manner as S. 321 described above, but would increase it thereafter by about 1 month every 3 years.

None of these bills were enacted in the 105th Congress.

(2) "Means Testing" 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).

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 that received 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 show that the number of Social Security recipients with annual incomes over $50,000 is estimated to be 6.6 million (estimate for 1997). 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.

As Congress addresses Social Security's long-range financing problems, means testing Social Security benefits may once again be raised as a cost-saving option.

(3) Bipartisan Panel to Design Long-Range Social Security Reform

In April 1998, the House of Representatives passed H.R. 3546 (the National Dialogue on Social Security Act of 1998). The measure would direct the President, the Speaker of the House of Representatives, and the Majority Leader of the Senate to convene a national dialog on Social Security through regional conferences and

Internet exchanges. The dialog would serve both to educate the public regarding the Social Security program and generate comments and recommendations for reform. The measure also would establish the Bipartisan Panel to Design Long-Range Social Security Reform which would be required to report a single set of recommendations for restoring long-range solvency to the system. The Senate did not act on the measure prior to adjournment of the 105th Congress.

(4) Use of Projected Federal Budget Surpluses

In September 1998, the House of Representatives passed H.R. 4578 which would create a "Protect Social Security Account" in the Treasury into which 90 percent of unified budget surpluses projected over the next 11 years would be deposited until the Social Security system is projected to be in long-term balance. Subsequently, the House inserted the language in H.R. 4578 into H.R. 4579 (the Taxpayer Relief Act of 1998) also passed by the House in September 1998. The Senate did not act on the measure prior to adjournment of the 105th Congress.

(5) Privatization

The 1994–1996 Advisory Council on Social Security issued a report in January 1997 on ways to solve the program's long-range financing problems. The Council could not reach a consensus on a single approach, so the report contains three different proposals that are intended to restore long-range solvency to the Social Security system. The first proposal, labeled the "maintain benefits" plan, keeps the program's benefit structure essentially the same by addressing most of the long-range deficit through revenue increases, including an eventual rise in the payroll tax, and minor benefit cuts. To close the remaining gap, it recommends that investing part of the Social Security trust funds in the stock market be considered. The second, labeled the "individual account" plan, restores financial solvency mostly with reductions in benefits, and in addition imposes mandatory employee contributions to individual savings accounts. The third, labeled the "personal security account" plan, achieves long-range financial balance through a major redesign of the system that gradually replaces a major portion of the Social Security retirement benefit with individual private savings accounts.

Elements of the Council's recommendations were reflected in a number of bills introduced in the 105th Congress. More than 30 financing reform bills were introduced, most of which would permit or require the creation of personal savings accounts to supplement or replace Social Security benefits for future retirees. Some of the bills would allow or require the investment of Social Security trust funds in the financial markets. Although none of these measures were acted upon during the 105th Congress, similar proposals may be considered during the 106th Congress.

B. SOCIAL SECURITY—DISABILITY INSURANCE

1. BACKGROUND

In recent years, Congress has raised concern over SSA's administration of the largest national disability program, Social Security Disability Insurance (SSDI). In particular, there was concern that some SSDI beneficiaries were using the benefit to purchase drugs and alcohol. As a result of extensive investigation, Congress responded to these concerns 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. The latest projections by the Social Security trustees show that the DI trust fund will remain solvent until 2019.

More recently, Congress has addressed concerns over the small number of disability recipients who leave the benefit rolls because they return to work. In June 1998, the House of Representatives passed H.R. 3433 (the Ticket to Work and Self-Sufficiency Act of 1998). Under the legislation, a disabled beneficiary would be given a "ticket" which could be used to obtain employment, vocational rehabilitation, or other support services from approved providers. The service provider, in turn, would be entitled to a share of the cash benefit savings that result from the beneficiary's return to work. The Senate did not take up the legislation prior to the adjournment of the 105th Congress.

(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 (CDRs) was to terminate benefits to recipients who were no longer disabled.

SSA had drastically cut back on CDRs partly due to budget shortfalls that left it unable to meet the mandated requirements for the number of CDRs it must perform. In addition, Congress continued to encounter evidence of a deterioration in the quality and timeliness of disability determinations being conducted by SSA, even as the agency was undertaking a system-wide disability redesign, intended to address backlogs and improve decision-making.

2. Issues and Legislative Response

(A) FINANCIAL STATUS OF DISABILITY INSURANCE TRUST FUND

The Social Security trustees warned in 1993 that the SSDI program was 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 reflected rapid enrollment increases over the past few years and tax revenues constrained by a stagnant economy.

The SSDI trust fund's looming insolvency 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 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 was in danger and to provide time to assess whether an improving economy would alter the outlook. Others favored only a temporary reallocation to force a careful assessment of the factors driving up enrollment and whether there were 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 have been 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 existed in the House and the Senate to address this issue again as soon as possible. Congress acted in late 1994 by enacting a reallocation as part of P.L. 103–387. According to the 1998 trustees' report, the DI trust fund is projected to remain solvent until 2019 and the OASI fund is projected to remain solvent until 2034 (on a combined basis, the trust funds are projected to remain solvent until 2032).

(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. Since the inception of Supplemental Security Income (or SSI, a program financed with general fund revenues and administered by SSA), 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 fi-

nances. 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.

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 1994 elections, 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 for receipt of Social Security benefits were rejected because there were no offsets to "pay for" the desired increase in the earnings limit. Senator McCain and Representative Bunning 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 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 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 its disability determination system. The problems were first identified at hearings in 1990. Congressional investigations found 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.

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 targeted the SSDI program and the disability component of SSI.

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. Rather, SSA plans to reengineer the process in a way that makes it easier for individuals to file for and, if eligible, to receive disability benefits promptly and efficiently, and that minimizes 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 redesigned process will include two basic steps, instead of a 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 claims processing system.

At the close of 1998, SSA continued to implement the disability process redesign. SSA's Accountability Report for Fiscal Year 1998 states:

> The initial DI claims workload continues to present challenges for SSA as it remains one of the largest workload categories in SSA. Its demands on our resources are considerable as we progress with our disability process redesign * * * The Agency is diligently working to fully transform the disability process redesign from a vision into a reality.

(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. 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. A GAO study was commissioned 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 study found that about 4.3 million DI and SSI beneficiaries were due or overdue for CDRs in fiscal year 1996. GAO found that SSA had already embarked on reforms that would improve the CDR process, although the agency found that the proposal would not address all of the problems.

In March 1996, Congress enacted H.R. 3136 (the Contract with America Advancement Act, P.L. 104–121) which provided a substantial increase in the funding for CDRs—more than $4 billion over 7 years. With this new funding, SSA developed a plan to conduct 8.2 million CDRs during fiscal years 1996 through 2002.

In September 1998, GAO released its findings that SSA is making progress in conducting CDRs, with 1.2 million processed during the first 2 years of the initiative. In its Accountability Report for Fiscal Year 1998, SSA reports that it expects to process a total of 9.4 million CDRs over 7 years (1.2 million more than originally estimated). The number of CDRs conducted in fiscal year 1998 exceeded the number conducted in fiscal year 1997 by 101 percent, and an estimated 1.6 million CDRs will be conducted in fiscal year 1999. According to SSA's estimates, the DI backlog will be eliminated in 2000, and the SSI backlog will be eliminated in 2002.

C. OUTLOOK FOR THE 106TH CONGRESS

The 106th Congress promises to be an important year on the legislative front. Hearings on Social Security reform will be held, and a variety of options, ranging from adjustments within the current program to a major restructuring of the system, likely will be considered to resolve Social Security's long-range financing problems.

Chapter 2

EMPLOYEE PENSIONS

BACKGROUND

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 1997, Congress took steps to strengthen protections for participants in § 401(k) salary deferral plans. Several measures relaxed Federal restrictions on government employer plans. An excise tax on large pension distributions was repealed. The Federal Thrift Savings Plan was authorized to establish three new investment options, and Federal employees under the closed Civil Service Retirement System (CSRS) were granted an "open season" to switch to the Federal Employees Retirement System (FERS).

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. About two out of every three private-sector workers who have attained age 21, work at least 1,000 hours per year, and have worked for at least 1 year are covered by a pension plan. Assets totaled $2.7 trillion at the end of 1995. Employees of larger firms are far more likely to be covered by an employer-sponsored pension plan than are employees of small firms.

Nearly half of 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.

Many 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 buildup) and the likelihood that benefits may be 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 Job 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 Job Protection Act of 1996 was 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 may 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 Job 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 "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, requires 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 Job Protection Act was to increase the number of employers who offer defined contribution plans to their employees. This reflects the preference for defined contribution plans by small employers because of their low cost and flexibility. This preference is demonstrated by the growth in the number of 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 restoring to 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, however.

The new law also authorized a "savings incentive match plan for employees" or SIMPLE. This authority replaced 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 1999 limit remains at $6,000 because of low inflation since authorization of SIMPLE.) 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 $5,000 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.

Some workers that receive lump-sum distributions spend them rather than save them. Thus, distributions appear to reduce retirement income rather than increase it. Survey data for 1996 indicate that only 46 percent of recipients put at least part of their lump-sum distributions into retirement accounts.

The Small Business Job Protection Act eliminated the 5-year averaging of lump-sum pension distributions. The 10-year averaging for the "grandfathered" class was maintained, however.

(B) TAX EQUITY

Private pensions are encouraged through tax benefits, projected by the Treasury to be $77.4 billion for fiscal year 2000. 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 by repealing 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. These limits were relaxed somewhat by the Taxpayer Relief Act of 1997 (P.L. 105–34). The $35,000 limit will rise gradually, reaching $60,000 in 2005. The $50,000 limit will reach $100,000 in 2007. Furthermore, the Roth IRA, which was authorized by The Taxpayer Relief Act of 1997, allows individuals to save after-tax income and make tax-free withdrawals if certain conditions are met. Roth IRAs are allowed for taxpayers with AGI no greater than $110,000 ($160,000 for joint filers).

The Small Business Job Protection Act included a major expansion of IRAs. The Act allows 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.

The Tax Reform Act of 1986 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 1999, the limit on contributions to 401(k) and 403(b) plans is $10,000. These limits are subject to annual inflation adjustments rounded down to the next lowest multiple of $500.

(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 $34,568 a year in 1998 (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.

Over time, concern grew that the single-employer termination insurance program was inadequately funded. A major cause of the PBGC's problem was 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 un-

able 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 considerably. 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 guaranteed 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 the Omnibus Budget Reconciliation Act of 1987 (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 had grown steadily until 1994, when PBGC estimated a shortfall of about $71 billion in assets, concentrated in the steel, airline, tire, and automobile industries. While three-quarters of the underfunding was in plans sponsored by financially healthy firms and did not necessarily pose a risk to PBGC or plan participants, the remaining plans were sponsored by financially troubled companies covering an estimated 1.2 million participants. In 1995, PBGC estimated a reduction in the asset shortfall to $64 billion, and the agency believes that further reductions have occurred since 1995.

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

(D) ISSUES FOR THE 106TH CONGRESS

It is clear that private pension plan coverage rates did not increase significantly in the period 1990–1996. The high concentration of small firms in the expanding service industry and the low coverage rates among service industry workers account largely for this stagnation in the private pension coverage rate. Congressional action in 1996 to authorize SIMPLE plans for small firms may have some impact on coverage, and the 106th Congress is likely to consider further measures to extend coverage in the small-business sector.

Another trend in pension coverage of concern to some is the shift away from traditional defined benefit plans toward discretionary employee retirement savings arrangements, which may lessen retirement income security for some workers. 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.

Pressure during the 1980's and 1990's to reduce Federal budget deficits led to a number of belt-tightening measures aimed at tax advantages for employer pensions, which account for the largest single Federal tax expenditure. Now that budget surpluses are projected, and there is a strong continuing interest in improving private retirement saving, the 106th Congress may revisit these issues and consider relaxing certain plan limits.

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

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 21st century, amounting to a benefit reduction, and further cuts are being contemplated. Thus, lawmakers, economists, consultants, and others concerned about retirement income security will likely continue to seek reforms in the private pension system.

Finally, the role that pension funds can play in improving the economy and public infrastructure is often debated because of the huge amount of money accumulated in pension funds and the budgetary constraints that limit the ability of Federal and State governments to address their economic problems. Proposals to attract public and private pension fund investment in financing the rebuilding of roads, bridges, highways and other public infrastructure have aroused concerns that the Nation's $4 trillion in pension funds may be placed at risk by those who advocate that pension managers engage in "economically targeted investing" (ETI). The Clinton Administration has backed away from active advocation of ETIs because of opposition in Congress, however.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. BACKGROUND

Pension funds covering 13.3 million State and local government workers and retirees held assets that were worth $1.4 trillion at the end of 1995. 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 face other fiscal demands and sometimes seek relief by reducing or deferring contributions to their pension plans in order 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 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. In the Taxpayer Relief Act of 1997 (P.L. 105–34), Congress permanently exempted public plans from Federal tax code rules regarding nondiscrimination among participants and minimum participation standards.

(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) an especially 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 $10,000 (in 1999). The maximum contribution to a 403(b) plan (tax-sheltered annuity for public school employees) was reduced to $9,500 a year (now also $10,000), and employer contributions for the first time were made subject to nondiscrimination rules. In ad-

dition, 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. (It has since been indexed for inflation and is $8,000 in 1999.) 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 nontaxable 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 provided for a one-time use of 5-year forward-averaging after age 59.5. However, 5-year averaging was later repealed, effective in 2000.

2. Issues and Legislative Response

Issues surrounding Federal regulation of public pension plans have changed little in the past 25 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 poor plan investment performance was often a problem. Many plans were not funded on the basis of sound actuarial principles and assumptions, resulting in funding levels 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 has been considerable variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the nondiscrimination 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. Congress acted in 1996 to exempt public employee plans from the nondiscrimination and minimum participation rules of the Federal tax code.

The issue of Federal standards has been tested partially in the courts. 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 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.

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 divergent 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 the opportunity for state and local governments to opt into Social Security coverage 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 "open seasons" in 1987 and 1998. 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; that is, retirement benefits are determined by a formula established in law that bases benefits on years of service and salary. Although employees are required to pay into the system,

the amounts workers pay are not directly related to the size of their 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 employees. 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.[1] These contributions covered 10 percent of the annual cost of benefits to current annuitants in fiscal year 1998.

The trust fund provides automatic budget authority for the payment of benefits to retirees and survivors without the Congress having to enact annual appropriations. So 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 1998, the value of trust fund holdings was $451 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 was estimated to be about $768 billion at the end of fiscal year 1997. This amount exceeded the balance in the fund at that time by about $341 billion, which represents the unfunded liability of the retirement systems.

Critics of the Federal pension plans sometimes cite the unfunded liability of the plans as a threat to future benefits or the viability

[1] These contribution rates were increased temporarily by a 1997 budget deficit reduction bill. The CSRS rates are 7.25 percent in 1999, 7.4 percent in 2000, and 7.5 percent in 2001. The FERS rates are 1.05 percent in 1999, 1.2 percent in 2000, and 1.3 percent in 2001. The permanent rates will again apply beginning on Oct. 1. 2001.

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 likely to go out of business. The estimated Federal pension plan liabilities represent a long-term, rolling commitment that never comes due at any one time. The Government's obligation to pay Federal pensions is spread over the retired lifetimes of past and current Federal workers, including 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 surplus or deficit. The only costs of the Federal retirement system that show up as outlays in the budget, and which therefore contribute to a deficit or reduce a surplus, 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. 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. Thus, it will never have to be paid off by the Treasury, as must other U.S. Government securities such as bonds or Treasury bills, which must be paid, with interest, to the private individuals who purchased 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 unfunded liability, while indicative of future costs that must be financed by government over a long time period, is not particularly relevant as a measure of a sum that might have to be paid at a point in time.

(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 thresholds 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. (As mentioned above, contribution rates are temporarily higher.) 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 in lieu of repayment of 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 no more than $4,128 per year in 1998 ($4,944 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 delayed 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 returned to January 1.

(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 service; 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 supple-

ment is also paid to involuntarily retired workers between ages 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 1.1 percent of high-3 for workers retiring at age 62 or over with at least 20 years of service. 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 percent of gross pay up to the taxable wage base of $72,600 (in 1999). The wage base is indexed to the annual growth of wages in the national economy. Under permanent law, executive branch employees enrolled in FERS contribute the difference between 7 percent of gross pay and the Social Security tax rate. Thus, in 1998, FERS participants contribute 0.8 percent of wages up to $68,400 and 7 percent on wages over $68,400. (The FERS contribution rate will rise temporarily to 1.05 percent in 1999, 1.2 percent in 2000, and 1.3 percent for the first 9 months of 2001.)

(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: $21,783 (in 1998, indexed annually by 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 pay partially for the cost of the survivor benefit.

Dependent children (defined the same 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, with this exception: the FERS COLA is reduced by 1 percentage point if the CSRS COLA is 3 percent or more; it is limited to 2 percent if the CSRS COLA falls between 2 and 3 percent. FERS COLAs are payable only 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, unlike CSRS, FERS nondisability retirees are ineligible for a COLA so long as they are under age 62.

(6) Thrift Savings Plan (TSP)

FERS supplements the defined benefits plan and Social Security with a defined 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, received through several periodic payments, 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 $10,000 in 1999. The employing agency matches the first 3 percent of pay contributed on a dollar-for-dollar basis and 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 equals 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 TSP accounts. Originally, loans were restricted to those for the purchase of a primary residence, educational or medical expenses, or financial hardship. However, P.L. 104–208 removed this restriction effective October 1, 1996.

The TSP allows investment in one or more of three funds: a stock index fund, an index fund that tracks fixed-income securities such as corporate bonds, and a fund that pays interest based on the yields on certain Treasury securities. In 1996, Congress authorized the TSP to initiate two additional funds: an international fund, and a fund that invests in small-capitalization stocks. These new funds are not expected to be in operation until 2000.

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. In 1995, Congress directed the Bureau of Labor Statistics to improve its measurement of inflation. These improvements are expected to result in slightly lower retirement benefit COLAs each year than would otherwise have occurred.

(B) RETIREMENT AGE

The age at which an employer permits workers to retire voluntarily 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 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 called the "golden handcuffs," 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 that 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. The matching rates have been criticized by some as overly generous. However, others advocate higher TSP contribution limits, with the goal of reducing or eliminating the FERS defined benefit pension.

(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 also to 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 but modified the formula before it was phased in completely.

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 rising wage levels. The formula for a worker who turns age 62 in 1999 is 90 percent of the first $505 in average monthly earnings, plus 32 percent of the amount between $505 and $3,043, and 15 percent of the amount over $3,043.

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.

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 service members 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 1998, 1.9 million retirees and survivors received military retirement benefits. For fiscal year 1998, total Federal military retirement outlays have been estimated at $31.5 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 formula 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) LONG-TERM COSTS

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 1.9 million retired officers, enlisted personnel, and their survivors received nearly $31.5 billion in annuity payments in fiscal year 1998. At the current rate of growth, this expenditure will reach an estimated $33.7 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 1998, military retirees and survivors received an average of $16,400 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 the Persian Gulf War in 1990–1991.

(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.

(B) CURRENT MILITARY RETIREMENT ISSUES

(1) Should the 1986 military retirement cuts be repealed?

The cost and benefit reductions in military retirement enacted in the Military Retirement Reform Act of 1986 were adopted with the stated purpose of bringing military retirement more in line with civilian systems; saving money; creating an incentive for longer military careers, thereby creating a more experienced and capable career force; and enabling the military to manage their career force better. However, concern is growing that their prospective effective date (the 1986 Act's reductions will first be effective for those retiring 20 years later, in mid-2006) is contributing to the departure of too many career people, by reducing the incentive to remain on active duty until retirement, and thereby hampering the ability of retirees to compensate for reduced civilian salaries in their second careers.

The services are experiencing considerable problems in recruiting and retaining sufficient career personnel, due to competition from a booming civilian economy where skilled labor shortages are wide-

spread; frequent moves for which the reimbursements are never complete; a military health care system adjusting to managed-care problems; and a high frequency of family separation. Dissatisfaction with the 1986 Act is frequently cited by active duty military personnel in press accounts of military retention problems. Although some economic analysts have suggested that there are better ways to inject more money into the compensation package (such as those proposed by the Rand Corporation, well-known for its extensive experience in application of economic analysis to military personnel and compensation programs), the very negative psychological effect of the 1986 Act's cuts among "the troops"—and the presumed positive effect of their repeal—may well carry the day in 1999. Secretary of Defense Cohen and Joint Chiefs of Staff Chairman General Hugh Shelton have recommended restoration of the cuts made by the 1986 Act, and the individual members of the JCS have recommended its complete repeal. A proposal to restore the cuts in the benefit formula made by the 1986 Act (but not its reductions in the COLA formula) were on the table during discussions on the FY1999 supplemental appropriations bill, but were rejected before actually being introduced. It seems certain that attempts will be made again when the 106th Congress convenes.

(2) Should a military Thrift Savings Plan (TSP) be created?

There has been considerable discussion about whether a Thrift Savings Plan for military personnel, analogous to the TSP for the Federal civil service, or to so-called "401k" programs in the private sector, should be established. Under such a plan, a portion of an active duty military member's pay would be deposited into a tax-deferred individual account where the funds are held in trust and invested, to be withdrawn in retirement. Adopting such a plan would give military personnel a retirement benefit now widely available to civilians, and would enable military personnel to share in the long-term rise in equity markets (especially because frequent moves usually make it difficult for military families to obtain long-term investment growth through home ownership over a long period of time). Some suggest that adopting a thrift savings plan would provide an excuse for DOD and/or the Congress to cut other aspects of military retirement, and would have enormous problems of design and administration; the unofficial Retired Officers Association is perhaps the best-known skeptic. However, partisans of current active duty personnel and future retirees, rather than advocates for those already retired, appear to be much more supportive.

(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 max-

imum 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 a 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 eligible 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, three 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 third group includes reservists who were eligible for retired pay except for the fact that they had not yet reached 60 years of age. The spouses or former spouses of military personnel who were not qualified to receive military re-

tired 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 retirees and survivor benefit recipients, along with Social Security and other Federal retirees, received a 2.1 percent COLA effective January 1, 1998. The next COLA will first be paid on January 1, 1999, as a 1.3 percent increase.

3. RECENT ISSUES AND LEGISLATIVE RESPONSE

In 1997, Congress enacted legislation that would provide a monthly annuity of $165 to so-called "forgotten widows." Two groups were deemed eligible for this annuity. The first consists of survivors of retired service members who died before March 21, 1974 and who were drawing military retired pay at the time of death. The second group consists of survivors of a Reserve member who had 20 years of qualified service at the time of death (but less than 20 years of active duty) and who died between September 21, 1972 and October 1, 1978. Survivors who are receiving Dependency and Indemnity Compensation from the VA are ineligible. Subsequent remarriage by the survivor may also affect eligibility. This amount is subject to cost-of-living adjustments.

Starting on May 17, 1998, participating retirees who retired on or before May 17, 1996 were given an opportunity to drop their coverage. These retirees will have 1 year to make this decision. In addition, those who have retired since May 17, 1996, including future retirees, will be provided with a 1-year open season to terminate their participation in SBP, beginning on the second anniversary of their retirement date.

In 1998, Congress created the so-called "paid up" provision that would retain coverage but discontinue retired pay withholdings for retirees who paid for this coverage for thirty years or reached age 70, whichever came later. These provisions are not scheduled to become effective until 2008.

E. RAILROAD RETIREMENT

1. Background

The Railroad Retirement program is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with Social Security. The system was first established during the period 1934–37, independent of the creation of Social Security, and remains the only federal 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 FY1998, $8.3 billion in retirement, disability, and survivor benefits were paid to 720,000 beneficiaries of the rail industry program. As of January 1999, the Railroad Retirement equivalent of Social Security (Tier I) is increased by 1.3 percent as a result of the Cost-of-Living Adjustment (COLA) applied to those benefits. The industry pension component (Tier II) is increased by 0.4 percent because of an automatic adjustment (32.5 percent of the Tier I COLA) to that benefit. As of January 1999, the regular Railroad Retirement annuities average $1,297 per month, and combined benefits for an employee and spouse average $1,887. Aged survivors average $777 per month.

2. Issues and Legislative Response

(A) THE EVOLUTION OF RAILROAD RETIREMENT

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 outlined by the 1937 legislation, the Railroad Retirement system was designed to provide annuities to retirees based on all rail earnings and length of service in the railroads. The present Railroad Retirement program dates to the Railroad Retirement Act of 1974 (the 1974 Act), which fundamentally reorganized the program. Most significantly, the Act created a two-tier benefit structure in which Tier I was intended to serve as an equivalent to Social Security and Tier II as a private pension.

Under current law, workers are eligible for benefits from Railroad Retirement, only if they have completed 10 years of railroad service. 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 1974 Act continued the previous practice of a separate system for railroad employees, but eliminated the opportunity to qualify for separate Railroad Retirement and Social Security benefits, based on mixed careers with periods of nonrail and rail employment.

In its initial report, the National Performance Review (NPR), a special study group created in the early days of the Clinton Administration, proposed to disperse the Railroad Retirement Board (RRB) functions to other agencies. 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 described below 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.

(B) FINANCING RAILROAD RETIREMENT, AND THE RAILROAD UNEMPLOYMENT/SICKNESS INSURANCE 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/Sickness Insurance 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 Railroad Unemployment/Sickness Insurance 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, a balance established through congressional legislation. 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 1999, the tax is 6.2 percent of pay for both employers and employees up to a maximum taxable wage of $72,600.

Tier II benefits are also financed by a payroll tax. In 1999, the payroll tax is 16.10 percent for employers and 4.90 percent for employees on the first $53,700 of a worker's covered railroad wages. The relative share of employer and employee financing of Tier II benefits is collectively bargained.

Financial "interchange" with Social Security.—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.

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 the Congress accepted a federal obligation for the costs of phasing out windfalls because no alternative was satisfactory. Congress apparently accepted 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 rail employees should not be expected to pick up the costs of a benefit to which they could not become entitled. For FY1999, Congress has appropriated $191 million (down from $314 million in FY1992).

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.

(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 revenue 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. Under legislation to reinforce Railroad Retirement financing in 1983, the proceeds from this tax are transferred to the railroad retirement Tier II account to help defray its costs. This transfer is a direct general fund subsidy to the Tier II account, 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 is no immediate impact of this transfer on federal taxpayers or on the federal budget.

(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 concluded 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.

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 Insurance programs will likely remain in their present form for the foreseeable future. There are no immediate threats to their financial stability, and no proposals are under consideration that would substantially alter their respective revenue or benefit structures.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

The Federal tax code recognizes the special needs of older Americans. The code, through special tax provisions designed for use by elderly American taxpayers, helps to preserve a standard of living threatened by reduced income and increased nondiscretionary expenditures such as those for health.

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 from higher income recipients are returned to the Social Security trust funds.

The Tax Reform Act of 1986 (TRA86) (P.L. 99–514) resulted in a number of changes to tax laws affecting older men and women. For example, the TRA86 repealed the extra personal exemption for the aged but replaced it with an extra standard deduction amount. This additional standard deduction amount is combined with an increased standard deduction available to all taxpayers and is indexed for inflation. Thus, the Congress wishes to target the tax benefits to lower and moderate income elderly taxpayers through the substitution.

The Omnibus Budget Reconciliation Act of 1990 (OBRA90) (P.L. 101–508) made changes to individual, corporate, excise, and employment provisions of the tax laws. In general, the individual income tax changes that were made affected the tax burden of the general population at large but did not include provisions specifically targeting the elderly. This Act did provide a tax credit to small businesses for expenditures made to remove architectural, communication, physical, or transportation barriers that prevented a business from being accessible to, or usable by, those either elderly or with disabilities.

The Congress passed the Taxpayer Relief Act of 1997 (TRA97) (P.L. 105–34) to provide a modest size tax cut that in the aggregate consists of a variety of measures applying to particular types of taxpayers, income, and activities. Included among its most prominent features and of interest to many older Americans are a cut in

the tax rates that apply to capital gains, reduction of estate taxes, and expansion of Individual Retirement Accounts.

A. TAXES

1. BACKGROUND

A number of longstanding provisions in the tax code are of special significance to older men and women. Examples 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, 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 tax provisions of importance to older persons. As an example, the extra personal exemption for the aged was repealed. However the personal exemption amount for taxpayers in general was substantially increased under the act and is now annually adjusted for inflation. In addition, the Act provides elderly and/or blind taxpayers who do not itemize an additional standard deduction amount. Like the personal exemption amount, this provision is also adjusted annually 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 revenues returned to the Social Security trust funds. This proposal was one 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 of that Act, 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 tax

when their income falls below the thresholds. 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 (such as 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). Benefits of recipients with combined incomes over $25,000 ($32,000 for joint filers) but not over $34,000 ($44,000 for joint filers) continue to be 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 1997, that figure rose to $7.9 billion. By the year 2000, they will reach an estimated $9.3 billion.

(B) THE TAX CREDIT FOR THE ELDERLY AND PERMANENTLY AND TOTALLY DISABLED

This credit was formerly called 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 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 or older 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 older, $5,000 for a married couple filing a joint return where only one spouse is age 65 or older 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 for the elderly and permanently and totally disabled. In addition, since the initial amounts have not been adjusted for inflation since enactment, the levels of tax free benefits are no longer similar when Social Security and other forms of taxable retirement benefits are compared.

(C) 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 years 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 1999 a taxpayer may lend up to $137,000 before being subject to the imputed interest rules.

(D) 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 particular significance to 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 available to all taxpayers, the provision of future inflation adjustments, and the addition to the Internal Revenue Code of an extra standard deduction amount for those elderly taxpayers who do not itemize deductions.

(2) Deduction of Medical and Dental Expenses

The Medicare program has grown from 19 million to 39 million today. 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 1970 to 1996 Medicare's average annual per enrollee spending growth was similar to that of the private sector (10.8 Medicare versus 11.3 for 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 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 19 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.

(A) 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 him being there, the entire cost of maintenance (including meals and lodging) may be included in medical expenses for purposes of the medical expense deduction.

(B) 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, installment 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 1998 is $2,700. The personal exemption amount will rise to $2,750 for tax year 1999. The standard deduction is $4,250 for a single person, $6,250 for a head of household, $7,100 for a married couple filing jointly, and $3,550 for a married person filing separately. For tax year 1999, the standard deduction amounts rise to $4,300 for a single person, $6,350 for a head of household, $7,200 for a married couple filing jointly, and $3,600 for a married person filing separately. The additional standard deduction amount for an elderly single taxpayer is $1,050 while married individuals (whether filing jointly or separately) may each receive an additional standard deduction amount of $850. These amounts will remain stable for tax year 1999.

(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 income tax forms. For tax year 1998, single persons age 65 or older do not have to file a return if their income is below $8,000. For married couples filing jointly, the limit is $13,350 if one spouse is age 65 or older and $14,200 if both are 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 $1,750 ($2,800 if 65 or older and blind), or their gross income exceeds the larger of $700 or the filer's earned income (up to $4,000) plus $250, plus $1,050 ($2,100 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 $4,400 ($5,250 if 65 or older and blind), their unearned income exceeds $1,550 ($2,400 if 65 or older and blind), or their gross income was more than the larger of $700 or their earned income (up to $3,300) plus $250, plus $850 ($1,700 if 65 or older and blind). All these amount's rise for tax year 1999.

(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."

(E) THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

The Omnibus Budget Reconciliation Act of 1990 (OBRA90) 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 1999, the 31 percent rate applies to single individuals with taxable income (not gross income) between $64,450 and $130,250. It applies to joint filers with taxable income between $104,050 and $158,550, and to heads of households with taxable income between $89,150 and $144,400. The Act set a maximum tax rate of 28 percent (which has since been reduced to 20 percent) on the sale of capital assets held for more than 1 year.

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," OBRA90 provided for the phasing out of personal exemptions and limiting itemized deductions for high income taxpayers. The phase out of personal exemptions for 1999 begins at $126,600 for single filers, $189,950 for joint filers, $158,300 for heads of households, OBRA90 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 $126,600. 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 OBRA90. 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 individ-

uals 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 OBRA90.

(F) 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.

(G) 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 OBRA90.

(H) 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.

(I) 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.

(J) 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.

(K) THE TAXPAYER RELIEF ACT OF 1997

The Taxpayer Relief Act (P.L. 105–34) provides a modest aggregate tax reduction consisting of several major tax cut measures aimed at particular categories of taxpayers, income, and activities (e.g., capital gains, saving and investment) along with a host of smaller, more narrow provisions. In targeting the tax reductions to certain activities and types of income, the bill was also intended to stimulate and encourage activities that were argued to be economically or socially beneficial. The tax cut for capital gains and liberalized IRA rules, for example, were supported on the grounds they would stimulate saving and investment.

(1) Capital Gains Provisions

The Act contains several provisions that reduce taxes on capital gains. The Act applies two reduced maximum rates: a maximum 10 percent rate to gains that would be taxed at 15 percent if ordinary income rates applied; and a maximum 20 percent rate to gains that would be subject to rates higher than 15 percent if they were ordinary income. Beginning in 2001, the Act reduces its 20 percent and 10 percent maximum rates to 18 percent and 8 percent for assets held more than 5 years. The Act also replaces prior law's benefits for gains from the sale of homes. The Act provides, instead, a $250,000 exclusion from gain from the sale of a principal residence ($500,000 for joint returns) that is not contingent on rollovers and is not restricted to those over 55.

(2) Individual Retirement Accounts

Prior law provided that participants and/or their spouses who were in retirement plans had contributions phased out beginning at AGIs of $25,000 ($40,000 for couples). Under the Act the phase-out thresholds for deductions is increased. The Act also created two new types of IRAs. A "back loaded" or Roth IRA provides that the contributions are not deductible but neither are the earnings on those accounts taxable. The Act also created education IRAs which allow contributions of up to $500 per student for secondary education expenses. Greater detail on the IRA provisions is provided later in this chapter.

(3) Estate and Gift

The Act reduces the estate and gift tax in a number of ways, but by far the largest reduction is a phased-in increase of the unified credit, which provides an effective tax exemption for transfers below a certain level. The 1997 Act gradually increases the exemption to $1,000,000, as follows: $625,000 in 1998; $650,000 in 1999; $675,000 in 2000 and 2001; $700,000 in 2002 and 2003; $850,000 in 2004; $950,000 in 2005; and $1,000,000 in 2006 and thereafter. The Act provides an additional benefit for estates comprised of family-owned businesses. Under its terms, up to $1,000,000 of a qualified estate can be excluded from tax. Among the other estate tax reductions are: indexation of several existing provisions that have the effect of reducing estate and gift taxes (e.g., the limit on "special use" valuation); reduction of estate tax for land subject to a conservation easement; and reduction of the interest rate applicable to installment payments of estate tax. Other provisions of interest to elderly taxpayers include technical corrections to medical savings accounts.

(4) The Impact of the Taxpayer Relief Act of 1997

To assess the Taxpayer Relief Act it helps to put it in perspective by comparing its policy direction to two landmark tax acts of the 1980s—the Economic Recovery Tax Act of 1981 and the Tax Reform Act of 1986. The 1981 and 1986 Acts are generally recognized to have been guided by opposing views of the appropriate role of tax policy in the economy. The 1981 Act was, in part, based on a belief in the economic efficacy of targeted tax incentives—that judiciously selected and aimed tax reductions could enhance economic performance. For example, one of ERTA's most prominent measures was expansion of Individual Retirement Accounts, which were designed to stimulate savings. Only 5 years later, however, the Tax Reform Act of 1986 was designed to promote economic efficiency, equity, and simplicity. It was based, in part, on the notion that the economy functions best when tax-induced distortions of behavior are minimized; both this idea and the Act's goal of horizontal equity led to an emphasis in its provisions on reducing differences in how different activities and types of income were taxed.

While a full assessment of the Taxpayer Relief Act is, of course, premature at this point, it is clear that the measure is closer to ERTA's guiding principles than those of the Tax Reform Act of 1986. For example, the 1997 Act's liberalized IRAs build on the

IRA concept that was expanded with ERTA. And both the Taxpayer Relief Act's IRA provisions and its cut for capital gains are based on the same belief in the efficacy of tax incentives for saving and investment that underlay much of the 1981 Act.

In contrast to the 1986 Tax Reform Act, there is little doubt that the 1997 Act added complications to the tax system as well as likely reducing horizontal equity. An important difference, however, between the 1997 Act and both ERTA and The Tax Reform Act is that the 1997 Act is substantially smaller than ERTA; and while the net revenue impact of the 1986 Act was quite small, it was substantially broader in scope than the Taxpayer Relief Act.

(L) BALANCED BUDGET ACT OF 1997

The Balanced Budget Act of 1997 (BBA97, P.L. 105–33) made several major changes to underlying Medicare law dealing with private health plans. It replaces the risk program (and other Medicare managed-care options, such as plans with cost contracts) with a program called Medicare+Choice (new Part C of Medicare). In doing so, it creates a new set of private plan options for Medicare beneficiaries. Every individual entitled to Medicare Part A and enrolled in Part B will be able to elect the existing package of Medicare benefits through either the existing Medicare fee-for-service program (traditional Medicare) or Medicare+Choice plan.

Distributions from Medicare+Choice MSAs used to pay qualified medical expenses are excludable from taxable income. Excludable amounts cannot be taken into account for purposes of the itemized deduction for medical expenses. Distributions for other than qualified medical expenses are includible in taxable income and a special tax applies to such amounts. This additional tax does not apply to distributions because of the disability or death of the account holder. Special provisions apply upon the death of the account holder.

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 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 many policy analysts.

For taxpayers who are young or have lower incomes, 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 1997, about two-thirds of those aged 65 and over had property income while only about one-third received income from pensions. Nearly 20 percent of all elderly income was accounted for by interest, dividends, or other forms of property income.

Some differences emerge when the elderly population is broken down by race. Property income accounted for about 21 percent of the total income of white households. Property income accounted for 7 percent and 5 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 through the early 1990s ranged between 4

percent and 9.5 percent of disposable income but, recently it has fallen below that range. 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 1998, Commerce Department figures indicate that the personal savings rate was 0.5 percent, compared to 2.1 percent for 1997. For the 1970's and 1980's, the rates averaged 8.3 percent and 7.0 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 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 implications for tax-favored retirement saving. When there is increasing competition among Federal tax expenditures, the continued exist-

ence 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 (IRAS)

(1) Brief History

"Deductible" IRAs began with the Employee Retirement Income Security Act of 1974 to offer tax-advantaged retirement saving for workers not covered by employer retirement plans. Tax-deferred contributions could be made up to the lesser of 15 percent of pay or $1,500 a year. The Economic Recovery Tax Act of 1981 hiked this limit to the lesser of 100 percent of pay or $2,000 and opened deductible contributions to all workers. However, the Tax Reform Act of 1986 limited deductibility of contributions by persons with employer coverage (or whose spouses have such coverage to those with income below certain limits. Filers ineligible to make deductible contributions can still make after-tax contributions to "non-deductible" IRAs, which defer income tax on investment earnings. If IRA funds that are taxable when withdrawn are withdrawn before age 59½, they are also subject to a 10 percent excise tax unless the withdrawal is: because of death or disability; in the form of a lifetime annuity; to pay medical expenses in excess of 7.5 percent of adjusted gross income (AGI); or to pay health insurance premiums while unemployed. Withdrawals must begin by April 1 of the year following the year in which age 70½ is attained in amounts that will consume the IRA over the expected lifetimes(s) of account holder and beneficiary.

The Taxpayer Relief Act of 1997 changed IRAs in numerous ways by: expanding the number of tax filers eligible for tax-deductible contributions; allowing penalty-free early withdrawals for higher education and qualified home purchase expenses; and authorizing Roth IRAs (back-loaded . . . i.e, the contributions are not deductible from income and earnings are nontaxable upon distribution from the account) and education IRAs funded by after-tax contributions that provide tax-free income.

(a) 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.

(b) Post-1986 tax reform proposals

In the 101st Congress (1989–1990) several proposals to restore IRA benefits were made: the Super IRA, the IRA-Plus, and the Family Savings Account (FSA).

The Super-IRA proposal suggested by Senator Bentsen and approved by the Senate Finance Committee in 1989 (S. 1750) would have allowed one half of IRA contributions to be deducted and would have eliminated penalties for "special purpose" withdrawals (for first time home purchase, education, and catastrophic medical expenses). The IRA proposal was advanced as an alternative to the capital gains tax benefits proposed on the House side.

The IRA-Plus proposal (S. 1771) sponsored by Senators Packwood, Roth and others proposed an IRA with the tax benefits granted in a different fashion from the traditional IRA. Rather than allowing a deduction for contributions and taxing all withdrawals similar to the treatment of a pension, this approach simply eliminated the tax on earnings, like a tax-exempt bond. This IRA is commonly referred to as a back-loaded IRA. The IRA-Plus would also be limited to a $2,000 contribution per year. Amounts in current IRAs could be rolled over and were not subject to tax on earnings (only on original contributions); there were also special purpose withdrawals with a 5-year holding period.

The Administration proposal for Family Savings Accounts (FSAs) in 1990 also used a back-loaded approach with contributions allowed up to $2,500. No tax would be imposed on withdrawals if held for 7 years, and no penalty (only a tax on earnings) if held for 3 years. There was also no penalty if funds were withdrawn to purchase a home. Those with incomes below $60,000, $100,000, and $120,000 (single, head of household, joint) would be eligible.

In 1991, S. 612 (Senators Bentsen, Roth and others) would have restored deductible IRAs, and also allowed an option for a nondeductible or back-loaded "special IRA." No tax would be applied if funds were held for 5 years and no penalties would apply if used for "special purpose withdrawals."

In 1992 the President proposed a new IRA termed a FIRA (Flexible Individual Retirement Account) which allowed individuals to establish back-loaded individual retirement accounts in amounts up to $2,500 ($5,000 for joint returns) with the same income limits as proposed in the 101st Congress. No penalty would be applied for funds held for 7 years.

Also in 1992, the House passed a limited provision (in H.R. 4210) to allow penalty-free withdrawals from existing IRAs for "special

purposes." The Senate Finance Committee proposed, for the same bill, an option to choose between back-loaded IRAs and front-loaded ones, with a 5-year period for the back-loaded plans to be tax free and allowing "special purpose" withdrawals. This provision was included in conference, but the bill was vetoed by the President for unrelated reasons. A similar proposal was included in HR 11 (the urban aid bill) but only allowed IRAs to be expanded to those earning $120,000 for married couples and $80,000 for individuals (this was a Senate floor amendment that modified a Finance Committee provision). That bill was also vetoed by the President for other reasons.

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 reduced the retirement income of spouses, primarily women, who spent 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.

The Contract with America and the 1995 budget reconciliation proposal included proposed IRA expansions, but these packages were not adopted. The Health Insurance Portability and Accountability Act of 1996 allowed penalty-free withdrawals from IRAs for medical costs. 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.

(c) 1997 revisions and establishment of Roth IRAs

The Taxpayer Relief Act of 1997 has a number of different provisions related to IRAs, including both liberalization of rules and restrictions governing the type of IRAs allowed under prior law; and creation of 2 new types of IRAs—so called "back loaded" IRAs (so called because contributions are not deductible, but qualified withdrawals are not taxed) and education IRAs. The 1997 Act gradually doubles the phase-out threshold for deductions to IRAs to $50,000 by the year 2005 ($80,000 for couples). The Act also provides that persons will not be disqualified from deducting IRA contributions if they, themselves, do not participate in a pension, but their spouse does. Finally, withdrawals from IRAs prior to age 59½ are subject to a 10 percent early withdrawal tax; the 1997 Act permits penalty free withdrawals of funds used to pay higher education ex-

penses or first-time home purchases. In the case of the new type of "back loaded" IRA—(also called Roth IRAs) if a person expects to have the same tax rate upon retirement as when contributions are made, the back loaded IRAs deliver the same magnitude of tax benefit, per dollar of contribution, as deductible IRAs. Somewhat different rules, however, apply to Roth IRAs: allowable contributions to them are phased out at higher AGIs than is the deduction—between $95,000 and $110,000 for singles (between $150,000 and $160,000 for couples). In addition contributions to all an individual's IRAs (i.e., deductible and Roth IRAs combined) are not permitted to exceed $2,000 in one year. As with deductible IRAs, penalty free withdrawals are permitted under the Act for first-time home purchases or higher education expenses. The Act also provides that funds can generally be shifted from prior-law type IRAs to Roth IRAs. The shifted amounts are included in taxable income. The Act permits taxpayers to establish education IRAs with annual contributions limited to $500 per beneficiary and allowable contributions phased out for AGIs between $95,000 and $110,000 ($150,000 and $160,000 for joint returns).

(2) Tax Benefits of IRAs: Front-Loaded and Back-Loaded

The two types of IRAs front-loaded (deductible) and back-loaded (nondeductible) are equivalent in one sense, but different in other ways. They are equivalent in that they both effectively exempt the return on investment from tax in certain circumstances.

(a) Equivalence of types

A back-loaded IRA is just like a tax-exempt bond; no tax is ever imposed on the earnings.

Assuming that tax rates are the same at the time of contribution and withdrawal, a deductible, or front-loaded, IRA offers the equivalent of no tax on the rate of return to savings, just like a back-loaded IRA. The initial tax benefit from the deduction is offset, in present value terms, by the payment of taxes on withdrawal. Here is an illustration. If the interest rate is 10 percent, $100 will grow to $110 after a year—$100 of principal and $10 of interest. If the tax rate is 25 percent, $2.50 of taxes will be paid on the interest, and the after-tax amount will be $107.50, for an after-tax yield of 7.5 percent. With a front-loaded IRA, however, the taxpayer will save $25 in taxes initially from deducting the contribution, for a net investment of $75. At the end of the year, the $110 will yield $8.25 after payment of 25 percent in taxes, and $8.25 represents a 10 percent rate of return on the $75 investment. The current treatment for those not eligible for a deductible IRA—a deferral of tax—results in a partial tax, depending on period of time the asset is held and the tax rate on withdrawal. For example, a deferral would produce an effective tax rate of 18 percent if held in the account for 10 years, and a tax rate of 13 percent if held for 20 years.

(b) Differences in treatment

There are, nevertheless, three ways in which these tax treatments can differ—if tax rates vary over time, if the dollar ceilings are the same, and if premature withdrawals are made. There are

also differences in the timing of tax benefits that have some implications for individual behavior as well as revenue costs.

(1) Variation in tax rates over time

The equivalence of front-loaded and back-loaded IRAs only holds if the same tax rate applies to the individual at the time of contribution and the time of withdrawal. If the tax rate is higher on contribution than on withdrawal, the tax rate is negative. For example, if the tax rate were zero on withdrawal in the previous example, the return of $35 on a $75 investment would be 46 percent, indicating a large subsidy to raise the rate of return from 10 percent to 46 percent. Conversely, a high tax rate at the time of withdrawal relative to the rate at the time of contribution would result in a positive tax rate. If tax rates are uncertain, and especially if it is possible that the tax rate will be higher in retirement, the benefits of a front-loaded IRA are unclear.

(2) Dollar ceilings

A given dollar ceiling that is binding for an individual for a back-loaded IRA is more generous than for a front-loaded one. If an individual has $2,000 to invest and the tax rate is 25 percent, all of the earnings will be tax exempt with a back-loaded IRA, but the front-loaded IRA is equivalent to a tax free investment of only $1,500; the individual would have to invest the $500 tax savings in a taxable account to achieve the same overall savings, but will end up with a smaller amount of after tax funds on withdrawal.

Another way of explaining this point is to consider a total savings of $2,000, which, under a back-loaded account with an 8 percent interest rate would yield $9,321 after, say, 20 years. With a front loaded IRA, an interest rate of 8 percent and a 25 percent tax rate (so $2,000 would be invested in an IRA and the $500 tax savings invested in a taxable account) the yield would be $8,595 in 20 years. In order to make a back-loaded IRA equivalent to a front loaded one, the back-loaded IRA would need to be 75 percent as large as a front-loaded one. (Since the relative size depends on the tax rate, the back-loaded IRA is more beneficial to higher income individuals than a front-loaded IRA, other things equal, including the total average tax benefit provided).

(3) Non-qualified withdrawals

Front-loaded and back-loaded IRAs differ in the tax burdens imposed if non-qualified withdrawals are made (generally before retirement age). This issue is important because it affects both the willingness of individuals to commit funds to the account that might be needed before retirement (or other eligibility) and the willingness to draw out funds already committed to an account.

The front-loaded IRA provides steep tax burdens for early year withdrawals which decline dramatically because the penalty applies to both principal and interest. (Without the penalty, the effective tax rate is always zero). For example, with a 28 percent tax rate and an 8 percent interest rate, the effective tax burden is 188 percent if held for only a year, 66 percent for 3 years and 40 percent for 5 years. At about 7 years, the tax burden is the same as an investment made in a taxable account, 28 percent. Thereafter,

tax benefits occur, with the effective tax rate reaching 20 percent after 10 years, 10 percent after 20 years and 7 percent after 30 years. These tax benefits occur because taxes are deferred and the value of the deferral exceeds the penalty.

The case of the back-loaded IRA is much more complicated. First, consider the case where all such IRAs are withdrawn. In this case, the effective tax burdens are smaller in the early years. Although premature withdrawals attract both regular tax and penalty, they apply only to the earnings, which are initially very small. In the first year, the effective tax rate is the sum of the ordinary tax rate (28 percent) and the penalty (10 percent), or 38 percent. Because of deferral, the tax rate slowly declines (36 percent after 3 years, 34 percent after 5 years, 30 percent after 10 years). In this case, it takes 13 years to earn the same return that would have been earned in a taxable account. These patterns are affected by the tax rate. For example, with a 15 percent tax rate, it takes longer for the IRA to yield the same return as a taxable account—11 years for a front-loaded account and 19 years for a back-loaded one.

Partial premature withdrawals will be treated more generously, as they will be considered to be a return of principal until all original contributions are recovered. This treatment is more generous than the provisions in the original Contract with America, where the reverse treatment occurred: partial premature withdrawals would be treated as income and fully taxed until the amount remaining in the account is equal to original investment.

These differences suggest that individuals should be much more willing to put funds that might be needed in the next year or two for an emergency in a back-loaded account than in a front-loaded account, since the penalties relative to a regular savings account are much smaller. These differences also suggest that funds might be more easily withdrawn from back-loaded accounts in the early years even with penalties. This feature of the back-loaded account along with the special tax-favored withdrawals make these tax-favored accounts much closer substitutes for short-term savings not intended for retirement.

It could eventually become more costly to make premature withdrawals from back-loaded accounts than from front-loaded accounts. Consider, for example, withdrawal in the year before retirement for all funds that had been in the account for a long time. For a front-loaded IRA, the cost is the 10 percent penalty on the withdrawal plus the payment of regular tax one year in advance—both amounts applying to the full amount. For a back-loaded account, where no tax or penalty would be due if held until retirement, the cost is the penalty plus the regular tax (since no tax would be paid for a qualified withdrawal) on the fraction of the withdrawal that represented earnings, which would be a large fraction of the account if held for many years.

(4) Timing of effects

The tax benefit of the front-loaded IRA is received in the beginning, while the benefit of the back-loaded IRA is spread over the period of the investment. These differences mean that the front-loaded IRA is both more costly than the back-loaded one in the short run (and therefore in the budget window) and that a front-

loaded IRA is more likely to increase savings. These issues are discussed in the following two sections.

Receiving the tax benefit up front might also make individuals more willing to participate in IRAs because the benefit is certain (the government could, in theory, disallow income exemptions in back-loaded IRAs already in existence). At the same time, however, the rollover provision makes it much less likely that the government would be willing to tax the return to existing IRAs, because a tax must be paid to permit the rollover.

Some have argued that the attraction of an immediate tax benefit has played a role in the popularity of IRAs and may have contributed to increased savings (see the following discussion of savings).

(3) Savings Effects

There has been an extensive debate about the effect of individual retirement accounts on savings. For a more complete discussion of the savings literature, see Jane G. Gravelle's The Economic Effects of Taxing Capital Income, Cambridge, Mass., MIT Press, 1994, p. 27, for a discussion of the general empirical literature on savings and pp. 193–197 for a discussion of the empirical studies of IRAs. Subsequent to this survey, a new paper by Orazio P. Attanasio and Thomas C. DeLeire, IRA's and Household Saving Revisited: Some New Evidence, National Bureau of Economic Research Working Paper 4900, October 1994 was published. That study found little evidence that IRAs increased savings.

Conventional economic analysis and general empirical evidence on the effect of tax incentives on savings do not suggest that IRAs would have a strong effect on savings. In general, the effect of a tax reduction on savings is ambiguous because of offsetting income and substitution effects. The increased rate of return may cause individuals to substitute future for current consumption and save more (a substitution effect), but, at the same time, the higher rate of return will allow individuals to save less and still obtain a larger target amount (an income effect). The overall consequence for savings depends on the relative magnitude of these two effects. Empirical evidence on the relationship of rate of return to saving rate is mixed, indicating mostly small effects of uncertain direction. In that case, individual contributions to IRAs may have resulted from a shifting of existing assets into IRAs or a diversion of savings that would otherwise have occurred into IRAs.

The IRA is even less likely to increase savings because most tax benefits were provided to individuals who contributed the maximum amount—eliminating any substitution effect at all. (Note that over time, however, one might expect fewer contributions to be at the limit as individuals run through their assets.) For these individuals, the effect of savings is unambiguously negative, with one exception. In the case of the front-loaded, or deductible IRA, savings could increase to offset part of the up-front tax deduction, as individuals recognize that their IRA accounts will involve a tax liability upon withdrawal. The share of IRAs that were new savings would depend on the tax rate with a 28 percent tax rate, one would expect that 28 percent would be saved for this reason; with a 15 percent tax rate, 15 percent would be saved for this reason.

This effect does not occur with a back-loaded or nondeductible IRA. Thus, conventional economic analysis suggests that private savings would be more likely to increase with a front-loaded rather than a back-loaded IRA.

Despite this conventional analysis, some economists have argued that IRA contributions were largely new savings. The theoretical argument has been made that the IRAs increase savings because of psychological, "mental account," or advertising reasons. Individuals may need the attraction of a large initial tax break; they may need to set aside funds in accounts that are restricted to discipline themselves to maintain retirement funds; or they may need the impetus of an advertising campaign to remind them to save. There has also been some empirical evidence presented to suggest that IRAs increase savings. This evidence consists of (1) some simple observations that individuals who invested in IRAs did not reduce their non-IRA assets and (2) a statistical estimate by Venti and Wise that showed that IRA contributions were primarily new savings. This material has been presented by Steve Venti and David Wise in several papers; see for example, Have IRAs Increased U.S. Savings?, Quarterly Journal of Economics, v. 105, August, 1990, pp. 661–698.

The fact that individuals with IRAs do not decrease their other assets does not prove that IRA contributions were new savings; it may simply mean that individuals who were planning to save in any case chose the tax-favored IRA mechanism. The Venti and Wise estimate has been criticized on theoretical grounds and another study by Gale and Scholz using similar data found no evidence of a savings effect. (See William G. Gale and John Karl Scholz, IRAs and Household Savings, American Economic Review, December 1994, pp. 1233–1260.) A study by Manegold and Joines comparing savings behavior of those newly eligible for IRAs and those already eligible for IRAs found no evidence of an overall effect on savings, although increases were found for some individuals and decreases for others; a study by Attanasio and DeLeire also using this approach found little evidence of an overall savings effect. (See Douglas H. Joines and James G. Manegold, IRAs and Savings: Evidence from a Panel of Taxpayers, University of Southern California; Orazio P. Attanasio and Thomas C. DeLeire, IRA's and Household Saving Revisited: Some New Evidence, National Bureau of Economic Research Work Paper 4900, October 1994.) And, while one must be careful in making observations from a single episode, there was no overall increase in the savings rate during the period that IRAs were universally available, despite large contributions into IRAs.

It is important to recognize that this debate on the effects of IRAs on savings concerned the effects of front-loaded, or deductible IRAs. Many of the arguments that suggest IRAs would increase savings do not apply to back-loaded IRAs such as those contained in the legislation reported out by the Ways and Means Committee or allowed as an option in other proposals. Back-loaded IRAs do not involve the future tax liability that, in conventional analysis, should cause people to save for it.

Indeed, based on conventional economic theory, there are two reasons that the proposal for back-loaded IRAs may decrease sav-

ings. First, those who are newly eligible for the benefits should, in theory reduce their savings, because these individuals are higher income individuals who are more likely to save at the limit. The closer substitutability of IRAs with savings for other purposes would also increase the possibility that IRA contributions up to the limit could be made from existing savings. Secondly, those who are currently eligible for IRAs who are switching funds from front-loaded IRAs or who are now choosing back-loaded IRAs as a substitute for front-loaded ones should reduce their savings because they are reducing their future tax liabilities.

Also, many of the "psychological" arguments made for IRAs increasing savings do not apply to the back-loaded IRA. There is no large initial tax break associated with these provisions, and the funds are less likely to be locked-up in the first few years because the penalty applying to withdrawals is much smaller. In addition, funds are not as tied up because of the possibility of withdrawing them for special purposes, including ordinary medical expenses.

Overall, the existing body of economic theory and empirical research does not make a convincing case that the expansion of individual retirement accounts, particularly the back-loaded accounts will increase savings. For three papers that review the evidence from differing perspectives see the three articles published in the fall 1996 issue of the Journal of Economic Perspectives, pp. 73–90, 91–112, and 113–138: R. Glenn Hubbard and Jonathan S. Skinner, "Assessing the Effectiveness of Savings Incentives," James Poterba, Steven F. Venti, and David A. Wise, "How Retirement Saving Programs Increase Saving," and Eric M. Engen, William G. Gale, and John Karl Scholz, "The Illusory Effects of Savings Incentives on Savings."

(4) Revenue Effects

The revenue loss from IRAs varies considerably over time. For a back-loaded IRA, the cost grows rapidly over time and the long-run revenue cost (in constant income levels) is about eight times as large as in the first 5 years, even if rollovers from existing accounts were not allowed. Front-loaded IRAs also have an uneven pattern of revenue cost, although they are characterized by a rise to a peak (as withdrawals occur) and then a steady state cost that could be a third or so larger than in the first 5 years.

The IRA provision allowing a rollover of existing front-loaded IRAs into back-loaded IRAs over a 4-year period has the effect of raising tax revenue in the short run although, of course, the rollover will result in lost revenues (with interest) in future years. As enacted, the IRA provisions are projected to ultimately result in a significant annual revenue loss. It can be expected that the revenue losses in the initial period understates the losses that will occur in the long run due to the shift to back-loaded accounts. The long phase-in of increased limits for deductible IRAs also causes costs to be lower in the short run.

(5) Distributional Effects

Who benefits from the expansion of IRAs? In general, any subsidy to savings tends to benefit higher income individuals who are

more likely to save. The benefits of IRAs for high income individuals are limited, however, compared to many other savings incentives because of the dollar limits. Nevertheless, the benefits of IRAs when universally allowed tended to go to higher income individuals. In 1986, 82 percent of IRA deductions were taken by the upper third of individuals filing tax returns (based on adjusted gross income); since these higher income individuals had higher marginal tax rates, their share of the tax savings would be larger.

In addition, when universal IRAs were available from 1981–1986, they were nevertheless not that popular. In 1986, only 15 percent of individuals contributed to IRAs. Participation rates were lower in the bottom and middle of the income distribution: only 2 percent of taxpayers in the bottom third of tax returns and only 9 percent of individuals in the middle third contributed to IRAs. Participation rose with income: 33 percent of the upper third contributed, 54 percent of taxpayers in the top 10 percent contributed, and 70 percent of taxpayers in the top 1 percent contributed.

The expansion of IRAs is even more likely to benefit higher income individuals because lower income individuals are already eligible for front loaded (deductible) IRAs that confer the same general tax benefit. Less than a quarter of individuals (1993 data) have incomes too large to be eligible for any IRA deduction (because they are above $50,000 for married individuals and $35,000 for singles) and less than a third exceed the beginning of the phaseout range. Also, those higher income individuals not already covered by a pension plan are also eligible. Therefore, only higher income individuals who did not otherwise have tax benefits from pension coverage were currently excluded from IRA coverage.

Overall, expansion of IRAs tends to benefit higher income individuals, although the benefits are constrained for very high income individuals because of the dollar ceilings and because of income limits which also apply to back-loaded IRAs.

(6) Administrative Issues

The more types of IRAs that are available, the larger the administrative costs associated with them. With the introduction of back-loaded accounts, three types of IRAs exist—the front-loaded that have been available since 1974 (and universally available in 1981–1986), the non-deductible tax deferred accounts available in prior law to higher income individuals and that are now superseded by more tax preferred plans for all but a very high income group and the new back-loaded accounts. Treatment on withdrawal will also be more complex, since some are fully taxable, some partially taxable, and some not taxable at all.

Another administrative complexity that arises is withdrawals prior to retirement for special purposes, including education and first time home purchase.

(7) Advantages of Front-Loaded Vs. Back-Loaded IRAs

Most individuals now have a choice between a front-loaded and a back-loaded IRA. An earlier section discussed the relative tax benefits of the alternatives to the individual. This section discusses

the relative advantages and disadvantages to these different approaches in achieving policy objectives.

From a budgetary standpoint, the short-run estimated cost of the front-loaded IRA provides a more realistic picture of the eventual long-run budgetary costs of IRAs than does the back-loaded. This issue can be important if there are long run objectives of balancing the budget, which can be made more difficult if costs of IRAs are rising. In addition, if distributional tables are based on cash flow measures, as in the case of the Joint Tax Committee distributional estimates, a more realistic picture of the contribution of IRA provisions to the total distributional effect of the tax package is likely to emerge. In that sense, allowing back-loaded IRAs, even as a choice, has probably made it harder to meet long-run budgetary goals because the budget targets did not take into account the out-year costs.

The front-loaded IRA is more likely to result in some private savings than the back-loaded IRA, from the perspective of either conventional economic theory or the "psychological" theories advanced by some; hence allowing back-loaded IRAs may have negative effects on national savings objectives. Of course, a front-loaded IRA also has so a larger revenue cost that overall saving is only different, under conventional analysis, if the difference in revenue costs is made up in some other way (and that offsetting policy does not itself affect savings.)

There are, however, some advantages of back-loaded IRAs. The backloaded IRA avoids one planning problem associated with front-loaded IRAs: if individuals use a rule-of-thumb of accumulating a certain amount of assets, they may fail to recognize the tax burden associated with accumulated IRA assets. In that case, the front-loaded IRA would leave them with less after-tax assets in retirement than they had planned, a problem that would not arise with the back-loaded IRA where no taxes are paid at retirement. A possible second advantage of back-loaded IRAs is that the effective tax rate is always known (zero), unlike the front-loaded IRA where the effective tax rate depends on the tax rate today vs. the tax rate in retirement. Yet another advantage is that the effective contribution limit in a back-loaded IRA is not dependent on the tax rate (although it would be possible to devise an adjustment to the IRA contribution ceiling based on tax rate).

(8) Conclusion

Unlike the initial allowance of IRAs in 1974 to extend the tax advantage allowed to employees with pension plans, the major focus of universal IRAs has been to encourage savings, especially for retirement. If the main objective of individual retirement accounts is to encourage private savings, the analysis does not suggest that we will necessarily achieve that objective. Moreover, the back-loaded approach allowed as an option is, according to many analysts, less likely to induce savings than the current form of IRAs or the form allowed during the period of universal availability (1981–1986). In addition, the ability to withdraw amounts for other purposes than retirement can dilute the focus of the provision on preparing for retirement.

This new law may also put some pressure on overall national savings in the future, as the IRA provisions involve a growing budgetary cost.

IRAs have often been differentiated from other tax benefits for capital income as the plan focused on moderate income or middle class individuals. The IRA has been successful in that more of the benefits are targeted to moderate income individuals than is the case for many other tax benefits for capital (e.g., capital gains tax reductions). Nevertheless, data on participation and usage, and the current allowance of IRAs for lower income individuals, suggest that the benefit will still accrue more to higher than to lower income individuals.

Certain features will complicate administrative costs, and there has been relatively little attention paid to the dramatic differences in the penalties for early withdrawal associated with back-loaded vs front-loaded accounts.

(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 incentive is the tax-free exclusion on up to $250,000 ($500,000 for married taxpayers) 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, 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, thereby reducing their retirement "nest egg." 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.

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 1998, the median job tenure for a current employee was as little as 3.6 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 1998 Bureau of Labor Statistics (BLS), the unemployment rate was 2.5 percent for workers age 55 to 59,2.7 percent for workers 60 to 64, 3.3 percent for workers age 65 to 69, and 3.2

percent for workers age 75 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 1970's and 1980's." 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 19,573 in fiscal year 1992. Since that time, however, preliminary data show the number of complaints has declined to 15,191 in fiscal year 1998.

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 1997, preliminary data show that the EEOC received 15,785 ADEA complaints and filed suit in less than 1 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.

The ADEA was amended again in 1998 by the Higher Education Amendments of 1998 (HEA of 1998) (P.L. 105–244). The HEA of 1998 creates an exception to the ADEA that allows colleges and universities to offer an additional age-based benefit to tenured faculty who voluntarily retire.

(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 col-

leges 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.

The 1998 ADEA amendments contained in the Higher Education Amendments of 1998 incorporate the suggestions of the Committee. The HEA of 1998 allows colleges and universities to create voluntary incentive programs through the use of supplemental benefits, or benefits in addition to any retirement or severance benefits that are generally offered to tenured employees upon retirement. Supplemental benefits may be reduced or eliminated on the basis of age without violating the ADEA. The amendment expressly prohibits non-supplemental benefits from being reduced or eliminated based on age. The voluntary incentive plans are subject to certain requirements. A tenured employee who becomes eligible to retire has 180 days in which time they may retire and receive both regular benefits and supplemental benefits. Upon electing to retire, an institution may not require retirement before 180 days from the date of the election.

(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 pub-

lic 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 concerning 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

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

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 Edu-

cation 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, The Age Discrimination in Employment Act Amendments of 1996 amended the ADEA to allow police and fire departments to use maximum hiring ages and mandatory retirement ages as elements in their overall personnel policies. The 1996 amendments to the ADEA were included in the Omnibus Consolidated Appropriations for fiscal year 1997 (P.L. 104–208).

(D) THE SUPREME COURT

The Supreme Court addressed the elements of an ADEA prima facie case in *O'Connor* v. *Consolidated Coin Caterers Corp.,* 517 U.S. 308 (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.[2] 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."[3] 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.[4] 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,* 507 U.S. 604 (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

[2] *O'Connor* v. *Consolidated Coin Caterers Corp.,* 517 U.S. 308(1996).

[3] 517 U.S. 308,310(1996).

[4] 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, 517 U.S. at 312 (quoting *Texas Dept. of Community Affair* v. *Burdine,* 450 U.S. 248, 254 n.7 (1981)).

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.

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,* 509 U.S. 502 (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, 506 U.S. 1014 (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 Eighth, 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 conclude 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."

In *Oubre* v. *Entergy Operations, Inc.,* 522 U.S. 422 (1998), the Supreme Court considered whether an employee had to return money she received as part of a severance agreement before bringing suit under the ADEA. The Older Workers Benefit Protection Act established new protections for workers who are asked to sign waivers of their ADEA rights. The employee received severance pay in return for waiving any claims against the employer. The Court held that the plaintiff did not have to return the money before bringing suit, because the employer failed to comply with three of the requirements of the waiver provisions under the ADEA.

A related issue is the effect of arbitration clauses on ADEA claims. The Court held in *Gilmer* v. *Interstate/Johnson Lane Corp.,* 500 U.S. 20 (1990), that the ADEA does not preclude enforcement of a compulsory arbitration clause. The plaintiff in *Gilmer,* signed a registration application with the New York Stock Exchange (NYSE), as required by his employer. The application provided that the plaintiff would agree to arbitrate any claim or dispute that arose between him and Interstate. Gilmer filed an ADEA claim with the EEOC upon being fired at age 62. In a prior decision, the Court held "by agreeing to arbitrate a statutory claim, a party does not forgo the substantive rights afforded by the statute; it only submits to their resolution in an arbitral, rather than a judicial, forum."[5]

The Supreme Court revisited the issue of mandatory arbitration of statutory antidiscrimination claims in *Wright* v. *Universal Mari-*

[5] *Mitsubishi Motors Corp.* v. *Soler Chrysler-Plymouth, Inc.,* 473 U.S. 614, 628 (1987).

time Service Corp., 119 S. Ct. 391 (1998). In *Wright,* the Court held that a general arbitration clause contained in a collective bargaining agreement's grievance procedure was not enough to waive an employee's right to pursue statutory antidiscrimination claims in court. Instead, the Court stated that any clause in a collective bargaining agreement requiring an employee to arbitrate a statutory antidiscrimination claim must be clear and express. However, the Court did not address the issue of whether such a clause, even if clear and express, would be valid.

B. FEDERAL PROGRAMS

There are two primary sources of federal employment and training assistance available to older workers. The first, and largest, is the Adult and Dislocated Worker Program authorized under Title I of the Workforce Investment Act of 1998. The second is the Senior Community Service Employment Program authorized under Title V of the Older Americans Act.

1. THE ADULT AND DISLOCATED WORKER PROGRAM AUTHORIZED UNDER THE WORKFORCE INVESTMENT ACT

The Workforce Investment Act of 1998 (WIA) was enacted on August 7, 1998. The intent of the legislation is to consolidate, coordinate, and improve employment, training, literacy, and vocational rehabilitation programs. Among other things, WIA repeals the Job Training Partnership Act (JTPA) on July 1, 2000, and replaces it with new training provisions under Title I of WIA. States may begin implementing WIA July 1, 1999 (assuming their state plans are approved by the Department of Labor) and must implement WIA no later than July 1, 2000.

Under JTPA, there is an adult training program (Title II–A) for low-income individuals and a dislocated worker program (Title III) for individuals who, in general, have lost their jobs as a result of structural changes in the economy and who are not likely to find new jobs in their former industries or occupations. Each program has its separate appropriation, list of authorized services, and could have a separate delivery system. Under WIA, one set of services and one delivery system is authorized both for "adults" and for "dislocated workers", but funds will continue to be appropriated separately for the two groups. Funds for these programs are contained in the Labor-HHS–ED appropriations act. The FY1999 appropriation under JTPA for adult training was $955 million, and for dislocated workers was approximately $1.4 billion. For FY2000, appropriations for these programs will be made under WIA authority.

Funds from the adult funding stream, under both JTPA and WIA, are allotted among States according to the following three equally weighted factors: (1) relative number of unemployed individuals living in areas with jobless rate of at least 6.5 percent for the previous year; (2) relative number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and (3) the relative number of economically disadvantaged adults.

Under JTPA, 77 percent of the funds allocated to States are allocated to local areas using the same three-part formula. Under WIA,

85 percent of the funds allocated to States are allocated to local areas by formula. Not less than 70 percent of the local funds must be allocated using the same three-part formula. The remainder of the adult funds allocated to local areas can be allocated based on formulas approved by the Secretary of Labor as part of the state plan that take into account factors relating to excess poverty or excess unemployment above the state average in local areas.

Under JTPA, 5 percent of the funds allocated to a State for adult training were to be set-aside training and placement for economically disadvantaged workers age 55 or older. This requirement is not contained in WIA. For the period between July 1, 1996, and June 30, 1997, over 16,000 adults who terminated from the JTPA adult training program were age 55 or older, representing 10 percent of total adult terminees. Of this total, over 13,000 were served under the older worker set-aside program.

Funds from the dislocated worker funding stream, under both JTPA and WIA, are allotted among States according to the following three equally weighted factors: (1) relative number of unemployed individuals; (2) relative number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and (3) the relative number of individuals unemployed 15 weeks or longer. Under WIA at least 60 percent of the funds allocated to States must be allocated to local areas based on a formula. This formula, prescribed by the Governor, must be based on factors such as, insured unemployment data, unemployment concentrations, and long-term unemployment data. For the period between July 1, 1995 and June 30, 1996, over 26,000 adults who terminated from the JTPA dislocated worker program were age 55 or older, representing 10 percent of total adult terminees. Local areas, with the approval of the Governor, may transfer 20 percent of funds between the adult program and the dislocated worker program.

Under WIA, any individual is eligible to receive core services, such as job search and placement assistance. To be eligible to receive intensive services, such as comprehensive assessments and individual counseling and career planning, an individual has to be unemployed, and unable to obtain employment through core services or employed but in need of intensive services to obtain or retain employment that allows for self-sufficiency. To be eligible to receive training services, such as occupational training, on-the-job training, and job readiness training, an individual has to have met the eligibility for intensive service and been unable to obtain employment through those services. Unlike JTPA, there is no income eligibility requirement for receiving services. Local areas are required, however, to give priority for receiving intensive services and training to recipients of public assistance and other low-income individuals if funds are limited in the local area. Training is provided primarily through "individual training accounts." The purpose of individual training accounts is to provide individuals with the opportunity to choose training courses and providers. Typically, under JTPA, services are procured for groups of individuals.

Under WIA, each local area must develop a "one-stop" system to provide core services and access to intensive services and training through at least one physical center, which may be supplemented by electronic networks. The law mandates that certain "partners",

including entities that carry out the Senior Community Service Employment Program, provide "applicable" services through the one-stop system. Partners must enter into written agreements with local boards regarding services to be provided, the funding of the services and operating costs of the system, and methods of referring individuals among partners.

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 1998 survey polled workers who lost their jobs between January 1995 and December 1997. 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 percent of the 55- to 64-year-olds, and 55 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 76 percent, while the rates for workers 55 to 64 years and 65 years and older were 60 percent and 35 percent respectively.

2. Title V of the Older Americans Act

The Senior Community Service Employment Program (SCSEP) has as its purpose to promote useful part-time opportunities in community service activities for unemployed low income persons with poor employment prospects. Created during the 1960s as a demonstration program under the Economic Opportunities Act, and later authorized under the Title V of the Older Americans Act, it is one of a few subsidized jobs programs for adults. The program provides low income older persons an opportunity to supplement their income through wages received, to become employed, and to contribute to their communities through community service activities performed under the program. Participants may also have the opportunity to become employed in the private sector after their community service experience.

SCSEP is administered by the Department of Labor (DoL), which awards funds to 10 national sponsoring organizations and to State agencies, generally State agencies on aging. These organizations and agencies are responsible for the operation of the program, including recruitment, assessment, and placement of enrollees in community service jobs.

Table 1 shows FY1999 funding to national organizations and state agencies. Total funding is $440.2 million which supports about 61,000 enrollee positions. Appropriations Committee directives for most recent years have stipulated that the ten national organization sponsors are to receive 78 percent of total funds, and state agencies are to receive 22 percent.

Persons eligible under the program must be 55 years of age and older (with priority given to persons 60 years and older), unem-

ployed, and have income levels of not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services (DHHS).

TABLE 1. FY1999 FUNDING TO NATIONAL ORGANIZATIONS AND STATE SPONSORS

Sponsor	FY1999 amount (millions)	Percent of total
American Association of Retired Persons	$50.6	11.6
Asociacion Nacional Por Personas Mayores	13.2	3.0
Green Thumb	106.6	24.3
National Caucus and Center on the Black Aged	13.0	3.0
National Council on the Aging	38.0	8.7
National Council of Senior Citizens	64.4	14.7
National Urban League	15.3	3.5
National Indian Council on Aging	6.0	1.4
National Asian Pacific Center on Aging	6.0	1.4
U.S. Forest Service	28.4	6.5
National organization sponsors, total	$341.5	78.0
State agencies, total	[1]$96.3	22.0
Total	[2]$437.8	100.0

[1] This amount includes funds allocated to the territories.
[2] This amount differs from the total appropriation of $440.2 million due to a set-aside by DoL of $2.4 million for experimental projects under Section 502(e) of the Act.

Enrollees are paid the greater of the Federal or State minimum wage, or the local prevailing rate of pay for similar employment, whichever is higher. 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 may receive physical examinations, personal and job-related counseling and, under certain circumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

Participants work in a wide variety of community service activities. In program year 1997–1998 (July 1, 1997-June 30, 1998), about one-third of jobs were in services to the elderly community, including nutrition services, senior centers, and home care, and about two-thirds were in services to the general community, including social services, education and recreation and parks. The average hourly wage paid was $5.36.

About 73 percent of participants were women. About 40 percent had a high school education, but 36 percent did not complete high school. About 60 percent of participants were age 65 and older and over one-third were 70 years or older. Members of minority racial or ethnic groups made up 41 percent of total participants.

For further information, see the Older Americans Act Section.

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 1998, 6.6 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 benefit standards have not been lowered (although certain groups, such as immigrants, drug addicts and alcoholics, and some children) have been barred from benefit receipt. 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 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 largely escaped the budget axe, 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 a quarter of a century ago, some 14.6 percent of the Nation's elderly lived in poverty. In 1997, the elderly poverty rate was 10.5 percent.

The effectiveness of SSI in reducing poverty is constrained by 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 one-half to two-thirds of those elderly persons poor enough to qualify for SSI actually receive program benefits.

In recent years, Congressional attention has focused on the need to eliminate abuses in the management of the SSI program. Legislation enacted in 1996 (P.L. 104–121 and 104–193) eliminated SSI benefits for persons who were primarily considered disabled because of their drug addiction or alcoholism. It severely restricted SSI to most noncitizens, made it more difficult for children with "less severe" impairments to receive SSI, required periodic system-

atic review of disability cases to monitor eligibility status, and allowed SSA to make incentive payments to correctional facilities that reported prisoners who received SSI. P.L. 105–33, enacted during the 105th Congress, reversed some of the effects of P.L. 104–193 allowing qualified noncitizen recipients who filed for benefits before August 22, 1996 to maintain their SSI eligibility.

In 1997, the General Accounting Office (GAO) designated SSI as a "high-risk" program because of its susceptibility to waste, fraud, and abuse and insufficient management of the program. This high risk label on the program has given rise to a desire among advocates, many Members of Congress, and SSA itself to try and correct the program's inadequacies. During 1998, a draft proposal to reduce SSI fraud and abuse was circulated, but not introduced. In October 1998, SSA released a report on management of the SSI program. According to SSA, its strategy to improve SSI program integrity and stewardship includes improving payment accuracy, conducting additional periodic continuing disability reviews and SSI redeterminations, implementing aggressive plans to deter, identify and prosecute fraud, and increasing debt collections.

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 at the time 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 (except of children under age 18) 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 adults are those unable to engage in any substantial gainful activity because of a medically determined physical or mental impairment that is ex-

pected 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 or if not a citizen, (a) be a refugee or asylee who has been in the country for less than 7 years, or (b) be a "qualified alien" who was receiving SSI as of August 22, 1996 or who was living in the United States on August 22, 1996 and subsequently became disabled. 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, $500 for an individual and $751 for a couple in 1999. 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. Since 1989, the asset limit has been $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 1999, that totaled $333 for a single person and $500 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 September 1998, 4.1 percent, or 270,538 recipients came under this "one-third reduction" standard. Sixty-five 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 monthly 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. Limitations of SSI Payments to Immigrants

The payment of benefits to legal immigrants on SSI has undergone dramatic changes during the last several 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 extended 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) had a direct impact on legal immigrants who were receiving SSI. The 1996 law barred legal immigrants from SSI unless they have worked 10 years or are veterans, certain active duty personnel, or their families. Those who were receiving SSI at the date of the legislation's enactment were to be screened during the 1-year period after enactment. If the beneficiary was unable to show that he or she had worked for 10 years, was a naturalized citizen, or met one of the other exemptions, the beneficiary was terminated from the program. After the 10 year period, if the legal immigrant has not naturalized, he or she will likely need to meet the 3 year deeming requirement that was part of the changes in the 1993 legislation.

SSI and Medicaid eligibility was restored for some noncitizens under P.L. 105–33, the Balanced Budget Act of 1997. The Balanced Budget Act (1) continued SSI and related Medicaid for "qualified alien" noncitizens receiving benefits on August 22, 1996, (2) allowed SSI and Medicaid benefits for aliens who were here on August 22, 1996 and who later become disabled, (3) extended the exemption from SSI and Medicaid restrictions for refugees and asylees from 5 to 7 years after entry, (4) classified Cubans/Haitians and Amerasians as refugees, as they were before 1996, thereby making them eligible from time of entry for Temporary Assistance for Needy Families (TANF) and other programs determined to be means-tested, as well as for refugee-related benefits, and (5) exempted certain Native Americans living along the Canadian and Mexican borders from SSI and Medicaid restrictions.

2. SSA Disability Redesign Project

SSA's 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 for both Social Security Disability Insurance (DI) and disabled adult SSI beneficiaries.

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

In 1998, it was estimated that 8.9 million DI and disabled adult SSI beneficiaries received benefits from SSA. The workload for initial disability claims was 2.0 million in fiscal year 1998. The initial case claims backlogs were 408,000 cases in fiscal year 1998 and are expected to remain at that level through fiscal year 2000. SSA's reported administrative budget for processing disability and appeals determinations was about $4 billion in fiscal year 1997, almost two-thirds of its reported administrative costs.

In response to concerns raised by 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 135 days (in fiscal year 1998) 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 be substantially reduced. The proposal also suggested providing applicants with a better understanding of how the disability determination process works and the current status of their claims.

Since 1994, SSA has been testing many of the initiatives outlined in its proposal, and has stated that decisions will be made in the near future on whether to implement some of them on a permanent basis.

3. 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 recipients with earnings has increased from 87,000 in 1980 to 282,600 in 1998. In addition, 25,000 aged SSI recipients had earnings in 1998.

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 activities 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. Despite SSI work incentives, few recipients are engaged in work or leave the rolls because of employment. In September 1998, only 4.7 percent of SSI recipients had earnings.

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. In 1997, out of a population of about 7 million DI and adult SSI beneficiaries, only about 297,000 individuals were referred to a State Vocational rehabilitation agency. Moreover, only 8,337 of these individuals were considered successfully rehabilitated (which meant that State agencies were able to receive reimbursement for the services provided). 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. GAO's report concluded that the work incentives are not effective in encouraging recipients with work potential to return to

employment or pursue rehabilitation options. In addition, it concluded that SSA has not done enough to promote the work incentives to its field employees, who in turn do not promote the incentives to beneficiaries.

According to a 1998 report by the Social Security Advisory Board, entitled, How SSA's Disability Programs Can Be Improved (p. 37):

> To a large extent, the small incidence of return to work on the part of disabled beneficiaries reflects the fact that eligibility is restricted to those with impairments which have been found to make them unable to engage in any substantial work activity. By definition, therefore, the disability population is composed of those who appear least capable of employment. Moreover, since eligibility depends upon proving the inability to work, attempted work activity represents a risk of losing both cash and medical benefits. While some of this risk has been moderated by the work incentive features adopted in recent years, it remains true that the initial message the program presents is that the individual must prove that he or she cannot work in order to qualify for benefits.

During the 105th Congress, the House passed H.R. 3433, the Ticket to Work and Self-Sufficiency Act of 1998. H.R. 3433 directed the Commissioner of Social Security to establish a Ticket to Work and Self-Sufficiency Program (TWSSP) under which a disabled SSI or DI beneficiary may use a ticket to work and self-sufficiency issued by the Commissioner to obtain employment services, vocational rehabilitation services, or other support services from an employment network of the beneficiary's choice which is willing to provide such services pursuant to an appropriate individual work plan. The bill authorized certain State agencies to elect to participate in the program as employment networks coordinating and delivering services to individuals with tickets to work and self-sufficiency. It permitted private entities to be employment networks. In addition, it required a written agreement stipulating how an employment network would reimburse a State agency before it or an approved State plan could accept any referral of a disabled beneficiary from the employment network to which the beneficiary assigned his or her ticket to work and self-sufficiency. H.R. 3433 also extended Medicare coverage to beneficiaries participating in the Ticket to Work and Self-Sufficiency Program. The Senate did not consider the legislation during the 105th Congress.

4. Fraud Prevention and Overpayment Recovery

During the 105th Congress, an anti-fraud proposal was circulated by the House Ways and Means Subcommittee on Human Resources, but was not introduced. The proposal included provisions that would seek to (1) ensure termination of SSI benefit payments for deceased recipients; (2) reduce the incidence of residency fraud; (3) penalize collaborators (i.e., "middlemen", doctors, health professionals, attorneys) who help aged, blind, or disabled persons to fraudulently qualify for SSI benefits; (4) promote cross-program recovery of SSI overpayments; and (5) make other changes in SSI

program rules to lower the incidence of fraud, abuse, and erroneous payments.

Until recently, because SSA was very lax in monitoring the current disability status of SSI recipients, many individuals whose medical condition had improved remained in the program. Members of Congress are now aware that there are huge costs associated with keeping ineligible persons on the rolls. In both the 104th Congress (P.L. 104–121) and the 105th Congress (P.L. 105–33), legislation was passed that provided additional funding for continuing disability reviews (CDRs). In addition, SSA has been increasing the number of SSI non-disability redeterminations (i.e., verifying income and resource requirements) it conducts.

Chapter 6

FOOD STAMPS

OVERVIEW: 1997–1998

In addition to nutrition programs for the elderly operated under Title III of the Older Americans Act (discussed in the chapter devoted to the Older Americans Act), the Federal Government supports three non-emergency food assistance efforts affecting significant numbers of older persons—the Food Stamp program, the Commodity Supplemental Food program, and the adult-care component of the Child and Adult Care Food program:[1] Three significant pieces of food stamp legislation were enacted in the 105th Congress. But no legislation affecting the Commodity Supplemental Food program or the adult-care component of the Child and Adult Care Food program was considered, other than annual appropriations.

- The 1997 omnibus emergency supplemental appropriations law (P.L. 105–18) included an amendment that allows *States* to opt to pay the cost of providing food stamps to noncitizens (and certain others) made ineligible for federally financed food stamp benefits by the 1996 welfare reform act (P.L. 104–193). And another 1997 law, the Balanced Budget Act (P.L. 105–33) directed increased Federal spending on work/training efforts for food stamp recipients.
- In 1998, food stamp provisions added to the Agricultural Research, Extension and Education Reform Act (P.L. 105–185) returned *federally financed* food stamp eligibility to many of the legal immigrants barred because of the 1996 welfare reform law—effective November 1, 1998. This legislation also reduced Federal spending for food stamp administrative costs.

In 1997 and again in 1998, food stamp enrollment and spending dropped significantly. Participation went from 25.5 million people in FY1996, to 22.9 million in FY1997 and 19.8 million in FY1998. An improved economy, program changes wrought by Federal and State welfare reform initiatives, and restrictions on eligibility (e.g., loss of eligibility by noncitizen legal immigrants) contributed to this decline. Participation by elderly persons, however, dropped much

[1] Nutrition programs that can provide help to elderly persons also include two emergency assistance programs—the Emergency Food Assistance program and the Emergency Food and Shelter program. The Emergency Food Assistance program provides Agriculture Department support (through the States), in the form of federally donated food commodities and funding for distribution costs, to aid food distribution to needy persons served by public and private nonprofit emergency feeding organizations, such as food banks, food pantries, emergency shelters, hunger relief centers, soup kitchens, and local governmental agencies. The Emergency Food and Shelter program, operated through the Federal Emergency Management Administration, makes grants to local public and private nonprofit entities to provide services to the homeless. No significant legislative changes were made to these two programs in the 105th Congress.

less (about 5 percent) than other participant categories (e.g., families with children); much of this drop was due to restrictions on the eligibility of legal immigrants enacted in 1996, and only partially reversed late in 1998. Spending for the regular Food Stamp program declined from $24.4 billion in FY1996, to $21.7 billion in FY1997 and $19.2 billion in FY1998.

On the other hand, participation in the Commodity Supplemental Food program grew noticeably in 1997 and 1998. Elderly enrollees in the program increased from 219,000 persons in FY1996, to 243,000 in FY1997 and 249,000 in FY 1998—while spending (for all recipients, including women, infants, and children) hovered around $90 million a year. And participation in and spending for the adult-care component of the Child and Adult Care Food program jumped significantly in FY1997 and FY1998—average daily attendance rose from 47,000 persons in FY1996 to 58,000 persons in FY1998; program costs increased from $25 million in FY1996 to $32 million in FY1998.

Recent information about food security among the elderly presents a mixed picture. A 1997 report from Second Harvest (a food bank organization) indicates that about 16 percent of persons served by food banks were 65 years and older. On the other hand, the Agriculture Department's Household Food Security survey covering 1995–1998, found that, for households with elderly members or elderly persons living alone, some 95 percent reported being "food secure"—as opposed to about 90 percent of all households in the survey.

A. BACKGROUND ON THE PROGRAMS

1. Food Stamps

The Food Stamp program provides monthly benefits—averaging $71 a person in FY1998—that increase low-income recipients' food purchasing power. Eligible applicants must have monthly income and liquid assets below federally prescribed limits (or be receiving cash public assistance) and must pass several nonfinancial eligibility tests: e.g., work requirements, bars against eligibility for many noncitizens and postsecondary students. Benefits are based on the monthly cost of the Agriculture Department's "Thrifty Food Plan," are adjusted annually for inflation, and vary with household size, amount and type of income (e.g., earnings are treated more liberally than income like Social Security or public assistance payments), and certain nonfood expenses (e.g., shelter costs, child support payments, dependent care and medical expenses). Basic eligibility and benefit standards are federally set, and the Federal Government pays for benefits (other than those financed by State reimbursements) and about half the cost of administration and work/training programs for recipients. States shoulder the remaining expenses and have responsibility for day-to-day operations (e.g., determining individuals' eligibility and issuing benefits) and a number of significant program rules. The regular Food Stamp program operates in the 50 States, the District of Columbia, Guam, and the Virgin Islands. Variants of the regular program are funded through nutrition assistance block grants to Puerto Rico, American Samoa, and the Northern Marianas.

The Food Stamp Act became law in 1964 (after a three-year pilot program); however, the program did not become nationally available until early 1975, when Puerto Rico and the last few countries in the country chose to enter. In 1977, the 1964 Act (as amended) was substantially rewritten and replaced with the Food Stamp Act of 1977, which greatly liberalized the program and increased participation. Amendments to the 1977 Act during the early 1980s significantly restricted eligibility and benefits. But, beginning in the mid-1980s and continuing through amendments in 1990 and 1993, program benefits were generally increased. In 1996, the welfare reform law (the Personal Responsibility and Work Opportunity Reconciliation Act; P.L. 104–193) incorporated the most extensive changes to the program since the 1977 rewrite of the law. Substantial benefit and eligibility cutbacks were legislated, and States were given more latitude in running the program. Among the changes most affecting the elderly was a provision that barred eligibility for most noncitizen legal immigrants (over 800,000 persons, many of them elderly). In 1997, provisions in P.L. 105–18 allowed States to choose to pay the cost of providing food stamp to noncitizens (and certain others) made ineligible by the 1996 welfare reform law, and, in 1998, amendments in P.L. 105–185 returned federally financed food stamp eligibility to many of those barred in the 1996 law. Two other recent legislative changes directed increased Federal spending on work/training programs for food stamp recipients (contained in the 1997 Balanced Budget Act; P.L. 105–33) and cut Federal spending for food stamp administrative costs (in P.L. 105–185).

Eligibility. The food stamp "assistance unit" is a household, typically those living together who also purchase and prepare food together. But not all co-residents are required to apply together (e.g., while spouses and parents and children must apply together, unrelated persons not purchasing and preparing food in common may apply separately). Food stamp eligibility depends primarily on whether a household has cash monthly income and liquid assets below Federal limits.

For the large majority of applicants, the income test confines eligibility to households with monthly total cash income at or below 130 percent of the Federal income poverty guidelines, annually adjust for inflation and differing by household size. Most income is counted in making an eligibility determination, but a few types of income are not (e.g., Federal energy assistance payments, most student aid, Earned Income Tax Credit payments, noncash income). For FY 1999, 130 percent of the poverty guidelines equals $873 a month for one person, $1,176 for two-person households, and higher amounts for larger households.[2] However, a slightly more liberal test is applied to households containing elderly or disabled persons (for more detail on this, see the later discussion of the elderly and the Food Stamp program).

The liquid asset limit is $2,000, or $3,000 for households with an elderly member. But all financial resources are not taken into account. Some important exclusions include a household's home, furnishings, and personal belongings, the first $4,650 of the market

[2] Income eligibility limits are 25 percent higher in Alaska and 15 percent higher in Hawaii.

value of any car, some retirement funds, burial plots, and work- or business-related assets.

With some exceptions, food stamps are available automatically (i.e., without regard to the income and asset tests noted above) to recipients of cash public assistance under States' Temporary Assistance for Needy Families (TANF) programs, Supplemental Security Income (SSI) payments, and State or local general assistance benefits. Under the two major exceptions, (1) SSI recipients in California are not eligible for food stamps because their SSI payment is assumed to include a food stamp component and (2) public assistance recipients living with persons not receiving public aid are not automatically food-stamp eligible.

Non-financial eligibility criteria include those related to work, student status, institutional residence, and citizenship. Most unemployed able-bodied non-elderly adults must meet work/training requirements to remain eligible, and eligibility is denied to households with strikers. Non-working postsecondary students without children are barred. Residents of institutions (other than residents in substance abuse programs and shelters for the homeless and battered women and children) are not eligible. And the eligibility of noncitizens is limited to (1) those with long U.S. work histories, (2) veterans and active duty military personnel and their families, (3) refugees and asylees (for seven years after entry), (4) legal immigrant children who entered the country before August 22, 1996, (5) elderly legal immigrants who were here before August 22, 1996, (6) disabled legal immigrants who entered before August 22, 1996 (including persons who become disabled after that date), and (7) Hmong refugees from Laos and certain Native Americans living along the Canadian and Mexican borders.

Finally, States may, at their own expense, take advantage of an option to provide food stamp benefits to (1) any noncitizen legal immigrant barred form federally financed food stamps and (2) persons made ineligible for federally financed food stamps by certain work/training rules for able-bodied adults without dependents.

Benefits. Food stamp benefits are aimed at increasing recipients' food purchasing power. In FY 1998, monthly benefits averaged $71 a person (about $170 for a typical household). They are inflation-adjusted each October, and vary with the type and amount of income, household size, and some nonfood expenses. Food stamps are provided monthly, and, except for very poor recipients, monthly allotments are not intended to cover all of a household's food costs—most recipients are expected to contribute a portion of their income to their food expenses.

To determine monthly benefit allotments, a household's total cash monthly income is reduced to a "net" income figure (representing income deemed available for food and other normal living costs) by allowing a "standard deduction" ($134 a month) and additional deductions for certain expenses. These include deductions for excessively high (but not all) shelter costs, 20 percent of earnings, dependent care expenses related to work/education, child support payments, and, for elderly and disabled, medical expenses above $35 a month. Deduction for dependent care costs and the shelter expenses of households without elderly or disabled person are subject to monthly dollar limits.

Food stamp allotments then equal the estimated monthly cost of an adequate low-cost diet (maximum benefits, set at the cost of the Agriculture Department's "Thrifty Food Plan" for the household's size and indexed annually for inflation), less 30 percent of monthly net income (the household's expected contribution toward its food costs). The theory is that food stamps should fill the deficit between what a household can afford for food (its 30 percent contribution) and the estimated expense of a low-cost diet (maximum benefits). For FY 1999, maximum monthly benefits in the 48 States and the District of Columbia are $125 for one person, $230 for two-person households, and larger amounts for bigger households; significantly higher maximums apply in Alaska, Hawaii, Guam, and the Virgin Islands.

Monthly allotments may be spent for virtually any food item (but not alcohol, tobacco products, or ready-to-eat hot foods) in approved food stores. They also may be used for some prepared meals (e.g., in shelters for the homeless and battered women and children, in elderly nutrition programs), seeds and plants for growing food, and hunting and fishing equipment in remote areas of Alaska. Purchases with food stamp benefits are not subject to sales taxes, and food stamp assistance is not counted as income under welfare, housing, and tax laws.

Food stamp allotments historically have been issued as paper "coupons." but food stamp recipients in all or part of nearly 40 States and the District of Columbia (about half of all recipients) now receive their benefits through "electronic benefit transfer" (EBT) systems that deliver them by using special "ATM-like" cards rather than coupons. And all States are expected to use EBT systems by 2002. Food stamp benefits also can, in some cases, be paid as cash—in a limited number of local projects for the elderly and disabled, for some recipients leaving cash welfare rolls, and in "work supplementation" programs (where the food stamp benefit is paid to a recipient's employer).

Puerto Rico, American Samoa, and the Northern Marianas. Variants of the regular Food Stamp program operate in Puerto Rico, American Samoa, and the Northern Mariana Islands. Puerto Rico's Nutrition Assistance program provides its benefits in cash under rules similar to (but generally more restrictive than) the regular program. Federal support is limited to an annual block grant ($1.2 billion in FY 1998) and the program serves some 1.3 million persons. The programs in American Samoa and the Northern Marianas also are to limited Federal grants, each funded at $3–$5 million a year and serving 3,000–4,000 people. They are not cash assistance programs and are roughly similar to the regular program, although American Samoa's program is limited to the elderly and disabled and the Northern Marianas' program has special rules directing use of some benefits to purchase local products.

The Elderly and the Food Stamp Program. Food stamp participation by eligible elderly persons is relatively low, about 30 percent by the most recent count (1994). This compares with a participation rate of some 70 percent among all those eligible. Based on 1997–1998 Agriculture Department survey data, households with at least one elderly member account for 18 percent of food stamp households. But, because the elderly generally live in small households

(78 percent live in single-person households, typically single women, and 16 percent live in two-person households), they make up only 8 percent of total food stamp enrollees. Overall, the survey information also shows that elderly food stamp recipients have income that generally is higher than other participants and, because of this and their smaller household size, have lower-than-average benefits. Average total monthly income for elderly persons in the Food Stamp program is about 80 percent of the Federal poverty income guidelines (compared to 53 percent of poverty among households with no elderly members), and their average household benefit is about one-third the average for all households in the program.

The Food Stamp program includes a number of special rules for the elderly—

- A more liberal income eligibility test is applied. Households with elderly (or disabled) members must have monthly income below the Federal poverty income guidelines after the standard and expense deductions noted in the earlier discussion of benefits. While their income is compared against a lower standard than most other households (who must have total income below 130 percent of the poverty guidelines), the amount of income counted is significantly less because the various deductions (nearly $300 a month on average) have been subtracted out.
- A more liberal liquid asset limit is used. Households with elderly members can have countable liquid assets of up to $3,000 and remain eligible (vs. $2,000 for others).
- When calculating benefits and income eligibility, no monthly dollar limit on the size of the deduction for excessively high shelter expenses is applied to households with elderly (or disabled) members; others are subject to a limit of $275 a month.
- When calculating benefits and income eligibility, elderly (and disabled) households can claim a deduction for any medical costs have $35 a month; this deduction is not available to others. For those claiming this deduction, it is typically about $100 a month, translating into a monthly benefit increase of some $3.
- Elderly (and disabled) persons who are applicants for or recipients of Supplemental Security Income benefits can make preliminary application for food stamps through their Social Security office and get assistance in completing their application.

In addition, some general food stamp rules can have special importance for the elderly—food stamp offices are required to have special procedures for those who have difficulty applying at the office, and applicants and recipients can designate "authorized representatives" to act on their behalf in the application process and using food stamp benefits.

2. The Commodity Supplemental Food Program

The Commodity Supplemental Food program provides supplemental foods to low-income elderly persons and to low-income infants, children, and pregnant, postpartum, and breastfeeding

women. It is authorized, through FY2002, under Section 4(a) of the Agriculture and Consumer Protection Act of 1973, as amended (7 U.S.C. 612c note), and operates through local projects in 17 States, the District of Columbia, and two Indian reservations. The program began in the late 1960s and is the predecessor of the Special Supplemental Nutrition Program for Women, Infants, and Children (the WIC program). Until 1995, it served primarily women, infants, and children not participating in the WIC program. But, some 65 percent of is recipients now are elderly—249,000 out of 377,000 in FY 1998. And, while women, infants, and children are accorded priority, the proportion of elderly enrollees is expected to continue increasing. Coverage of this program is limited by annual appropriations, and, without significantly increased appropriations, new projects or substantially enlarged overall caseloads are unlikely.

FY1998 spending for the Commodity Supplemental Food program was $89 million ($20 million of which represented support for administrative costs); in addition, almost $10 million worth of commodities donated from excess Federal stocks were made available. But, while elderly participants made up nearly two-thirds of participants, their proportion of the value of the food packages distributed to them (about $15 a person) was significantly less than for packages provided to women, infants, and children (just over $19 a person).

Participtig local projects establish most of their operating rules and receive (1) food items purchased with annually appropriated funds, (2) food commodities donated from excess Agriculture Department stocks, and (3) cash grants to help cover administrative costs. Food packages distributed by local sponsors are designed with the specific nutritional needs of the elderly and women, infants, children in mind. They include foods such as canned fruits, vegetables, meats, and fish, peanut butter, cereal and grain products, and dairy products.

3. The Child and Adult Care Food Program

The adult-care component of the Child and Adult Care Food program provides Federal cash subsidies for meals and snacks served to chronically impaired disabled adults, or those 60 years of age or older, in licensed non-residential day care settings ("adult day care centers"). It is permanently authorized under Section 17 of the National School Lunch Act and offers the same subsidies given for meals and snacks served in child day care centers. Each meal and snack served that meets Federal nutrition standards is subsidized at a legislatively set (and inflation-adjusted) rate, with meals/snacks served to lower-income persons subsidized at a higher rate than others. For July 1998-June 1999, the subsidy rates ranged from $1.94 for lunches/suppers served free to those with income below 130 percent of the Federal poverty income guidelines to 4 cents for snacks served to those with income above 185 percent of the poverty guidelines. In FY 1998, average daily attendance at the 1,700 sites operated by 1,100 sponsors was just over 58,000 persons, and Federal subsidies totaled $32 million.

B. LEGISLATIVE DEVELOPMENTS

There was no legislative activity associated with the Commodity Supplemental Food program or the adult-care component of the Child and Adult Care Food program during the 105th Congress. However, three laws were enacted that significantly affected the Food Stamp program.

The 1997 omnibus emergency supplemental appropriations law (P.L. 105–18) added a provision to the Food Stamp Act that allows States to opt to pay the cost of providing food stamp benefits to noncitizens made ineligible for federally financed food stamp benefits by the 1996 welfare reform act (the Personal Responsibility and Work Opportunity Reconciliation Act; P.L. 104–193). The 1996 law made all legal immigrants ineligible for food stamps except (1) those with long U.S. work histories, (2) veterans and active duty military personnel and their families, and (3) refugees and asylees (for 5 years after entry). When enacted, it was estimated that over 800,000 persons were barred because of this rule. Some 17 States took advantage of this new option to pay for food stamps for all or some of the noncitizens ineligible for federally funded benefits. P.L. 105–18 also permitted States to pay the cost of food stamp benefits to able-bodied non-elderly adults without dependents if they lost eligibility for food stamps because of a special work requirement limiting their time on food stamps; however, no States took advantage of this option.

A separate 1997 law the Balanced Budget Act (P.L. 105–33) directed increased Federal spending on work/training programs for food stamp recipients—a total of $1.5 billion over five years.

In 1998, food stamp provisions added to the Agricultural Research, Extension, and education Reform Act (P.L. 105–185) returned federally financed food stamp benefits to an estimated 250,000 legal immigrants (primarily elderly and disabled persons) affected by the 1996 welfare reform law's withdrawal of eligibility. Effective November 1, 1998, eligibility was reinstituted for legal immigrant children who entered the country before August 22, 1996 (the effective date of the 1996 welfare reform law), elderly legal immigrants (65 or older) here before August 22, 1996, disabled legal immigrants who entered before August 22, 1996 (including those who become disabled after that date), and Hmong refugees from Laos and certain Native Americans living along the Canadian and Mexican borders. Moreover, eligibility for refugees and asylees was extended from 5 to 7 years after entry. P.L. 105–185 also reduced Federal spending for food stamp administrative costs by over $200 million a year.

C. FOOD SECURITY AMONG THE ELDERLY

A review of the available data from the last three decades on the nutritional health and food security of the elderly reveals that a variety of research has been conducted. However, the findings of that research also reveal both a mixed and inconclusive picture of the actual nutritional status of this age group.

Concern about nutrition problems, particularly food insecurity, among the elderly is the result, in part, of the general characteristics of this age group. As a group, older Americans are a growing

proportion of the U.S. population, yet there is relatively little data collected on the elderly compared to certain other high risk groups, such a children. As a group, the elderly seem to be more reticent to admit to being "hungry" and needing assistance of any kind. Fixed incomes, a variety of health problems and loss of independence can all contribute to general health, nutrition and food security problems of older Americans. They seem less likely to use emergency feeding or participate in Federal food assistance programs. At the same time, the elderly are disproportionately heavy users of health care. A major concern has become minimizing health care costs, while maintaining a desirable quality of life in old age. It is well recognized that poor nutrition increases health problems and thus health care costs. Thus attention to the food security of elderly Americans is acknowledged as a way to help in reducing health care costs.

The issue of hunger in America captured public attention in 1967 when members of the then-Senate Subcommittee on Employment, Manpower and Poverty visited the rural South. The Subcommittee held hearings on the impact of the "War on Poverty" policy initiated during the Johnson administration and heard witnesses describe widespread hunger and poverty. Later that year, a team of physicians under the auspices of the Ford Foundation observed severe nutritional problems in various areas of the country where they traveled.

Subsequently Congress authorized a national nutrition survey to determine the magnitude and location of malnutrition and related health problems in the country. The results of the Ten State Nutrition Survey revealed that persons over 60 years of age showed evidence of general undernutrition which was not restricted to the very poor or to any single ethnic group. The most significant nutritional problems in those over 60 years of age were in the intakes of iron, vitamins A, C and thiamin, as well as obesity (in elderly females).

Reports on hunger and malnutrition in the United States, as well as the 1970 White House Conference on Food, Nutrition and Health, contributed to changes in several Federal programs in the 1970s. During this period the results of the Ten State Nutrition Survey led to the addition of a nutrition component to the health examination survey conducted by the then Department of Health, Education and Welfare. This addition created the Health and Nutrition Examination Survey (HANES), which was designed to collect and analyze data on the nutritional status of the U.S. population. The voluntary nutrition labeling program was initiated to provide consumers with more information on the nutrient content of the foods that they were purchasing. The Federal food assistance programs also underwent significant expansion during this period. In 1977 the physicians returned to the same communities visited a decade earlier to evaluate progress made in combating hunger. They discovered dramatic improvements in the nutritional status of the residents, which were attributed to the expansion of the Federal food programs.

Throughout the 1980s, considerable attention was focused on the re-emergence of widespread hunger in the United States. Beginning in 1981 numerous national, State and local studies on hunger

have been published by a variety of governmental agencies, universities and advocacy organizations. The reports have suggested that hunger in America is widespread and entrenched, despite national economic growth. However, the problem that exists has few clinical symptoms of deprivation, unlike the hunger observed during drought, famine, and civil war elsewhere in the world.

In 1983 President Ronald Reagan appointed a commission to investigate allegations that hunger was widespread and actually growing in America. The President's Task Force on Food Assistance concluded that there was little evidence of widespread hunger in the United States and reductions in Federal spending for assistance had not hurt the poor. However, it did note that there was likely hunger that went undetected in certain high risk groups, including the elderly. The Task Force formulated several modest recommendations to make the Food Stamp Program more accessible to the hungry, along with offsetting cost-reduction measures that increased State responsibility for erroneous payments and offered the option of block granting food assistance.

During the 1980s, numerous nongovernmental groups continued to document the prevalence of hunger and malnutrition throughout the country. Many reports focused specifically on children and families. The Harvard School of Public Health conducted a 15-month examination of the problem of hunger in New England and concluded in 1984 that substantial hunger existed in every State examined, was more widespread than generally believed, and had been growing at a steady pace for at least three years. The researchers reported that an increasing number of elderly persons were using emergency food programs, while many others were suffering quietly in the privacy of their homes. The report expressed concern about reports from medical practitioners that were increasing numbers of malnourished children and greater hunger among their elderly patients. The researchers cited the impact of malnutrition on health in general and emphasized that children and the elderly are likely to suffer the greatest harm from inadequate diets.

In 1984 the U.S. Conference of Mayors issued its first report which detailed a significant increase in requests for emergency food assistance, citing unemployment as a primary cause. Subsequent reports published indicated annual increases ranging from 9 to 28 percent during the period of 1985 to 1998. In 1998 emergency food assistance requests by the elderly increased in 67 percent of the 30 cities surveyed and requests increased by an average of six percent in each city.

The New York Times reported in 1985 that scientists estimated 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 were becoming increasingly alarmed by evidence that 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) may be attributable to malnutrition. Experts reported that many elderly fall victim to the spiral of undereating, illness, physical inactivity, and depression. Reports more recently suggest that a significant amount of the illness

among the elderly could be prevented through aggressive nutrition aid. Many physicians believe that immunological studies hold promise that many elderly could reduce their disease burden in old age by eating better.

In 1987 a national survey of nutritional risk among the elderly was conducted by the Food Research and Action Center. Despite the fact that the majority of the elderly surveyed participated in an organized food service for older persons, many respondents reported signs of nutrition risk. Over half of those surveyed reported that they did not have enough money to purchase food they needed at least part of the time. Over one-third usually ate less than three meals a day and 17 percent felt like eating noting at all at least once a week. Twenty percent had lost weight over the last month without trying. Some 17.2 percent could not shop for or prepare their own food, and 18.3 percent could not leave home without assistance of another person. Over 25 percent of respondents had no one to help them if they were sick in bed. Twenty percent responded affirmatively to at least five of the risk questions, which put them into nutritional risk category and this was especially true of the seniors who were living below the poverty level. Seniors living below the poverty level were much less likely to report being able to purchase the food they needed than those living on incomes above the poverty level.

Because of well-organized concerns about poor nutritional status in older Americans, the Nutrition Screening Initiative was formed in 1990 by three health professionals and aging groups as a five-year multifaceted effort to promote nutrition screening and better nutritional care in the America's health care system. It was a direct response to the call for increased nutrition screening of the 1988 Surgeon General's Workshop on Health Promotion and Healthy People 2000. The group identified a number of risk factors or early warning signs that might be associated with poor nutritional status in older Americans. The risk factors included such elements as inappropriate food intake, poverty, social isolation, dependency/disability, acute/chronic diseases or conditions, chronic medication use and advanced age. Identification of these risk factors led to the creation of relatively easily administered screening tools that can be used in settings where social service or health care professionals are in contact with the elderly. The information obtained allows for the detection of common nutritional problems for which an intervention may be indicated and managed by qualified professionals. Nutrition Care Alerts were subsequently developed and distributed for use by caregivers in long term care facilities.

The General Accounting Office reported in June 1992 on elderly Americans and the health, housing and nutrition gaps between the poor and nonpoor. GAO reported that the information on the relationship between poverty and nutrition among the elderly is limited, but that the available data indicate that poor elderly persons consume less of some essential nutrients than do nonpoor elderly persons. As many as one half of poor elderly persons consumed less than two thirds of the recommended daily allowance of vitamin C, calcium and other nutrients. However, the agency indicated that the data were limited by being a decade old, lacking information

on specific elderly subpopulations and the absence of adequate nutritional standards or guidelines by which to judge the elderly population. GAO indicated that improvements were needed in both nutrition data and nutrition guidelines before definitive conclusions could be drawn about the poor elderly's nutritional status.

In 1993, the Urban Institute released a report based on about 4300 interviews conducted in both community and meal program settings to determine the extent of food insecurity among the elderly. The findings showed no difference between the rate of food insecurity in urban and rural locations, which was about 37 percent experiencing food insecurity in a six-month period. Hispanic elderly had the highest levels of food insecurity followed by blacks and the elderly of other races, while whites had the lowest levels. Other indicators of food deprivation, including eating fewer meals a day, eating a less balanced diet, experiencing days with no appetite, and reporting not getting enough to eat, provided an indication that these populations face a number of problems associated with food insecurity. Seniors with below poverty incomes appeared to suffer the greatest food insecurity, but those with incomes up to 150 percent of poverty still report considerable food insecurity. The report concluded that between 2.8 and 4.9 million elderly Americans experience food insecurity in a six-month period.

A 1993 study published in the Journal of the American Dietetic Association reported that over one-third of the elderly who are admitted from their homes into a nursing facility were malnourished at the time of admission and nearly forty percent of those admitted from acute care facilities were malnourished. At the same time the prevalence of malnutrition in nursing home patients is between 35 and 85 percent of the population. The high prevalence of malnutrition in the nursing home population may reflect in part the transfer of malnourished patients from acute-care hospitals to the nursing facility or the progressive development of malnutrition during nursing home stays.

The 1996 Administration on Aging report on the national evaluation of the elderly nutrition program in 1993–1995 indicated that individuals who receive elderly nutrition program meals have higher daily intake for key nutrients than similar nonparticipants. These meals seem to provide between 40 and 50 percent of participants' daily intakes of most nutrients. Participants have more social contacts per month than similar nonparticipants and most participant report satisfaction with the services provided.

The Second Harvest (the largest domestic hunger relief organization) report, Hunger 1997: The Faces and Facts, concluded that about 16 percent of the clients being served by its network were 65 years and older. This age group were reported to represent 16.5 percent of clients in food pantries, 17.2 percent in soup kitchens and 4.3 percent in shelters.

The recent advanced report of Household Food Security in the United States released by USDA contained survey data from 1995 to 1998. It indicated that 90 percent of all U.S. households were food secure, that is they had access at all times to enough food for an active healthy life with no need for recourse to emergency food sources or other extraordinary copying behaviors to meet their basic food needs. About 10.2 percent of households were food inse-

cure. For the households with elderly and elderly living alone, 94.5 percent and 94.6 percent respectively reported being food secure. For the remaining approximately 5.5 percent in each group during this period, about 40 percent reported being food insecure with hunger, meaning that they did not have access to enough food to fully meet basic needs at all times during the year.

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 in 1965, and the expansion of private health insurance-covered services contributed to a health spending trend that grew much more quickly than the overall economy. By 1990, spending on health care was at $699.4 billion, or 12.2 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, had an impact on U.S. health care spending patterns. While spending for health care reached $1 trillion for the first time in 1996, growth in spending between 1993 and 1997 steadily slowed. Health spending growth was only 4.8 percent in 1997, the lowest rate in more than 3½ 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. There are concerns, however, as to whether these trends in health care expenditures and costs will continue. Both the Health Care Financing Administration (HCFA) and the Congressional Budget Office (CBO) project larger increases in health care spending in the coming years. Both HCFA and CBO expect national health spending to reach over $2 trillion by 2008, or approximately 15.5 percent to 16.2 percent of GDP.

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, medical care 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 1997, spending for health care in the United States totaled $1.1 trillion, with 89 percent of expenditures on personal health care, or services used to prevent or treat diseases in the individual. The remaining 11 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, philanthropic contributions, or other means. However, there has been a substantial shift over the past four decades in the relative role of various payers of health services. In 1960, almost half of all health expenditures were paid out-of-pocket by consumers, while private health insurance represented only 22 percent and public funds (federal, state, and local governments) 25 percent. The growth of private health insurance and the enactment of the Medicare and Medicaid programs changed the system from one relying primarily on direct patient out-of-pocket payments to one which depends heavily on third-party private and government insurance programs. In 1997, individual out-of-pocket spending (including coinsurance, deductibles, and any direct payments for services not covered by an insurer) represented only 17.2 percent of all health expenditures.

Since 1990, the difference between the share of health spending financed by private and public sources has narrowed. In 1990, private spending paid for 59.5 percent and public programs funded 40.5 percent. While all private sources combined continued to finance most health care spending in 1997 ($585.3 billion, or 53.6 percent), public program funding increased to 46.4 percent ($507.2 billion). It is federal spending that is the largest single contributor, financing 34 percent of all spending. The federal government assumed an increasingly significant role in funding national health expenditures in 1965 with the enactment of the Medicare and Medicaid programs. In 1960 the federal government contribution represented about 11 percent of all health expenditures; by 1970, the federal government's share increased to 24 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 1997. The federal government spent $367 billion, 33.6 percent of total national health expenditures, in 1997. 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.

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 three parts. Part A (Hospital 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. Part C (Medicare+Choice) offers managed care options to beneficiaries. Most outpatient prescription drugs are not covered under Medicare, and some other services (such as coverage for care in skilled nursing facilities) 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 percent 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 1997, Medicare expenditures ($210.4 billion) accounted for 57.3 percent of all federal health spending and 19.2 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 1980–1990 period, total outlays grew from $35 billion to $109.7 billion, for an average annual rate of growth of 12.1 percent. For the 1990–1997 period, total outlays grew from $109.7 billion to $210.4 billion, for an average annual growth rate of 9.5 percent. Different trends are recorded for spending on Part A and Part B. The average annual rate of growth in Part A spending remained the same at 10.6 percent over the FY1980–FY1990 and the FY1990–FY1997 periods. However, the average annual rate of growth for Part B declined from 14.9 percent in the FY1980–FY1990 period to 7.6 percent over the FY1990–FY1997 period.

The Balanced Budget Act of 1997 provided for structural changes to the Medicare program and slowed the rate of growth in reimbursements for providers. Since passage of the Act, CBO has revised its projections for Medicare spending. It projects that Medicare outlays will be $334.8 billion in 2007. This represents a dramatic decrease in the average annual overall rate of growth to 4.75 percent for the time period FY1997–FY2007.

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 FY1989 through FY1992. This was attributed to increased enrollment, increases in spending per beneficiary, and growth in disproportionate share hospital (DSH) payments. Growth slowed down, however, to an average of about 10 percent from 1993 to 1995. This may be due to improvements in the overall economy,

decreased enrollment, and increased use of managed care programs by states for Medicaid beneficiaries. Total federal and state outlays for Medicaid in 1998 were $177.4 billion. The federal government pays about 57 percent of total Medicaid costs. CBO projects that federal outlays for Medicaid will grow from $101 billion in 1998 to $205 billion in 2007, an average growth rate of 8.1 percent.

Medicare covers about 53 percent of the total medical costs of the non-institutionalized elderly. About 14.4 percent of total costs are paid by the elderly out-of-pocket. The remaining costs are paid by private insurance coverage (including retiree health insurance plans and Medigap), government sources such as Medicaid or state assistance programs, or other private sources such as charity.

Among the elderly in institutions (such as nursing homes), 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. Institutionalized elderly pay about 35 percent of the costs of care out-of-pocket. 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 1997, an estimated 34 percent, or $371.1 billion, of national health care expenditures was paid to hospitals. Hospital care expenditures had reached 41.5 percent of total health expenditures in 1980, growing at an average annual rate of 31.9 percent. In 1983, Medicare's prospective payment system (PPS) was introduced. Under this program, hospitals are paid a predetermined rate for each patient based on the patient's diagnosis. With this incentive to provide care more efficiently, the hospital share of total health expenditures declined to 36.6 percent in 1990. The rate of growth in hospital spending continued to decrease in the past decade, falling to only 2.9 percent in 1997. This was slower than spending for any other personal health care service.

In 1997, public (federal, state, and local) sources accounted for over 61 percent of hospital service expenditures. The federal government's share has grown from 17.3 percent in 1960 to 50 percent in 1997, making it the single largest payer. Medicaid spending for hospitals dropped by 2.4 percent in 1997 as a result of growing managed care enrollment, decline in the number of Medicaid recipients, and restrictions on states' disproportionate share payments to hospitals. Medicare spending for hospital services, however, grew by 6.3 percent, more than twice as fast as overall hospital spending in 1997.

Private health insurance is responsible for about one-third of all hospital spending. In 1990, its portion was 37.3 percent, but this has been declining as a larger portion of care has been provided in ambulatory settings, and managed care plans have negotiated lower prices for services. Out-of-pocket expenditures by consumers represented 20.7 percent of payments for hospital care before the

enactment of Medicare and Medicaid; they represented only 3.3 percent in 1997.

The introduction of Medicare's PPS in 1983 also had an effect on hospital admissions and the number of inpatient days. Hospital admissions for all age groups increased at an average annual rate of 1.0 percent between 1978 and 1983. After the start of PPS, however, total admissions decreased each year until 1993 and 1994, when they rose 0.7 percent and 0.9 percent respectively. In 1995, total admissions increased 1.5 percent over the previous year, the largest increase in 15 years. (While this number was higher because of the growth of the 65 and over population, incentives such as the utilization of managed care and outpatient care actually led to a 6 percent reduction in hospital admissions per capita from 1990 to 1997.)

Hospital inpatient admissions for persons 65 and over had been increasing an average of 4.8 percent per year since 1978. After introduction of PPS, admissions among the older population decreased from 1984 to 1986 and then grew more slowly at an average increase of 1.6 percent from 1987 to 1992. From 1993 to 1995, growth in hospital admissions of elderly patients ranged from 2.0 percent-2.9 percent. In 1996, however, there was a much smaller increase of 0.4 percent in the number of hospital admissions for the elderly.

While average length of stays in a hospital tend to be almost two days longer for the elderly than for those under 65, the length of hospital stays for elderly patients declined by an average of two days from 1990 to 1996. The average stay for persons aged 65–74 was about 6.2 days in 1996, compared with 6.8 days for the group aged 85 and older.

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 5.8 contacts per annum per year in 1995. 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. This decreased slightly to 11.1 contacts in 1995.

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 90 percent in 1995. 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 54 percent of physician visits by the elderly in 1995 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.

Expenditures for physician services, the second largest component of personal health care expenditures, stood at $5.3 billion in 1960, and in 1980 had reached $45.2 billion. This represents a decline in the percentage of personal health care spending from 22.5 percent in 1960 to 20.8 percent in 1980. This percentage grew in the 1980s, reaching 23.8 percent in 1990. Since 1991, the annual

rate of growth in payments for physician services has been the slowest since the 1960s, falling from 10.9 percent in 1991 to 2.9 percent in 1996. Expenditures for physician services was $217.6 billion in 1997, or 22.5 percent of personal health care expenditures. This slowdown in the rate of growth could be attributable to several factors, including adjustments in private sector payment systems, reflecting Medicare's fee schedule (see Chapter 8); and increased use of managed care.

In 1997, approximately 16 percent of the cost of physician services was paid out-of-pocket. These payments include copayments, deductibles, or in-full payments for services not covered by health insurance plans. Like hospital services, the probability of individuals paying for physicians services has declined sharply since the 1960s. However, unlike hospital services, the single largest payer for physician services is not the federal government, but rather private health insurance companies. In 1960, private health insurers contributed about 30 percent of the total; by 1990 this figure had reached 46 percent. In 1997 private health insurers paid for 50 percent of all physician services.

Medicare spending for physician services was $46.4 billion in 1995, or 21.3 percent of total funding for care by physicians. In comparison, Medicare paid for only 12.5 percent or $1.7 billion of total physician service expenditures in 1970. According to HCFA, the change in the average annual rate of growth in Medicare payments for physician services 1970–1990 was 15.3 percent. National payments for physician services in this time period grew at an average annual rate of 12.6 percent. Because of changes in the Medicare physician payment system, the growth of Medicare spending for physician services has decelerated substantially. The change in the average annual rate of growth in Medicare physician payments increased by 6.8 percent between 1990 and 1997, compared with 5.8 percent for national physician payments during the same time period.

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. Services are provided either in a nursing home or in home and community-based care settings. 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 $115.1 billion in 1997, and includes all age groups needing long-term care.

In 1997, almost three-fourths of long-term care spending, or $82.8 billion, was for nursing home care. Nursing home care represented 7.6 percent and home care services represented 3 percent

of national health care expenditures. The cost of long-term care can be catastrophic. The average cost of nursing home care is in excess of $40,000 a year. 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 4 percent of spending in 1997. The elderly can qualify for Medicaid assistance with nursing home 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—47.6 percent in the 1997. Medicare's role as a payer for nursing home care has also increased in the last several years to 12.3 percent. This accounts for much of the increase in the federal government's share of nursing home spending, which rose from 31 percent in 1990 to 41.7 percent in 1997.

About 1.56 million Americans were receiving nursing home care in 1996. This represented only 4.6 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 $32.3 billion in 1997. In 1997, Medicare paid $17.6 billion for home health services, or 54.5 percent of the total. 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, state programs, and 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 1997, there were 34 million people aged 65 and over representing 12.7 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 1997 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

(A) BACKGROUND

According to data from HCFA's National Health Expenditures, in 1997, prescription drug expenditures in the United States were approximately $78.9 billion, or about 7.2 percent of total health care

spending. This figure measures spending for outpatient prescription drugs, over-the counter medicines, and sundries purchased in retail outlets. It does not include the value of drugs and other products provided by hospitals, nursing homes, or health professionals. These drug costs are included with estimates of spending for those providers' services. In recent years, the rate of growth in spending for prescription drugs has risen at a faster rate than other health care spending. For example, between 1996 and 1997, spending on hospital care grew 2.9 percent, physician services spending rose 4.4 percent, and dental services spending grew 6.5 percent. Spending on prescription drugs in the same period grew 14.2 percent.

(B) ISSUES FOR OLDER AMERICANS

(1) Prescription Drug Coverage Among Older Americans

Most older Americans receive health insurance coverage through the Medicare program. However, Medicare provides limited coverage for drugs. The program provides coverage for drugs administered in a hospital or skilled nursing facility and for some drugs administered by physicians, but does not generally provide coverage for outpatient prescription drugs. For those that it does cover (see below), payments are made under Part B of the program. In FY1997, Medicare, which covered approximately 38 million beneficiaries, paid $2.75 billion for outpatient prescription drugs.

Medicare provides coverage for drugs which cannot be self- administered and are "incident to" a physician's professional service. Coverage is generally limited to those drugs which are administered by injection.

Despite the general limitation on coverage for outpatient drugs, the law specifically authorizes coverage for certain classes of drugs: those used for the treatment of anemia in dialysis patients, immunosuppressive drugs for three years following an organ transplant paid for by Medicare, certain oral cancer and associated antinausea drugs, and certain immunizations.

Most beneficiaries have some form of private or public health insurance coverage to supplement Medicare. In 1996, 88.7 percent had additional insurance coverage through managed care organizations, employer-sponsored plans, Medigap (three of the 10 standardized Medigap plans offer some level of drug coverage), Medicaid, or other public sources. However, many persons with supplementary coverage have limited or no coverage for prescription drug costs. According to the Health Care Financing Administration (HCFA), in 1995, 65 percent of beneficiaries had some drug insurance coverage. HCFA reported that 95 percent of those enrolled in Medicare HMOs, 88 percent of those with Medicaid,[1] 84 percent of those with employer-sponsored plans, and 29 percent of those with Medigap plans had primary drug coverage. Beneficiaries with supplementary prescription drug coverage use prescriptions at a considerably higher rate than those without supplementary coverage. In 1995, persons with coverage used an average of 20.3 prescriptions per year compared to 15.3 for those without supplementary

[1] Persons with full Medicaid coverage have Medicaid drug coverage. Persons covered under the Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLIMB) programs, but not otherwise Medicaid-eligible, do not have drug coverage.

coverage. In addition, several states and the pharmaceutical industry offer assistance with prescription drug costs for low-income individuals.

(2) Prescription Drug Spending by Older Americans

Older Americans take more prescription drugs on average than the population under age 65. In 1996, individuals aged 25 to 44 filled an average of two to three prescriptions for the year; those 65 and over filled approximately nine to twelve. While the elderly represent about 13 percent of the population, about 34 million individuals, they account for almost 35 percent of all prescriptions dispensed in the United States.

In 1997, spending for prescription drugs by persons aged 65 and over amounted to more than $20 billion or 25 percent of total expenditures for prescription drugs. Medicare beneficiaries (including disabled individuals under age 65) pay about half of their drug costs out-of-pocket; this compares with 34 percent paid out-of-pocket by the population as a whole. Beneficiaries spent an average of $600 a year on outpatient prescription drugs in 1995. The National Academy of Social Insurance (NASI) estimates that this number has increased to over $900 per beneficiary in 1999.

Out-of-pocket spending varies depending on the beneficiary's coverage by supplemental health insurance. NASI has estimated 1999 out-of-pocket drug expenditures for non-institutionalized Medicare beneficiaries who are not in Medicare+Choice plans. It estimates that 17 percent will have no drug expenditures. For the remainder, 34 percent will have out-of-pocket expenditures under $200, 21 percent will spend $200–$499, 15 percent between $500 and $999, 7 percent between $1,000 and $1,499, and 3 percent between $1,500 and $1,999. An estimated 4 percent will have out-of-pocket expenses of $2,000 or more.

Some observers contend that prices paid by the elderly paying cash for their prescriptions are significantly higher than those paid by large purchasers, such as managed care organizations and the federal government. One study conducted in 1998 by staff on the House Government Reform and Oversight Committee surveyed the prices of particular drugs used often by seniors. The results of their findings, cited in Table 1, list bulk and retail prices for an average monthly supply. Some analysts have criticized the methodology used in the study. One analysis of the data cites a problem with comparing the bulk buyer prices on the Federal Supply Schedule (FSS) with retail prices. Whereas the FSS price is the "direct-from-the-manufacturer" price, the retail price includes markups made over and above the manufacturer price at both the wholesale and retail levels.

Drug name	Prices for bulk buyers	Retail prices paid by senior citizens
Synthoid	$1.75	$27.05
Micronase	10.05	46.50
Zocor	42.95	104.80
Prilosec	56.38	111.94
Norvasc	58.83	113.77
Procardia XL	67.35	126.86

Drug name	Prices for bulk buyers	Retail prices paid by senior citizens
Zoloft	123.88	213.72

AAAASource: House Government Reform and Oversight Committee, Democratic Staff Report.

(B) DRUG INDUSTRY ISSUES

(1) Growth in Prescription Drug Expenditures

As stated earlier, spending on prescription drugs grew 14.2 percent in 1997. According to the Bureau of Labor Statistics, a relatively small portion of this aggregate spending growth (2.5 percentage points) was due to price inflation. In fact, drug price inflation has been consistent with other medical care inflation, rising 3.7 percent in 1998, compared with a 3.3 percent rise in hospital costs and a 3.0 percent rise in physician service costs. A much larger portion of the growth in spending (11.7 percentage points) was due to an increased volume of purchases of existing drugs and new products.

Health plans have experienced large increases in their prescription drug costs. A recent Wall Street Journal article stated that spending for drugs by the automaker Chrysler has risen 86 percent in five years, and that for Blue Cross/Blue Shield of Michigan, spending for drugs is 28 percent of total spending—more than spending for physician visits.[2]

Profit margins in the pharmaceutical industry are high: they are predicted to grow approximately 16 percent-18 percent, compared to 4 percent-7 percent expected growth for other Fortune 500 companies. However, a 1994 study by the Congressional Budget Office stated that, with proper accounting for the inherent riskiness in pharmaceutical research and development, profit margins would be only slightly above industry in general.

(2) Research and Development

The American pharmaceutical industry contends that higher profits are necessary to draw the investment capital needed for research and development. The industry has been described as one of the most innovative, producing almost half of the new drugs introduced internationally. About 20 percent of the industry's revenues are invested in R&D compared to 3 percent-6 percent for other industries. Costs can be higher than 150 million for clinical trials of a new drug. The drug development process, including the pre-clinical trial phase, clinical trials, and the approval phase, can take over 15 years. A relatively small percentage of drugs which enter these trials actually go on the market. New drugs have up to 22 years of patent protection (and exclusivity of sales), after which the generic drug industry can market their equivalents of brand name drugs. However, Food and Drug Administration (FDA) approval for new drugs sometimes comes several years after the drug was patented. The drug industry maintains that this limits

[2] Elyse Tanouye, "Drug Dependency: U.S. Has Developed an Expensive Habit: Now, How to Pay for It?" Wall Street Journal, November 16, 1998, p. A1.

their ability to recover the cost (which averages 500 million) of bringing a new drug to market.

(3) Health Benefits and Cost-Effectiveness of Drugs

The pharmaceutical industry argues that another reason for increasing expenditures on drugs is that drugs are used as substitutes for other more expensive health treatments. There are several studies that show cost savings result when drugs are used to treat certain conditions. For example, a study by the Agency for Health Care Policy and Research found that 40,000 strokes per year could be prevented through the use of a blood-thinning drug at a savings of $600 million per year. A study published in the New England Journal of Medicine found that providing treatment with beta-blockers to patients following a heart attack can reduce deaths by 40 percent.[3] Another study published in the New England Journal of Medicine showed that an ACE (angiotensin converting enzyme) inhibitor given to patients for congestive heart failure saved $9,000 per year in hospital costs and reduced deaths by 16 percent.[4] New drugs used to treat AIDS have dramatically reduced death from the disease and decreased hospitalization costs. But, according to a study by the drug manufacturer Merck, the short-term costs of treating HIV-positive patients have not dropped; they have just been transferred from hospitals to drugs.[5]

(4) Role of Large Payers

Another issue facing the drug industry is the role of large payers, such as insurance companies, hospitals, HMOs and other managed care organizations, and federal and state governments.

Through the use of formularies (lists of drugs approved for use), insurers may limit the type of drugs that they will cover. Their large market share allows them the clout to negotiate significant discounts on prices paid to drug manufacturers. Additionally, manufacturers negotiate contracts with federal purchasers buying drugs through the Federal Supply Schedule. Under the Medicaid program, manufacturers must provide rebates to states for drugs purchased by beneficiaries.

(5) Generic Manufacturers

Competition from generic drug manufacturers also affects sales in the brand name pharmaceutical industry. The Drug Price Competition and Patent Term Restoration Act of 1984 (P.L. 98–417), referred to as 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 brand name drug's patent. According to one market analyst, the generic drug market share increased from 18.6 percent in 1984 to 42.8 percent in 1995. Managed care organizations and other large purchasers encourage the use of less expensive generic brands.

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[3] Gottlieb, et al., "Effect of Beta-Blockade Among High-Risk and Low-Risk Patients After Myocardial Infarction, *New England Journal of Medicine,* 339 (8), 489–497, 1998.

[4] The SOLVD Investigations, *New England Journal of Medicine,* 325 (5) 393–203, 1991.

[5] Tanouye.

Brand name manufacturers employ methods to diminish the encroachment on their markets by generic manufacturers. In some instances, they release a new, improved version of a drug just as the patent on the old drug expires. They also employ direct-to-consumer (DTC) advertising to encourage individuals to ask their physicians to prescribe specific drugs by name. DTC advertising, once thought inappropriate by the drug industry, is used to supplement industry representative visits to physicians and hospitals. Between 1996 and 1997, DTC advertising increased 46 percent.

(C) CONGRESSIONAL RESPONSE

(1) Previous Efforts To Expand Medicare's Coverage of Prescription Drugs

Since its inception in 1965, congress has been concerned over the lack of prescription drug coverage in the Medicare program. Over the past decade, two major attempts were made to add this coverage. The first was the Medicare Catastrophic Coverage Act of 1988 (P.L. 100–366). It contained catastrophic prescription drug coverage subject to a $600 deductible and 50 percent coinsurance. The Act was repealed the following year. The second attempt was during the health reform debate in 1994. The Health Security Act, proposed by the Clinton Administration, would have added a prescription drug benefit to Medicare Part B beginning in 1996. After a $250 deductible had been met by the beneficiary, Medicare would pay 80 percent of the cost of each drug; the beneficiary would pay the remaining 20 percent. This plan was never enacted into law.

(2) Current Debate

Several proposals have been advanced in the 106th Congress affecting prescription drugs for Medicare beneficiaries. Some would extend coverage to the entire population while others would limit coverage to low-income beneficiaries. Most proposals would rely on pharmacy benefit managers or similar entities to administer the benefit and negotiate with manufacturers. A few measures would not add a new benefit, but rather would focus on reducing the price beneficiaries pay for drugs.

The issue of prescription drug coverage was one of the most difficult facing the National Bipartisan Commission on the Future of Medicare. Although a plan was not issued from the Commission, Congressional attention was again directed at the lack of a comprehensive drug benefit.

A number of issues must be considered in formulating a drug benefit for Medicare.

Persons Covered. Some observers have recommended extending prescription drug coverage to the entire Medicare population; others have suggested targeting a new benefit toward those most in need, such as those with incomes below 135 percent of poverty who are not eligible for full Medicaid benefits.

Medigap Mandates. As stated earlier, only three of the 10 standardized Medigap plans offer some level of drug coverage. Many observers have noted that only persons who expect to utilize a significant quantity of prescriptions actually purchase Medigap plans with drug coverage. This adverse selection tends to drive up the

premium costs of these policies. Some have suggested that all Medigap plans be required to offer prescription drug coverage. Unless the benefit were identical across all plans, there would still be some adverse selection. In addition, requiring prescription drug coverage could potentially make any Medigap coverage unaffordable for some beneficiaries, and result in less health coverage for any beneficiary forced to drop their Medigap coverage.

Scope of Benefits. There is debate as to whether the benefit should be catastrophic or more comprehensive in scope. A catastrophic benefit would only help a small portion of the population and would likely have a high deductible and perhaps high coinsurance charges. A more comprehensive benefit would have lower beneficiary cost-sharing charges, perhaps more comparable to current beneficiary cost-sharing under Part B ($100 deductible; 20 percent coinsurance).

Cost Control Strategies. There is currently concern that Medicare pays more for prescription drugs than do other government programs or private managed care organizations. Some observers have suggested that cost control methods should be adopted. However, the pharmaceutical industry is concerned that cost controls could shrink industry profits and hinder future research and development of new drugs. Possible cost control methods being considered include drug formularies, manufacturers' discounts, rebates, prior authorization for use of certain categories of drugs, implementation of quantity limits (for example, drugs limited to 30- or 60-day supplies with a limited number of refills), and utilization review.

Pharmacy Benefit Managers (PBMs). A growing number of health insurers have contracted with PBMs, companies which manage pharmacy benefit programs on behalf of health plans. Through the use of various strategies (developing retail pharmacy network arrangements, operating mail order pharmacies, developing formularies, negotiating discounts, etc.) PBMs are credited with controlling rapidly rising pharmacy costs. They have been attributed with saving the Federal Employees Health Benefits Program plans significant costs.

Cost and Financing. The issues of cost and financing also must be addressed. The Congressional Budget Office (CBO) has estimated that a new benefit with a $250 deductible, 20 percent coinsurance, and an annual cap on out-of-pocket costs of $1,000 would have a net cost of $22.5 billion in 2000.[6] NASI has estimated that a drug benefit could add between 7 percent-13 percent to Medicare's cost over the next decade.

There is no consensus on how a drug benefit would be financed. Currently, Medicare's limited drug benefit is funded under Part B of the program. Under Part B, beneficiary premiums cover 25 percent of program costs and federal general revenues cover the remaining 75 percent. The addition of a comprehensive drug benefit under this arrangement would mean a substantial increase in overall Medicare expenditures paid by general revenues, and a significant increase in the Part B premium, above current CBO projec-

[6] U.S. Congressional Budget Office. Health Care and Medicare Spending, by Dan Crippen. Handouts presented to the Subcommittee on Health, House Committee on Ways and Means. March 8, 1999.

tions. It is expected that financing a drug benefit will be one of the most difficult issues to resolve.

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 1997, the average life expectancy at birth increased from 46 years to 73.6 years for men, and from 48 to 79.2 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. Currently, those aged 65 and over comprise 13 percent of the population. By 2015, they will constitute 15 percent, and will be 20 percent by 2030. The fastest growing group among those 65 and over is people aged 85 and over. Currently 1.5 percent of the population, by 2050 they will comprise 4.6 percent.

Increased longevity raises questions about the quality of these extended years and whether they can be spent as healthy, active members of the community. According to the Medicare Current Beneficiary Survey,[7] in 1996, although 79 percent of the elderly aged 65 to 74 rated their health as good, very good, or excellent, that number falls to 64 percent in the 85+ group. While only 6.7 percent of the 65–74 age group reported that their health was poor, over 10 percent of the 85+ group reported their health as poor. Age is not the only factor affecting health status. Among individuals aged 65–74, 21.4 percent of whites and 19 percent of Hispanics reported their health as excellent, compared to 12.5 percent of blacks. Only 9.6 percent of whites and Hispanics aged 85 and over reported their health as poor; 16.5 percent of blacks in the same age group reported their health as poor. Another factor affecting self-reported health status is insurance coverage. Of those beneficiaries with only Medicare fee-for-service coverage, 61.7 percent reported their health as excellent, very good, or good; 14.45 percent reported poor health. Those percentages for beneficiaries in Medicare managed care were 80.3 percent and 5.4 percent. Beneficiaries with Medicaid as their insurance to supplement Medicare reported poorer health (50 percent reported excellent, very good, or good health; 21 percent reported poor health). People with both individually-purchased and employer-sponsored private health insurance to supplement their Medicare coverage reported the best health in 1996: 84 percent in the good-very good-excellent category, and 5.3 percent in the poor category.

Although most elderly Medicare beneficiaries consider their health good, about 75 percent report having two or more chronic conditions. The most common of these are arthritis and hypertension. With age, rates of hearing and visual impairments also increase rapidly. Alzheimer's disease is expected to become a significant source of disability and mortality in coming years, as the numbers of the oldest old grow. According to the National Institute on

[7] Data is based on the Medicare Current Beneficiary Survey Access to Care files which cover beneficiaries who were always enrolled in the program, i.e., those beneficiaries who were enrolled on January 1, 1996, and were still enrolled on December 31, 1996. It does not include beneficiaries who became eligible for the program after January 1, 1996, nor does it include beneficiaries who died during that year.

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 (such as dressing, eating, moving about, and toileting)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 1996 increased with age, from only 29 percent of persons aged 65 to 74 up to 77 percent of those aged 85 and older.

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 1995, 73 percent of elderly beneficiaries reported incomes of less than $25,000. Twenty-eight percent had incomes of 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 population who depend heavily on the program to meet all of their 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 not covered by Medicare. 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 their higher usage of health care services, payments for long-term care services, and the premiums paid by those 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. One major concern is the availability and affordability of long term care. It is difficult however to predict the numbers of people that will need this service. Much depends on whether medical technology, which has contributed to the lengthening life expectancy, can increase active life expectancy among the oldest old. If symptoms of diseases which disproportionately afflict the aged could be delayed by five or 10 years, more of the end of life could be lived independently with less need for expensive medical services.

Chapter 8

MEDICARE

A. BACKGROUND

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Since then, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In fiscal year 1998, Medicare insured approximately 39 million aged and disabled individuals at an estimated cost of $198.1 billion ($218.8 billion in gross outlays offset by $20.8 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. It is a non-means-tested program, that is, 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). A new Medicare-Choice program (Part C), providing managed care options for beneficiaries, was established by the Balanced Budget Act of 1997 (BBA 97, P.L. 105–33).

As 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 these costs, and there are some services, such as long term care and prescription drug costs, which the program does not cover. To allay these expenses, in 1996, approximately 88.7 percent of aged Medicare beneficiaries had supplemental coverage, including employer-based coverage, individually-purchased protection (known as Medigap), and Medicaid. Another 8.0 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 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 the establishment of the Medicare+Choice program; payment reform for skilled nursing fa-

cilities and home health agencies; and expansion of preventive care coverage.

The 105th Congress passed the Balanced Budget Act of 1997 which achieved Medicare savings of $116 billion over the period of FY1998 to FY2002. It provided for new payment methodologies for skilled nursing facilities, home health agencies, and other service categories. It also provided for additional coverage of preventive services. It established the Medicare-Choice program which expands capitated private plan options for beneficiaries to include preferred provider organizations, provider-sponsored organizations, and private fee for service plans; modifies payment methods for managed care organizations; and provides for a demonstration project allowing a limited number of beneficiaries to establish medical savings accounts in conjunction with a high deductible health insurance plan.

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 provided they pay the full actuarial cost of such coverage. The monthly premium for those persons is $309 for 1999. 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 1997, payroll taxes for the HI Trust Fund amounted to an estimated $114.7 billion, accounting for the bulk of HI financing. An estimated $138 billion in Part A benefit payments were made in fiscal year 1997.

Benefits included under Part A, in addition to inpatient hospital care, are skilled nursing facility (SNF) care, home health care and hospice care. For inpatient hospital care, the beneficiary is subject to a deductible ($768 in 1999) for the first 60 days of care in each benefit period. For days 61–90, a coinsurance payment of $192 is required. For hospital stays longer than 90 days, a beneficiary may elect to draw upon a 60-day "lifetime reserve." A coinsurance payment of $384 is required for each lifetime reserve day. For skilled nursing facility services, for each benefit period, there is no coinsurance payment required for the first 20 days, and a $96 coinsurance payment for the 21st through the 100th day. The home health benefit requires no coinsurance payment. For hospice care, a limited coinsurance payment is required for prescription drug coverage and inpatient respite care.

Hospital reimbursement.—Most hospitals are reimbursed for their Medicare patients on a prospective basis. The Medicare prospective payment system (PPS) pays hospitals fixed amounts which have been established in advance of the provision of services and are based on the average costs for treating a specific diagnosis. Each beneficiary admitted to a hospital is assigned to one of ap-

proximately 500 diagnosis-related groups (DRGs). 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.

Underlying Medicare law requires that the base PPS rate be updated annually by a measure (known as the Market Basket Index, or MBI) of the costs of goods and services used by hospitals. Since hospital payments represent a significant part of total Medicare spending, and 66 percent of total Part A payments, reductions in the growth of Medicare payments to hospitals provides significant budgetary savings. BBA 97 provided for limits to future growth in hospital spending, including reductions to the MBI update factor.

In addition to the basic DRG payment, hospitals may also receive certain adjustments to their Medicare payments. Teaching hospitals may receive adjustments for indirect medical education costs (those not directly related to medical education but which are present in teaching hospitals, such as a higher number of more severely ill patients or an increased use of diagnostic testing by residents and interns). Certain hospitals which serve a higher number of low-income patients, known as Disproportionate Share Hospitals (DSH), also receive adjustments to their Medicare payments. Adjustments are also made to hospitals for atypical cases, known as "outliers," which require either extremely long lengths of stay or extraordinarily high treatment costs. BBA 97 made reductions to each of these types of adjustments.

Additional changes were made by BBA 97 to the way Medicare reimburses hospitals in other areas including the direct costs of graduate medical education (including salaries of residents and teachers, fringe benefits, and overhead costs related to teaching activities), capital-related costs, and enrollee bad debt payments.

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. A fuller discussion of the SNF and home health benefits under Medicare is provided in the next chapter.

2. Supplementary Medical Insurance (Part B)

Part B of Medicare, also called supplementary medical insurance, is a voluntary program. Anyone eligible for Part A and anyone over age 65 can obtain Part B coverage by paying a monthly premium ($45.50 in 1999). 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.

Physician Payment.—The Omnibus Budget Reconciliation Act of 1989 made substantial changes in the way Medicare pays physi-

cians, effective in 1992. A fee schedule was established based on a relative value scale (RVS). The RVS is a method of valuing individual services in relationship to each other. The 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. Geographically adjusted relative values are converted into a dollar payment amount by a dollar figure known as the conversion factor. Prior to BBA 97 there were three conversion factors—one for surgical services, one for primary care services, and one for other services. BBA 97 amended this, establishing a single conversion factor beginning in 1998. The conversion factor is updated by a "sustainable growth rate" formula based on real gross domestic product growth.

Practice Expenses.—Practice expenses include such items as salaries for a physician's staff, equipment and supplies, and overhead. 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 develop a resource-based methodology for practice expenses to be implemented in January 1998. A proposed rule was issued in June 1997. However, its methodology was the subject of considerable controversy. Many observers suggested that sufficient, accurate data was not collected. They also cited the potential large scale payment reductions that could result for some physician specialties, particularly surgical specialties. BBA 97 addressed these concerns. It delayed implementation of a resource-based practice expense methodology until 1999 and provided for a 4-year transition. On November 2, 1998, the Health Care Financing Administration (HCFA) issued a final rule regarding the methodology used to calculate resource-based practice expense component. HCFA used the American Medical Association's Socioeconomic Monitoring System for practice costs by specialty. It calculates practice expenses per hour by one of six cost pools (including clinical labor, medical supplies, office expenses, administrative labor). This is multiplied by total number of physician hours spent treating patients to determine practice expense pools by specialty and cost category. Then each practice expense cost pool is allocated to individual procedure codes, thus deriving costs of each procedure performed by a specialty. (Where more than one specialty performs the service, weighted average allocations are made.) This is known as the "top-down" approach. Although opposed by a number of specialists groups, this final rule is somewhat less controversial than the proposed rule issued in June 1997. In 1999, the payment will be based 75 percent on the 1998 charge-based relative value unit, and 25 percent on the resource-based relative value; in 2000, the ratio will be 50 percent/50 percent; in 2001 it will be 75 percent resource-based and 25 percent charge-based. Beginning in 2002, the values will be totally resource-based.

Private contracting.—Physicians are required to submit claims for services provided to their Medicare patients. They are subject to limits on the amounts they can bill these patients. Prior to BBA 97, the law was interpreted to prohibit physicians from entering

into private contracts with Medicare beneficiaries to provide services for which no Medicare claim would be submitted. BBA 97 permitted private contracting under specified conditions. Among other things, a contract, signed by the beneficiary and the physician, must clearly indicate that the beneficiary agrees to be responsible for payments for services rendered under the contract. In addition, the beneficiary must acknowledge that no Medicare charge limits apply. An affidavit, filed with the Secretary of Health and Human Services, must be in effect at the time the services are provided. The affidavit, signed by the physician, must provide that the physician will not be reimbursed under the Medicare program for any item or service for a 2-year period beginning on the date the affidavit is signed.

Outpatient services.—Medicare beneficiaries receive services in a variety of outpatient settings, including hospital outpatient departments (OPDs) and ambulatory surgical centers (ASCs). In the past, Medicare reimbursed OPDs on a reasonable cost basis with certain adjustments. BBA 97 mandated a prospective payment system (PPS) for OPDs (currently scheduled to take effect soon after the start of calendar year 2000). Unlike most other Part B services where beneficiary cost sharing is 20 percent of the approved Medicare payment, for OPD services, beneficiary coinsurance is 20 percent of actual charges. Because actual charges are higher than approved payments, beneficiaries often pay a higher percentage of the Medicare approved payment. BBA 97 included a provision which will eventually correct this situation.

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. Prosthetics and orthotics are items which replace all or part of an internal organ, 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. If it is determined that the amount paid by the program is "grossly excessive or grossly deficient and not inherently reasonable," the Secretary is authorized to adjust this amount accordingly. This is known 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. Investigations have shown that Medicare payments for some DME and PO are higher than those made by other health care insurers, 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. BBA 97 required the Secretary to establish five 3-year competitive bidding demonstration projects, in which suppliers of Part B items and services (except physician services) compete for contracts to furnish Medicare beneficiaries with these items and services. The Secretary is permitted to limit

the number of suppliers in an area to the number necessary to meet the projected demand for the contracted goods. The first site, Polk County, Florida, was announced on May 29, 1998.

Preventive care benefits.—Medicare covers health services which are reasonable and necessary for the diagnosis and treatment of illness of injury. In general the program has not covered preventive services. In recent years, Congress has responded to concerns about the lack of this coverage by adding specific benefits to Medicare law. BBA 97 further expanded these services. 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. 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. The benefit includes the vaccine and its administration.

Screening Pap Smears and Pelvic Examinations.—On July 1, 1990, Medicare began covering pap smears to screen for early detection of cervical cancer. The benefit includes the test, which must be prescribed by a physician, and its interpretation by a doctor. BBA 97 expanded the benefit, beginning January 1, 1998, to include a screening pelvic examination (defined to include a clinical breast examination) for the early detection of vaginal cancer, once every 3 years. The law also provides for an annual screening pelvic examination for certain high-risk individuals. The Pap smear and screening pelvic examination benefits are not subject to the deductible; beneficiaries are liable for coinsurance payments for the screening pelvic examinations.

Screening Mammography.—Medicare began covering screening mammographies for early detection of breast cancer, subject to specified frequency limits by age group, on January 1, 1991. BBA 97 authorized coverage of an annual screening mammography for all women over age 39, effective January 1, 1998. The benefit is not subject to the deductible.

Influenza Vaccination.—Medicare began 100 percent coverage 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.

Prostate Cancer Screening.—Beginning January 1, 2000, Medicare will cover annual prostate cancer screening tests for men over age 50. The benefit will cover digital rectal examinations and prostate specific antigen (PSA) blood tests. After 2002, Medicare will cover other procedures determined effective by the Secretary.

Colorectal Cancer Screening.—Effective January 1, 1998, Medicare provides coverage of several screening procedures for early detection of colorectal cancer: annual screening fecal-occult blood tests for beneficiaries over age 49; screening flexible sigmoidoscopy, every 4 years for beneficiaries over age 49; screening colonoscopies

every 2 years for high-risk beneficiaries. Barium enema tests can be substituted for either of the two last procedures.

Diabetes Self-Management.—On July 1, 1998, Medicare began covering educational and training services provided on an outpatient basis by physicians or other certified providers to qualified beneficiaries. Blood testing strips and home blood glucose monitors are covered for diabetics regardless of whether they are insulin-dependent.

Bone Mass Measurement.—Beginning July 1, 1998, Medicare covers the cost of procedures used to measure bone mass, bone loss, or bone quality for certain high-risk beneficiaries.

3. MEDICARE+CHOICE (PART C)

The Medicare+Choice program (M–C) was established by the Balanced Budget Act of 1997. It provides expanded options for Medicare beneficiaries who are enrolled in both Parts A and B. In addition to the traditional fee-for-service program, Medicare will provide coverage in several managed care and other health plan options: (1) Health Maintenance Organizations (HMOs) allow beneficiaries to obtain services from a designated network of doctors, hospitals, and other health care providers, usually with little or no out-of-pocket expenses. (This option has been available since 1983.) (2) HMOs with a Point-of-Service (POS) option allow beneficiaries to selectively go out of the designated network of providers to receive services. Higher out-of-pocket expenses are required when a beneficiary goes out of the network. (3) Preferred Provider Organizations (PPOs) are networks of providers which have contracted with a health plan to provide services. Beneficiaries can choose to go to providers outside the network, and the plan will pay a percentage of the costs. The beneficiary is responsible for the rest. (4) Provider-Sponsored Organizations (PSOs) are similar in operation to an HMO, but they are generally cooperative ventures among a group of providers (such as hospitals and physicians) who directly assume the financial risk of providing services. (5) Private Fee-for-Service (PFFS) plans. Under these arrangements, the beneficiary chooses a private indemnity plan. The plan, rather than the Medicare program, decides what it will reimburse for services. Medicare pays the private plan a premium to cover traditional Medicare benefits. Providers are permitted to bill beneficiaries beyond what the health plan pays, up to a limit, and the beneficiary is responsible for paying this additional amount. The beneficiary might also be responsible for additional premiums. (6) Medical Savings Accounts (MSAs). BBA 97 authorized an MSA demonstration program for up to 390,000 participants. The beneficiary chooses a private high-deductible (up to $6,000) insurance plan. Medicare pays the premium for the plan and makes a deposit into the beneficiary's MSA. The beneficiary uses the money in the MSA to pay for services until the deductible is met (and for other services not covered by the MSA plan). There are no limits on what providers can charge above amounts paid by the MSA.

A number of protections were established, including a guarantee of beneficiary access to emergency care, quality assurance and informational requirements for M–C organizations, and external review, grievance, and appeal requirements.

Payment to plans is made in advance on a monthly basis. They are generally set by county. Prior to BBA 97, payments for beneficiaries in HMOs with risk-sharing contracts with Medicare were based on the adjusted average per capita cost (AAPCC) which was calculated by a complex formula based on the costs of providing benefits to Medicare beneficiaries in the fee-for-service (i.e., non-managed care) portion of the Medicare program. Under BBA 97, a county's M–C rate is the maximum of the following three rates: (1) A floor, equal to the minimum of either $380 per month in 1999, for the 50 states and the District of Columbia, updated annually by the national growth percentage. (2) A "minimum update" rate equal to the previous year's payment rate plus an increase of 2 percent. (3) A "blended" rate equal to a combination of local area-specific (i.e., county) and national input-price adjusted rates. AAPCCs have been criticized for their wide variation across the country. To reduce variation, the blended rate will reduce payments in counties that have traditionally been higher than the national average, and increase those that have been traditionally lower. Over time, the blended rate will rely more heavily on the national rate, and less heavily on the local rate, thus reducing variation in rates across the country. Rates must produce budget-neutral payments. If the budget neutrality target would be exceeded, counties scheduled to receive a blended rate would have rates reduced, but never below the higher of the floor or minimum update rate. In both 1998 and 1999, no counties received blended rates because of the budget neutrality provision.

4. Supplemental Health Coverage

At its inception, Medicare was not designed to cover 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, 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. Over 80 percent of beneficiaries have insurance to supplement their Medicare coverage. The term "Medigap" is commonly used to describe an individually purchased private health insurance policy that is designed to supplement Medicare's coverage. These plans offer coverage for Medicare's deductibles and coinsurance and pay for some services not covered by Medicare. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) provided for a standardization of Medigap policies, in order to enable beneficiaries to better understand policy choices and to prevent marketing abuses.

Standardized packages.—Generally, there are 10 standardized Medigap benefit packages which can be offered in a state, designated as Plans A through J. Plan A offers a core group of benefits, with the other nine offering the same core benefits and different combinations of additional benefits. BBA 97 added two additional high-deductible plans which offer the same benefits as either Plan F or J, but the deductible is $1,500 for 1999 and will be in-

creased by the CPI in subsequent years. Not all 10 plans are available in all states; however, all Medigap insurers are required to offer the core plan. Insurers must use uniform language and format to outline the benefit options, making it easier for beneficiaries to compare packages. All Medigap policies sold in a state must be approved by that state under a regulatory program with standards at least as stringent as those established by the National Association of Insurance Commissioners and approved by the Secretary. There are no Federal limits set regarding premium prices; however, plans must return a certain percentage of the premiums in the form of benefits. States are required to have a process for approving premium increases proposed by insurers.

Prevention of Duplicate Medigap Coverage.—Before issuing a Medigap policy to a Medicare beneficiary, the seller must ascertain what type of health insurance the applicant has, the source of this insurance, and whether the applicant is entitled to Medicaid. With certain limited exceptions, it is unlawful to sell a health insurance policy to a Medicare beneficiary with knowledge that it duplicates Medicare, Medicaid, or private health insurance benefits to which a beneficiary is otherwise entitled.

Renewability, Preexisting Condition, and Medical Underwriting Limitations.—Medigap policies are required to be guaranteed renewable. Issuers must have a 6-month open enrollment period for beneficiaries who are turning 65 (this period is not required for the under-65 disabled population). Prior to BBA 97, issuers were permitted to exclude coverage for services related to a pre-existing condition, for no longer than 6 months. An individual meeting the 6-month period in one Medigap plan was not required to meet it again for a new plan. BBA 97 guaranteed issuance for certain specified beneficiaries without the 6-month pre-existing-condition exclusion, provided they enroll within 63 days of termination of other enrollment. The guarantee issue is, with certain exceptions, for Plans A, B, C, or F. BBA 97 also prohibits pre-existing condition exclusions for individuals enrolling in the guaranteed open enrollment period who have at least 6 months of creditable coverage, as defined in the Health Insurance Portability and Accountability Act (HIPAA, P.L. 104–191), for that condition. Medigap insurers are prohibited from discriminating in policy pricing based on an applicant's health status, claim experience, receipt of health care, or medical condition.

Medicare Select.—OBRA 1990 established a demonstration project under which insurers could market a Medigap product known as Medicare SELECT which provides services through designated health professionals and facilities known as preferred providers. 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 was authorized unless the Secretary 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

A number of observers have stated that the Medicare program is now at a critical juncture. Efforts have delayed the program's insolvency, but have not addressed completely the underlying problems. It is argued that the whole structure of the program needs to be reexamined. BBA 97 provided for the establishment of the National Bipartisan Commission on the Future of Medicare to develop recommendations concerning a number of program issues. Some proposals being considered would involve modifications to the program's structure; others would involve major restructuring.

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. Unlike the HI trust fund, the SMI trust fund does not face insolvency because it is financed 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 continue to be of concern. Both funds are maintained by the Treasury and evaluated each year by a board of trustees.

Trustee 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. Their April 1997 report predicted that the fund would 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 would be insufficient to cover that year's payment for Part A benefits.

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.

In response to the impending insolvency (as well as the larger goal of bringing the overall Federal budget into balance), the Balanced Budget Act of 1997 was enacted. This legislation provided for $116 billion in Medicare savings over the FY1998–FY2002 period. The legislation achieved these savings by again slowing the rate of growth in payments to providers and by establishing new payment methodologies for certain service categories. It also provided for a significant expansion in the choices available to beneficiaries for obtaining covered services. BBA 97 also provided for the transfer of some home health spending from Part A to Part B of the program. While this action does not reduce overall program spending,

it does reduce Part A spending and thus delays the Part A projected insolvency date. In January 1999, the Congressional Budget Office (CBO) projected that the fund would be solvent at least through 2009. The April 1998 HI trustees report estimated insolvency in 2008. Both estimates show that while BBA 97 addressed the immediate short-term financing concerns, it did not resolve the longer-term financial problems.

Major demographic changes are slated to affect the Medicare program. First, beginning in 2011, the baby boom 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 to 2.3 by 2030.

The 1998 trustees' report stated that "to bring the HI fund into financial solvency for over 25 years, either outlays would have to be reduced by 18 percent or total income increased by 22 percent (or some combination thereof)" throughout the 25-year period. To accomplish this just through an increase in the payroll tax, the rate would have to be raised from the current 1.45 for employees and employers to 1.81 percent each; the rate for self-employed individuals would go from 2.9 percent to 3.62 percent. Many observers have recommended that reforms be developed and enacted as rapidly as possible.

2. Program Modifications

Increasing Eligibility Age from 65 to 67.—Some observers have suggested that the Medicare eligibility age should be increased according to the same phase-in schedule established for Social Security benefits under the Social Security Act Amendments of 1983. This legislation provided that the full retirement age be raised from 65 to 67 over the 2003–2027 period. Proponents of raising Medicare's eligibility age argue that it is reasonable given the increase in life expectancy and improvements in health status which have occurred since Medicare was created in 1965. They further argue that needed program savings would result. CBO estimated in 1997 that such a provision would save $10.2 billion over the FY2003–FY2007 period. Opponents of the proposal argue that it would place a number of seniors at risk. They refer to problems faced by the population aged 62–64, 16 percent of whom were uninsured in 1996. Of these, 25 percent were poor and 51 percent were neither employed nor the dependent spouse of an employed person characteristics that would make it unlikely for them to afford health insurance. Opponents suggest that the problems could be magnified for the population aged 65–67. They also contend that some employers who currently offer health insurance to their retirees might decide that it would be too expensive to extend that coverage for additional years. Raising the eligibility age would also have implications for Medicaid. The program would (under current law) assume some of the expenses previously assumed by Medicare, resulting in some Medicare savings being transferred to Federal and state Medicaid costs.

Some observers suggest that if Medicare's eligibility age is raised, the affected population should be able to buy into the pro-

gram. According to an estimate by the American Association of Retired Persons, the premium for these individuals would be $420 per month ($5,041 per year), assuming a 20 percent participation rate. Higher participation rates could mean lower premiums. The Congressional Budget Office estimates that the premiums would be between $300 and $400 per month. Some are concerned about the possible effects of adverse selection (i.e., only those individuals anticipating higher than average medical costs enroll) which could drive up the per capita costs of the program.

Means Testing.—Currently, Medicare is not a means tested program. There are no income or assets tests for eligibility. The Senate-passed version of BBA 97 would have provided for an income-related Part B premium. The Congressional Research Service estimated that 1.6 million persons aged 65 or older would have been affected. The provision was dropped in conference. The major issue during the debate was how means-testing would be administered. Although the Internal Revenue Service (IRS) maintains income information, there is no such operational system in HCFA. Some argued that establishing such a system in HCFA would require a large resource commitment and that the IRS should administer an income-related premium. Others felt that this would be perceived as a tax.

Increased Beneficiary Cost-Sharing.—Various proposals have been offered to increase beneficiary cost-sharing, including increasing Part B coinsurance from 20 percent to 25 percent, increasing the Part B deductible from $100 to a level more comparable to that in private insurance plans ($200 to $225), and imposing coinsurance on services not currently subject to such charges. Increased cost-sharing would presumably make beneficiaries more cost conscious in their use of services. However, some observers are concerned that it would impede access to care for low-income beneficiaries.

Medigap Modifications.—Beneficiaries with Medigap coverage tend to perceive services as free at the point when they are actually receiving them; thus they use more services and cost Medicare more money than those without supplementary coverage. Some observers have suggested that incentives in current Medigap policies should be revised. Specifically, two Medigap plans offer identical coverage as Plans F and J except that they have high deductibles in exchange for lower premiums. Some have suggested that this approach be extended to some or all of the standard 10 Medigap packages, prohibiting insurers from offering plans without any deductible. This could have the effect of making beneficiaries more aware of their medical expenditures and could lower Medigap premium rates.

3. Program Restructuring

A number of observers have suggested that more than program modifications are necessary to address Medicare's problems. They argue that Medicare has not kept pace with changes in the health care delivery system as a whole. Some suggest redesigning the benefit package to reflect employment-based coverage. This might include a prescription drug benefit or a catastrophic limit on out-of-pocket expenses. In order to avoid significantly increasing Medi-

care's costs, modifications could be considered in the context of other reforms. These might include higher Part B premiums, more freedom in selecting a package tailored to individual needs, or placing an overall per capita cap on expenditures. Another proposal entails combining Parts A and B of the program, noting that most beneficiaries are enrolled in both parts and that the program is increasingly emphasizing managed care approaches which cover both parts. One concern about this approach is the different ways in which the two parts are financed. Under current law, general revenue financing is not available for Part A. Some are concerned that if the programs were combined, there would be less incentive to control costs since general revenues might be available. However, such a plan would likely include some overall limit on general revenue expenditures.

Defined Contribution/Premium Support.—Under the traditional fee-for-service program, Medicare itself assumes the financial risk associated with the provision of benefits. Under the Medicare+Choice program, individual plans assume the risk; however, they are required to offer beneficiaries coverage for at least the same services as are provided under the fee-for-service program. Payments to the M+C plans are based on a formula established in law and a specific dollar amount is paid on behalf of each Medicare recipient. Under a premium support plan, payments would be made using the same approach as the M+C program. However, unlike the current system, plans would not be required to offer a specified package of benefits. The approach most frequently suggested is that used under the current Federal Employees Health Benefits Plan (FEHBP). Under this proposal, the government would set minimum standards for plans to participate, provide a process for qualifying plans, and provide information on plan choices to the beneficiary population. Beneficiaries would select from a variety of plans with different benefits, cost-sharing requirements, and premium levels. Presumably, beneficiaries would no longer purchase Medigap coverage, but would purchase a single package for all their health insurance needs. The Federal Government would make a specified payment ("premium contribution") per beneficiary. The beneficiary would pay the plan the difference between the Federal contribution and the plan's premium. A number of key design issues would need to be addressed, including how the initial Federal contribution amount would be set and the potential for adverse selection. Proponents of a defined contribution system argue that it would enable the Federal Government to control aggregate Federal outlays and would enable beneficiaries to purchase coverage more tailored to their individual needs. Critics suggest that the system may place individual beneficiaries at undue risk if the per capita payment fails to keep pace with the rising costs of plans.

Private Investment Approaches.—Some persons have recommended that the current Medicare program be replaced by an investment-based system under which people build up assets during their working years to fund their medical costs in retirement. This is referred to as "privatization." Privatization proposals would move away from the current system under which current workers pay for the Part A expenses of current retirees. Instead, workers

would be saving for their own future health care needs. A number of proposals have been offered recently to privatize the Social Security cash benefits program. One would replace the current system with a system of personal investment accounts. Another would combine the current system with a new personal savings account system. A third would retain the current program structure but create a social security investment board with authority to invest in the stock market. Some aspects of these plans could be adopted in modified form for the Medicare program. Proponents of privatization hold that investment in stocks or mutual funds would allow the holdings to grow at rates significantly exceeding those of government securities. Opponents caution that the recent upsurge in the stock market may not continue over the long term. Another concern is how the transition from the old system to the new system would be financed and structured. Current workers pay for current retirees. If workers shifted some or all of their funds to saving for their own retirement, these funds would stop entering the system for current retirees.

4. Prescription Drugs

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:

- Erythropoietin (EPO), used by end-stage renal disease (ESRD) patients for the treatment of anemia, which often is a complication of chronic kidney failure;
- drugs which cannot be self-administered which are incidental to a physician's service if provided in the physician's office, such as an injectable product;
- those used in immunosuppressive therapy, such as cyclosporin, for the first 36 months beginning after an individual receives a Medicare-approved transplant, such as a kidney or liver transplant;
- oral cancer drugs, in certain cases; and
- acute oral anti-emetic (anti-nausea) drugs used as part of an anticancer chemotherapeutic regimen.

As an option to the current fee-for-service program, Medicare beneficiaries can choose to obtain all their health care services through a managed care plan. Many of these managed care plans offer outpatient prescription drug coverage as part of their standard benefits package. As of May 1998, 68 percent of these plans offered this coverage.

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 (Plans H, I, and J). However, these plans require that a $250 deductible be met and then the plans cover 50 percent of the cost of drugs with an annual limit of $1,250 for Plans H and I and a $3,000 limit with Plan J. Beneficiaries who are "dually eligible," (i.e., are also eligible for full Medicaid coverage) have prescription drug coverage.

Payment for drugs prior to BBA 97 was based on the lower of the estimated acquisition cost or the national average wholesale price. Payment could also have been made as a part of a reasonable cost or prospective payment. BBA 97 provided that in any case

where payment is not made on a cost or prospective payment basis, the payment will equal 95 percent of the average wholesale price.

The cost of prescription drugs can significantly affect the elderly. A prescription drug benefit for Medicare beneficiaries has been considered in the past. A limited benefit was included in the Medicare Catastrophic Coverage Act of 1988. The Act was repealed in 1989. During consideration of the Health Security Act in 1994 the debate was again taken up. Some current Medicare reform proposals (including those being considered by the Bipartisan Commission) address the issue of expanding Medicare's coverage of prescription drugs.

Chapter 9

LONG-TERM CARE

OVERVIEW

Long-term care encompasses a wide range of health, social, and residential services for persons who have lost some capacity for self-care. Among older people, who still use the majority of long-term care services, there is a drive for change in how long-term care is financed and delivered. 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.

At the same time, many older people and their families prefer to receive services in home and community-based settings. However, 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 older family members at home and help pay for uncovered expenses, many older and disabled Americans 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 payer of long-term care costs in this country. According to the Health Care Financing Administration's (HCFA) National Health Expenditures report, in 1997 Federal, State, and local spending for nursing home care, mostly through the Medicaid program, was $51.4 billion; and an additional $17.7 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 grow as the population grows older in the next few decades, both 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 is often best to meet their needs. Because an individual's needs can change, long-term care is most effective when it encompasses an appropriate mix of health and social services.

Despite changing ideas about long-term care, neither the private nor public sector have found adequate ways to finance it. With the trend toward reducing the growth of entitlement programs and the fact that institutions 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, only a fraction of the population is covered for these 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 confronting Congress and State legislators throughout the country.

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 payers of long-term care services. 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, and ethical issues.

A. BACKGROUND

1. What Is Long-Term Care?

Long-term care 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 disabling 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. The following is a description of the services most commonly included in the long-term care continuum.

(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 and/or cognitive 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. Services that are generally provided include client assessment, nursing, social services, personal care, physical, occupational, and speech therapies, nutrition, counseling, and transportation. 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.

Federal standards for adult day care do not exist. Many States have requirements for licensure and/or certification to assess the eligibility of centers for particular sources of funding; however, requirements for licensure and certification vary widely among States. NCOA has developed national standards that are designed to assure quality services delivery. In 1999, adult day care programs may voluntarily choose to be accredited under these standards. Accreditation is designed to assist families, consumers, and health and social services providers to choose quality programs.

(B) HOME CARE

Several categories 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 over 20,000 home care agencies in the United States as of 1999. Of those agencies, 9,655 are Medicare-certified home health agencies, 2,287 are Medicare-certified hospices. The rest are home health agencies, home care aide organizations, and hospices that do not participate in Medicare.

In the past few years, Medicare expenditures for home health have increased dramatically. Medicaid, through the home and community-based service waiver program, provides support for long term care 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 are 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. However, there has been concern regarding quality of care in some assistive living facilities.

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 COMMUNITIES

Continuing care retirement communities (CCRCs) are special housing 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. Because of mounting costs, 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. Nursing homes have begun 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 sometimes resulted in 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, provided through the Older Americans Act and the Social Services Block Grant (SSBG), ensure that frail older people, particularly those living alone, have an adequate supply of calories and important nutrients. 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 add a social component to the standard nutrition service. In addition to providing a hot nutritious meal, the din-

ing 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?

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 the need for assistance with ADLs, and may require hands-on assistance, or direction, instruction, or supervision from another individual.

Another set of limitations that reflect lower levels of disability is 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 medicine.

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 required assistance with ADLs or IADLs in 1994. This is nearly one-quarter of the Nation's elderly population. Of this total, an estimated 2.1 million elderly persons were living in the community with severe disabilities, needing help with at least three ADLs or requiring substantial supervision due to cognitive impairment or other behavioral problems. Another 1.6 million elderly were residing in nursing homes.[1]

Long-term care services are usually differentiated by the settings in which they are provided, with services provided either in nursing homes and other institutions or in home and community-based settings. The great majority of elderly 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 having difficulty with ADLs or IADLs, live in their own homes or other community-based settings.[2]

The need for long-term care assistance by the elderly is expected to become more pressing in years to come, given the aging of the population and especially the growing numbers of the age 85+ population who are at the greatest risk of using long-term care. 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 2020, and 14 to 24 million by 2060.[3]

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 co-

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[1] U.S. General Accounting Office. Long-Term Care. Diverse, Growing Population Includes Millions of Americans of All Ages. GAO/HEHS–95–26. November 1996. Washington, 1996. Note that estimates of the number of elderly persons with long-term care needs varies according to criteria used to measure impairment. Greater or smaller numbers of elderly might be judged to need long-term care if fewer or greater numbers of ADL limitations, or if IADL limitations, are used to measure impairment. In the past, legislation that would establish new long-term care benefits has targeted those elderly with two or more or three or more limitations in ADLs, for example.

[2] Ibid.

[3] Ibid.

hort 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. While only 5 percent of the elderly reside in nursing homes, research has shown that many more are expected to use nursing home care at some time in their lives. Of those aged 65 and living in the community in 1995, 39 percent are expected to use nursing home care for some period in their lives; 20 percent for more than one year; and 10 percent for more than 5 years. As people age, their need for nursing home care increases. Of those aged 85 and living in the community in 1995, 49 percent are expected to use nursing home care at some point in their lives.[4]

Analysis of nursing home utilization has found a high degree of variance in length-of-stay patterns among nursing home residents. The majority (65 percent) of persons entering a nursing home stay less than one year; 17 percent stayed for one to three years, and 19 percent stayed for three years or more.[5] Nursing home residents are more likely to be very old and female. In 1996, residents age 85 and older comprised 44 percent of the nursing home population, and 68 percent of elderly residents (over age 65) were female. A similar pattern exists for men, although their utilization rates are much lower.[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] Komisar, Harriet L., Jeanne M. Lambrew, and Judith Feder. Long-Term Care for the Elderly: A Chart Book. Institute for Health Care Research and Policy, Georgetown University.

[5] Ibid.

[6] U.S. Health Care Financing Administration. Medicare Current Beneficiary Survey. Data Tables. 1996.

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. Despite substantial public spending for long-term care, families provide the bulk of long-term care services to family members with physical and cognitive disabilities. About 37 million caregivers provide informal, or unpaid, care to family members of all ages. Typically, this care is provided by adult children to elderly parents. About two-thirds of the functionally impaired elderly rely exclusively on informal assistance. Research has documented the enormous responsibilities that families face in caring for relatives who have significant impairments. For example, caregivers of the elderly with certain functional limitations provide an average of 20 hours of unpaid help each week. Unpaid work, if replaced by paid home care, would cost an estimated $45 billion to $94 billion annually.[7]

Formal caregivers in community-based settings include those professionals and paraprofessionals who provide in-home health care and personal care services. According to the National Association for Home Care (NAHC), there were 373,000 personnel delivering home care in Medicare-certified agencies in 1998. Of those, most were registered nurses and home care aides. According to a NAHC survey of home health agency compensation conducted in 1998, the median hourly salary for registered nurses was $18.22, and for home health aides was $8.76.

5. Who Pays for 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 twenty 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 1960s and early 1970s 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

[7] Coty, Pamela. Caregiving: Compassion in Action. U.S. Department of Health and Human Services, 1998. p.13. This estimate is based on elderly persons who need assistance with ADL and IADL limitations.

lack of coordination in Federal support for long-term care, led to the development of a number of legislative proposals in previous Congresses.

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. The table below indicates that the nation already spends a great deal of money on long-term care for the elderly nearly $91 billion in 1995. Federal and State governments account for the bulk of this spending, $55 billion or 60 percent of the total.

TABLE 1. ELDERLY LONG-TERM CARE EXPENDITURES, BY SOURCE OF PAYMENT, 1995

[In billions of dollars]

	Nursing home care	Home care
Medicaid	$24.2	$4.3
Medicare	8.4	14.3
Other Federal	0.7	1.7
Other State and local	0.6	0.5
Out-of-pocket payments and other	30.0	5.5
Private Insurance	0.4	0.3
Total	64.4	26.5
Total Long-Term Care: $90.9.		

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS. Totals may not add due to rounding.

Approximately 70 percent of long-term care spending for the elderly is for nursing home care. Examination of the sources of payment for nursing home care reveals that the elderly face significant uncovered liability for this care. Two sources of payment—the Medicaid program and out-of-pocket payments—account for nearly 84 percent of this total.

Medicaid is the Federal-State health program for the poor. It limits coverage to those people who are poor by welfare program standards or those who have become poor as the result of incurring large medical expenses. 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. In most States, this "spend-down" requirement means that a nursing home resident without a spouse cannot have more than $2,000 in countable assets before becoming eligible for Medicaid coverage of their care. This is not difficult for persons needing nursing home care, with average cost in excess of $40,000 per year. It is the impoverishing consequences of needing nursing home care that has led policymakers over the years to try to look for alternative ways of financing long- term care.

The table also indicates that nearly all private spending for nursing home care is paid directly by consumers out-of-pocket. At present, private insurance coverage for long-term nursing home care is very limited, with private insurance payments amounting to 0.6 percent of total spending for nursing home care in 1995. This pattern of private spending for nursing home care is also a driving force in the long-term care debate. The only way individuals have been able to pay privately for expensive nursing home care is with their own accumulated resources and/or income. Some policymakers, especially during the last decade, have looked for alter-

native sources of private sector funding, through such mechanisms as private insurance, to provide protection against the risk of catastrophic nursing home expenses.

While most persons needing long-term care live in the community and not institutions, many fewer public dollars are available to finance the home and community-based services that the elderly and their families prefer. In 1995, elderly spending for home care amounted to $26.5 billion, or almost 30 percent of total long-term care spending for the elderly in that year. This spending does not take into account the substantial support provided to the elderly informally by family and friends. Research has shown that about 95 percent of the functionally impaired elderly living in the community receive at least some assistance from informal caregivers, but about two-thirds rely exclusively on unpaid sources, generally family and friends, for their care. Caregiving frequently competes with the demands of employment and requires caregivers to reduce work hours, take time off without pay, or quit their jobs.

The table also reveals that Medicare plays a relatively small role in financing nursing home care services. Medicare, the Federal health insurance program for the elderly and disabled, is focused primarily on coverage of acute health care costs and was never envisioned as providing protection for long-term care. Coverage of nursing home care is limited to short-term stays in certain kinds of nursing homes, referred to as skilled nursing facilities, and only for those people who demonstrate a need for daily skilled nursing care or other skilled rehabilitation services following a hospitalization. Many people who require long-term nursing home care do not need daily skilled care, and, therefore, do not qualify for Medicare's benefit. As a result of this restriction, Medicare paid for only 13 percent of the elderly's nursing home spending in 1995.

For similar reasons, Medicare covers only limited, albeit rapidly growing, amounts of community-based long-term care services-through the program's home health-benefit that impaired elderly persons could use. To qualify for home health 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 nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel. When added together, Medicare's spending for nursing home and home health care for the elderly amounted to approximately 25 percent of total public and private long-term care spending in 1995, as shown on Table 1.

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. In addition to these Federal programs, a number of States devote significant State funds to home and community-based long-term care services.

- The SSBG provides block grants to States for a variety of home-based services for the elderly, as well as for younger adults and children with disabilities.
- The Older Americans Act also funds a broad range of in-home services for the elderly, including home- delivered meals,

and authorizes a specific program for in-home services for the frail 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 problems in long-term care is also limited. Recent decreases in Federal funding for the SSBG has affected States' abilities to support home care services for the frail elderly. Funding for the Older Americans Act in-home services program has remained stable in recent years.

B. FEDERAL PROGRAMS

Although a substantial share of long-term care costs are paid out-of-pocket, 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

Title XIX of the Social Security Act is a Federal-State matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965, jointly funded between the Federal and State Governments. Each State designs and administers its own Medicaid Program, setting eligibility and coverage standards within broad Federal guidelines. Medicaid is the largest of the joint Federal/State entitlement programs and can be thought of as three distinct programs—one program funds long-term care for chronically ill, disabled and aged; another program provides comprehensive health insurance for low-income children and families; and, finally, Medicaid's disproportionate share (DSH) program assists hospitals with the cost of uncompensated care. In FY 1997, HCFA estimates that Medicaid enrolled 41.4 million persons at a total cost of almost $166 billion. The Federal share of the cost was $95.6 billion.

Although Medicaid was originally intended to provide basic medical services to the poor and disabled, it has become the primary source of public funds for nursing home care. The aged and disabled totaled about 31 percent of Medicaid recipients, but ac-

counted for about 64 percent of spending in FY 1997.[1] This disparity is due largely to Medicaid's coverage of long-term care services, the greater likelihood that elderly and disabled persons will need and use these services than younger groups, and the high cost of these services. 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. Medicaid is the largest insurer of long-term care for all Americans, including the middle class.

Though Medicaid's long-term care payments are primarily for nursing home care, some coverage of home and community-based care is provided mostly through the Section 2176 waiver program, also called the Section 1915(c) waiver program. Congress established these waiver programs 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, personal care services, adult day care, rehabilitation, respite, and others.

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—which is a predetermined fixed payment nursing homes receive for each day of care needed by a Medicaid enrollee. This payment is intended to cover all costs of care provided to the nursing home resident; if costs exceed the payment, the nursing home receives no additional amount and the nursing home faces a loss. In addition, 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 Omnibus Budget Reconciliation Act of 1987 (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 specialized facilities or their own homes or in the community if appropriate services were 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.

The Balanced Budget Act of 1997 included another option for States to provide home and community-based services to persons who would otherwise require institutional care known as PACE (Programs of All-inclusive Care for the Elderly). This option would

[1] HCFA's Financial Report for FY 1997. Apr. 1, 1998.

allow eligible persons, generally very elderly frail individuals, to receive all health, medical, and social services they need in return for a prospectively determined monthly capitated payment. This care is provided largely through day health centers and in persons' homes but also includes care provided by hospitals, nursing homes and other practitioners determined also necessary by the PACE provider. PACE is a covered Medicare benefit as well. Regardless of source of payment, PACE providers receive payment only through the PACE agreement, and must make available all items and services covered under both Titles XVIII and XIX without amount, duration or scope limitations, and without application of any deductibles, copayments or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

(B) MEDICAID AVAILABILITY AND ELIGIBILITY

In general, Medicaid is a means-tested entitlement program; it covers certain groups of persons such as the aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children 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 aggregate matching payments. Allowable claims are matched according to a formula which varies inversely with a State's per capita income. Therefore States with higher per capita income will receive a lower percentage of Federal matching funds and vice versa. The established minimum matching rate is 50 percent and may not exceed 83 percent. For FY 1998, 9 States had matching rates of 50 percent. Twenty-three States had matching rates between 50 percent and 60 percent. Sixteen States and the District of Columbia had matching rates over 70 percent. Mississippi had the highest rate in effect, 77.09 percent. The national average matching rate was 57 percent.

Each State establishes its own eligibility rules with broad Federal guidelines. States must cover certain population groups such as recipients of Supplemental Security Income (SSI), i.e., the aged, the blind and disabled, and have the option of covering others. Historically, Medicaid eligibility for poor families (generally women with dependent children) was linked to receipt of cash welfare payments. In recent years, Medicaid's ties to welfare benefits have been loosened. This trend culminated in creation of the Temporary Assistance for Needy Families (TANF) program in 1996. The new welfare law includes provisions severing the automatic link with Medicaid but allows States to maintain the link as an option. Medicaid does not cover everyone who is poor, reaching only 46 percent of persons in poverty in 1996. Eligibility is also subject to "categorical" restrictions; benefits are available only to members of families with children and pregnant women, and to persons who are aged, blind, or disabled.

Special eligibility rules apply to persons receiving care in nursing facilities and other institutions. Many of these persons have incomes well above the poverty level but qualify for Medicaid because

of the high cost of their health care. Medicaid has thus emerged as the largest source of third-party funding for long-term care.

The State-by-State variation in eligibility that Medicaid allows can mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another State. State officials have made the case that some individuals are likely to choose their State of residence according to how generous Medicaid benefits are.

States are required under their Medicaid plans to cover certain services and have the option of covering others. Mandatory services include: physicians' and hospital services, and care in a nursing facility. Optional services include: prescription drugs; eyeglasses; and services in an intermediate care facility for the mentally retarded. States may also limit the amount, duration and scope of coverage of services; e.g., they may limit the number of covered hospital days. Reimbursement levels vary from State to State as well.

(C) QUALIFIED MEDICARE BENEFICIARY PROGRAM

Because the Medicare program requires beneficiaries to pay a portion of the cost of acute health care services themselves in the form of cost-sharing charges as well as a monthly premium for enrollment in Part B, such charges posed a potential hardship for some persons—especially those who did not have supplementary protection through an individually purchased "Medigap" policy or employer-based coverage. In response to this concern, the Qualified Medicare Beneficiary (QMB) Program was enacted in 1988. Additional changes were made to the program by the Balanced Budget Act of 1997.

Under this program, certain low-income Medicare beneficiaries are entitled to have their Medicare cost-sharing charges (Medicare premiums, co-payments, and deductibles) paid by the Federal-State Medicaid program. These persons are: qualified Medicare beneficiaries (QMBs), specified low-income beneficiaries (SLIMBs), and certain other qualified individuals. Persons meeting the qualifications for coverage under one of these categories, but not otherwise eligible for Medicaid, are not entitled to the regular Medicaid benefit package. The following are the four coverage groups:

Qualified Medicare Beneficiaries (QMBs). QMBs are aged and disabled persons with incomes at or below the Federal poverty line ($8,240 for a single individual and $11,060 for a couple in 1999)[2] and assets below $4,000 for an individual and $6,000 for a couple. QMBs are entitled to have their Medicare cost-sharing charges, including the Part B premium, paid by the Federal-State Medicaid program. Medicaid protection is limited to payment of Medicare cost-sharing charges (i.e., the Medicare beneficiary is not entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.

Specified Low-Income Medicare Beneficiaries (SLIMBs). These are persons who meet the QMB criteria, except that their income is over the QMB limit. The SLIMB limit is 120 percent of the Federal poverty level. Medicaid protection is limited to payment of the

[2] The levels are actually higher since $20 per month of unearned income is disregarded in the calculation.

Medicare Part B premium (i.e., the Medicare beneficiary is not entitled to coverage of Medicaid plan services) unless the individual is otherwise entitled to Medicaid.

Qualifying Individual (QI–1). These are persons who meet the QMB criteria, except that their income is between 120 percent and 135 percent of poverty. Further, they are not otherwise eligible for Medicaid. Medicaid protection is limited to payment of the Medicare Part B premium.[3]

Qualifying Individuals (QI–2). These are persons who meet the QMB criteria, except that their income is between 135 percent and 175 percent of poverty. Further, they are not otherwise eligible for Medicaid. Medicaid protection is limited to payment of that portion of the Part B premium attributable to the gradual transfer of some home health visits from Medicare Part A to Medicare B ($1.07 in 1998; $2.23 in 1999).[4]

For purposes of the QMB program, income includes but is not limited to Social Security benefits, pensions, and wages. Assets subject to the $4,000 limit for a single individual include bank accounts, stocks, and bonds Certain items such as an individual's home and household goods are always excluded from the calculation.

Participation rates in the QMB program have been lower than anticipated. According to a 1998 report by Families USA,[5] "nationally, between 3.3 and 3.9 million low-income senior citizens and disabled individuals were eligible for QMB and SLMB benefits but were not receiving it." Many low-income elderly and disabled were unaware of the program. The Health Care Financing Administration (HCFA) has embarked on an outreach program to enroll those who may be eligible and HCFA also screens newly entitled Medicare beneficiaries to determine their QMB eligibility.

(D) SPOUSAL IMPOVERISHMENT

The need for nursing home care—whose average cost can be in excess of $40,000 per year—can rapidly deplete the lifetime savings of elderly couples. In 1988, in the Medicaid Catastrophic Care Act, Congress enacted provisions to prevent what has come to be called "spousal impoverishment"—a situation that leaves the spouse who is still living at home in the community (the community spouse) with little or no income or resources when the other spouse requires nursing home care or other long-term care. These rules are intended to prevent the impoverishment of the community spouse. Under the spousal impoverishment program, some of the spouse's

[3] In general, Medicaid payments are shared between the Federal Government and the States according to a matching formula. However, expenditures under the QI–1 and QI–2 programs are paid for 100 percent by the Federal Government (from Part B trust fund) up to that State's allocation level. A State is only required to cover the number of persons which would bring its spending on these population groups in a year up to its allocation level. Any expenditures beyond that level are paid by the State. Total allocations are $200 million in FY1998, $250 million for FY1999, $300 million for FY2000, $350 million for FY2001, and $450 million for FY2002. Assistance under the QI–1 and QI–2 programs is available for the period January 1, 1998 to December 21, 2002.

[4] For more detailed information on Qualified Medicare Beneficiaries, see: CRS Report No. RL30147, Medicare: Prescription Drug Coverage for Beneficiaries and CRS Report No. 95–854, Qualified Medicare Beneficiary Program, both authored by Jennifer O'Sullivan.

[5] Shortchanged: Billions Withheld From Medicare Beneficiaries. Families U.S.A. Foundation, July 1998. #98–103.

ownership in assets and income can be transferred to the community spouse.

Treatment of Resources.—The spousal impoverishment resource eligibility rules require States under their Medicaid programs to use a specific method of counting a couple's resources in initial eligibility determinations. Under these rules, States must assess a couple's combined countable resources, when requested by either spouse, at the beginning of a continuous period of institutionalization, defined as at least 30 consecutive days of care. HCFA's guidance on implementing spousal impoverishment law requires that nursing homes advise people entering nursing homes and their families that resource assessments are available upon request. The couple's home, household goods, personal effects, and certain burial-related expenses are excluded from countable resources; however, States are required to recover from the nursing home resident's estate, following the death of both the resident and community spouse, amounts paid by Medicaid on behalf the of the recipient.

From the combined resources, an amount is required to be protected for the spouse remaining in the community. This amount is the greater of an amount equal to one-half of the couple's resources at the time the institutionalized spouse entered the nursing home, up to a maximum $81,960 as of January 1999, or the State standard. As of January 1999, Medicaid law requires the State resource standard to be no lower than $16,392 and no greater than $81,960. These amounts are adjusted each year to reflect increases in the Consumer Price Index (CPI). When the community spouse's half of the couple's combined resources is less than the State standard, the institutionalized spouse transfers resources to the community spouse to bring that spouse up to the State standard. In other cases, the community spouse may be required to apply resources to the nursing home spouse's cost of care.

Spousal Impoverishment Post-Eligibility Rules.—Spousal impoverishment law also established new post-eligibility rules for determining how much of the nursing home spouse's income must be applied to the cost of care. The rules require that States recognize a minimum maintenance needs allowance for the living expenses of the community spouse. As of 1999, the minimum is $1,383 per month. States may set the maintenance needs minimum allowance as high as $2,049 per month in 1999. These amounts may be increased, depending on the amount of the community spouse's actual shelter costs and whether minor or dependent adult children or certain other persons are living with the community spouse. Both of these minimum and maximum amounts are adjusted to reflect increase in the CPI. To the extent that income of the community spouse does not meet the State's maintenance need standard and the institutionalized spouse wishes to make part of his or her income available to the community spouse, the nursing home spouse may supplement the income of the community spouse to bring that spouse up to the State standard.

(E) PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Medicaid law allows nursing home residents to retain a small portion of their income for personal needs. This personal needs allowance (PNA) covers each month 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. As of September 1996, 26 States did ranging from $34 in Colorado to $75 in Alaska. 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 non institutionalized 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, eyeglasses, clothing laundry, newspapers, and phone calls. In addition to personal needs, many nursing home residents may have 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 costs for items such as hearing aids and dentures.

If a nursing resident enters a hospital, a daily fee must be paid to the nursing facility to reserve a bed for her return. PNA funds are often used for this payment. A number of Medicaid programs will make payments to reserve a bed for a predetermined amount of days for hospitalization or "therapeutic leave"—such as a home visit, or vacation days—and all other absent days are considered noncovered expenses. When a resident cannot pay this fee, he/she is likely to lose their place in the nursing home. Those Medicaid plans that don't make payments will not guarantee the nursing home resident a bed to come back to. As a result of this and various other 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) 1915(C) WAIVER PROGRAM

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—known as Medicaid Home and Community-Based Services Waiver (HCBW)—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 for the mentally retarded, 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.

While, typically, programs are not managed care plans in a strict sense that they use capitation arrangements such as HMOs, they often incorporate case management principles and occasionally use service-bundled rates reimbursed under fee-for-service. States use diverse models of care delivery, management and financing for waiver programs.

The number of waivers and expenditures under them continue to grow dramatically, despite a lack of documentation on the effects of these waivers on cost, quality of care, or quality of life. According to HCFA, in FY1998, total expenditures for HCBW was $9.1 billion. The Federal share was $5.12 billion. The total number of operating waivers was 249. There are no accurate estimates for the number of individuals receiving services through these waivers[6] (though in 1996 an estimated 250,000 individuals were served). A high proportion of expenditures are directed toward services for the mentally retarded and developmentally disabled (nearly ¾ of all those served). State Medicaid agencies must assure HCFA that, on average, the cost of providing home and community-based services does not exceed the cost of institutional care.

(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 their comprehensive health and medical package under the program.

The Federal share of expenditures for Medicaid prescription drugs was a little over $7.1 billion in 1997[7] and nearly 21 million Medicaid recipients received prescription drugs under the Medicaid program in FY1997.[8] The average Medicaid prescription cost in 1997 ranged from $28.82 in Alabama to $47.17 in Alaska. The average annual Medicaid drug payment per recipient for prescription drugs was $571 in 1997.

(2) Medicaid Drug Rebate Program

Created by the Omnibus Budget Reconciliation Act (OBRA) of 1990, the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive Federal funding for outpatient drugs dis-

[6] As per phone conversion with Larry Cutler, HCFA, with Rachel Kelly at CRS.
[7] As per phone conversation with Miles McDermott, HCFA.
[8] Phone conversation with Tony Parker, HCFA.

pensed to Medicaid patients. The drug rebate program is administered by HCFA's Center for Medicaid and State Operations (CMSO). All 50 States and the District of Columbia cover drugs under the Medicaid program.

As of January 1, 1996, the rebate for covered outpatient drugs is as follows:

Innovator Drugs—the larger of 15.1 percent of the Average Manufacturer's Price (AMP) per unit or the difference between the AMP and the manufacturer's best price per unit and adjusted by the CPI–U based on launch date (fall of 1990) and current quarter AMP.

Non-innovator Drugs—11 percent of the AMP per unit.

The best price is the lowest price offered to any other customer, excluding Federal Supply Schedule prices, prices to State pharmaceutical assistance programs, and prices that are nominal in amount, and includes all discounts and rebates. Reimbursement for generic drugs requires a rebate of 11 percent of each product's AMP. Medicaid managed care plans arrange their own discounts with manufacturers and rebates are not required.[9]

(4) Medicaid Drug Use Review Program

The Medicaid Drug Utilization Review (DUR) Program was created by the Omnibus Budget Reconciliation Act of 1990. The main emphasis of the program is to promote patient safety by an increased review and awareness of outpatient prescribed drugs. States were encouraged by enhanced Federal funding to design and install point-of-sale electronic claims management systems that interface with their Medicaid Management Information System (MMIS) operations (the mechanized claims processing and information retrieval system which States are required to have, unless waived by the Secretary). The annual report requirement provides an excellent measurement tool to assess how well States have implemented the DUR program and the effect DUR has had on patient safety, provider prescribing habits and dollars saved by avoidance of problems such as drug-drug interactions, drug-disease interactions, therapeutic duplication and over-prescribing by providers. It is the intent of HCFA to summarize the annual State reports and make them available to the public via electronic media. The first reports reviewed were for FY1994. Subsequent yearly reports will be added as they become available.

(5) State-Based Pharmaceutical Assistance programs for Older Americans

To assist low-income elderly who are ineligible for Medicaid's outpatient prescription drug benefits, 14 States have pharmaceutical assistance programs (PAPs) for the elderly. These States are Connecticut, Delaware, Illinois, Maine, Maryland, Michigan, Minnesota, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Wyoming. These State-financed programs assist the elderly (and in some cases, the disabled) by subsidizing the cost of their prescription drugs. Traditionally, these programs serve elder-

[9] See: Pharmaceutical Research and Manufacturers of America Foundation, 1998 Industry Profile.

ly patients who are poor, but have income levels that make them ineligible to receive Medicaid. These programs offered subsidized benefits to some 700,000 persons in 1997.

Funding sources for State PAPs include general revenues, State lottery proceeds (Pennsylvania), and casino fund revenues (New Jersey). States have experienced increasing costs for their programs and several have enacted their own rebate program.[10]

Nursing home quality

The Senate Aging Committee held a hearing in March 1999 on nursing home enforcement and complaint investigations[11] continuing the committee's oversight of quality of care provided by nursing homes. The hearing concluded that nursing home complaints must be investigated promptly and thoroughly and enforcement must be applied consistently. The General Accounting Office (GAO) released two reports that day discussing the danger faced by nursing home residents when complaint investigations aren't followed through.

One report[12] indicated that nursing home compliance with Medicare and Medicaid standards had "serious deficiencies." A common pattern was that "HCFA would give notice to impose a sanction, the home would correct its deficiencies, HCFA would rescind the sanction, and a subsequent survey would find that the problems had returned." The second report determined that "Federal/State's practices for investigating complaints in nursing homes often are not as effective as they should be" and that "serious complaints of nursing home residents being harmed can remain uninvestigated for weeks or months." Although Federal funds finance over 70 percent of complaint investigations nationwide, HCFA plays a minimal role—leaving it largely to the States to decide which complaints place residents in immediate jeopardy.[13]

An Office of the Inspector General's (OIG) report[14] found that quality of care problems still persist. Problems included a lack of supervision to prevent accidents, improper care for pressure sores, and lack of proper care for activities of daily living. According to the report, the OIG has excluded 668 nursing home workers from participation in the Medicare/Medicaid programs as a result of convictions related to patient abuse or neglect and approximately 1 percent or more of nursing home residents have had an abuse experience serious enough to register a complaint.

In March 1999, the Clinton Administration took action to enforce current standards for 1.6 million elderly and disabled Americans in nearly 17,000 nursing homes. HCFA will strengthen complaint-investigation requirements because some State investigations have lagged; HCFA will also launch a national education campaign in

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[10] Sources: 1998 Industry Profile report issued by the Pharmaceutical Research and Manufacturers Of America Foundation; and State Pharmacy Assistance Programs, AARP Public Policy Institute #9905. Apr. 1999.

[11] Residents at Risk? Weaknesses Persist in Nursing Home Complaint Investigation and Enforcement, March 22, 1999. Special Committee on Aging.

[12] Nursing Homes: Additional Steps Needed to Strengthen Enforcement of Federal Quality Standards. GAO/HEHS 99–46, Mar. 1999.

[13] Nursing Homes: Complaint Investigation Processes Often Inadequate to Protect Residents, GAO/HEH–99–80, March 1999.

[14] Brown, June Gibbs. Department of Health and Human Services. Office of Inspector General. Quality of Care in Nursing Homes: An Overview. Mar. 1999.

the spring on how to identify, report, and stop neglect which will also enable Americans to more easily obtain and review that information and also help them make educated decisions about nursing homes. The Administration has legislative proposals to require nursing homes to conduct criminal background checks of employees; to establish a national registry of workers who have been convicted of abusing residents; and to allow more types of nursing home workers with proper training to help residents eat and drink during mealtimes.

Asset transfer

Under the Medicaid transfer of assets provisions, States must deny eligibility to persons who need various long-term care services when they dispose of their assets for less than fair market value in order to qualify for Medicaid. These provisions apply when assets are transferred by individuals in long-term care facilities or receiving home and community-based waiver services, or by their spouses, or someone else acting on their behalf.

States must "look back" to find transfers of assets for 36 months prior to the date the individual is institutionalized or, if later, the date he or she applies for Medicaid. For certain trusts, this look-back period extends to 60 months.

If a transfer of assets for less than fair market value is found, the State must withhold payment for nursing facility care (and certain other long term care services) for a period of time referred to as the "penalty period." The length of the penalty period is determined by dividing the value of the transferred asset by the average monthly private-pay rate for nursing facility care in the State. For example: A transferred asset worth $90,000, divided by a $3,000 average monthly private-pay rate, results in a 30-month penalty period. There is no limit to the length of the penalty period.

For certain types of transfers, these penalties are not applied. The principal exceptions are: transfers to a spouse, or to a third party for the sole benefit of the spouse, transfers by a spouse to a third party for the sole benefit of the spouse, transfers to certain disabled individuals, or to trusts established for those individuals, transfers for a purpose other than to qualify for Medicaid, and transfers where imposing a penalty would cause undue hardship.

Estate recovery provision

The estate recovery law requires States to claim a portion of the estates belonging to certain Medicaid recipients in order to recover funds Medicaid paid for the recipient's health care. Beneficiaries are notified of the Medicaid estate recovery program during their initial application for Medicaid eligibility and their annual redetermination process. Individuals in medical facilities (who do not return home) are sent a notice of action by their county Department of Social Services informing them of any intent to place a lien/claim on their real property. The notice also informs them of their appeal rights. Estate recovery procedures are initiated after the beneficiary's death.

In addition, for individuals age 55 or older, States are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and re-

lated hospital and prescription drug services. States have the option of recovering payments for all other Medicaid services provided to these individuals. In addition, States that had State plans approved after May 14, 1993 that disregarded assets or resources of persons with long-term care insurance policies must recover all Medicaid costs for nursing facility and other long- term care services from the estates of persons who had such policies. California, Connecticut, Indiana, Iowa, and New York are not required to seek adjustment or recovery from the estates of persons who had long-term care insurance policies. These States had State plans approved as of May 14, 1993 and are exempt from seeking recovery from individuals with long-term care insurance policies. For all other individuals, these States are required to comply with the estate recovery provisions as specified above. States are also required to establish procedures, under standards specified by the Secretary for waiving estate recovery when recovery would cause an undue hardship.

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 daily skilled nursing care and rehabilitation services following a hospitalization. The program does not cover custodial care.

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. To qualify for the SNF benefit, a beneficiary must have been an inpatient of a hospital for at least three consecutive days and must be transferred to a SNF usually within 30 days of discharge from the hospital. The beneficiary is entitled to 100 days of SNF care per spell of illness. Days 21–100 are subject to a daily coinsurance charge equal to one-eighth of the hospital deductible ($96.00 in 1999).

The SNF benefit has become one of Medicare's fastest growing benefits. Growth in spending can be explained largely by an increasing number of persons qualifying for the benefit and increases in reimbursements per day of care. The number of persons receiving SNF care increased from 384,000 in 1988 to 1,630,000 in 1998, an average annual growth rate of 16 percent. Reimbursements per day of covered care increased from $87 in 1988 to $262 in 1998, an increase on average of 12 percent. The average number of days per

person served increased from about 28 days in 1988 to 32 days in 1998.

Prior to passage of the Balanced Budget Act of 1997 (BBA 97, P.L. 105–33), Medicare reimbursed the great bulk of SNF care on a retrospective cost-based basis. This meant that SNFs were paid after services were delivered for the reasonable costs (as defined by the program) they had incurred for the care they provided. BBA 97 required a 3-year phase-in of a prospective payment system (PPS) for SNFs, beginning July 1, 1998. Prospective payment involves setting a rate for a specific amount of services before the service is provided. Because SNFs would know in advance what payments they could expect and would have to keep their costs within these limits or incur losses, prospective payment is expected to improve provider efficiency.

The PPS established by BBA 97 incorporates the costs of all covered service 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. It does not cover costs associated with approved educational activities. Covered services also includes services provided to SNF residents during a Part A-covered stay for which payment previously had been made under Part B (excluding physician services, certain non-physician practitioner services, and certain services related to dialysis).

BBA 97 provided the basis for establishing a per diem federal payment rate which includes adjustments for case-mix and geographic variations in wages. A transition period covering three cost reporting periods was established to phase in the PPS.

In addition, BBA 97 included requirements for reimbursing the SNF for covered Part B services provided to beneficiaries who are residing in SNFs but who are no longer eligible for coverage under Part A. Under this requirement, known as "consolidated billing," the SNF bills Medicare for all items and services received by its residents, regardless of whether the item or service was furnished by the facility, by others under arrangement, or under any other contracting or consulting arrangement. Payments for Part B services are based on existing fee schedules. On May 12, 1998, the Health Care Financing Administration issued final interim regulations establishing the PPS and consolidated billing.[15]

(C) THE HOME HEALTH BENEFIT

Both Part A and Part B of the Medicare program cover home health services for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy.

Persons must be homebound and under the care of a physician who establishes and periodically reviews a plan of care for the patient. Medicare's home health benefit is intended to serve beneficiaries needing acute medical care that must be provided by skilled health care personnel, and was never intended to cover nonmedical supportive or personal care assistance needed by chron-

[15] For SNFs which have not begun the transition to PPS, consolidated billing has been postponed for those beneficiaries whose services are not covered under Part A.

ically impaired persons. If beneficiaries meet the required eligibility criteria, they become entitled to an unlimited number of home health visits, which are not subject to deductibles or coinsurance.

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-language pathology services;
- 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 who has successfully completed a training program approved by the Secretary of HHS.

The home health benefit has been one of Medicare's fastest growing benefit. Most of the growth can be attributed to an increasing volume of services covered under the program, as measured by increases in the numbers of users as well as the number of covered visits per user. The number of persons receiving coverage increased from 1,582,000 in 1988 to 3,865,000 in 1997, an average annual growth rate of 10 percent. The average number of visits per person served increased from 23 in 1988 to 72 in 1997, an increase of 14 percent per year. In addition, a large portion of growth in volume of home health visits can be attributed to heavy users: by FY 1996, home health users with more than 100 visits had grown to 21 percent of all users, up from 4 percent in 1988. Increasing costs for home health services have accounted for comparatively little of the growth in spending. Payments per visit increased at an average annual rate of 1.5 percent between 1988 and 1997.

Prior to enactment of the Balanced Budget Act of 1997 (BBA 97), Medicare reimbursed home health agencies on a retrospective cost-based basis. In an effort to control the growth of the benefit, BBA 97 provided for the establishment of a prospective payment system (PPS) for home health services to begin October 1, 1999. This date was subsequently delayed by one year by the FY 1999 omnibus appropriations act. For the new system, the Secretary of HHS will consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

Prior to implementation of the PPS, BBA 97 mandated that home health agencies be paid under an interim payment system (IPS). Under BBA 97, agencies will be paid the lesser of (1) their actual costs; (2) per-visit limits; or (3) a new blended agency-specific per-beneficiary annual limit. In January and March, 1998, the Health Care Financing Administration issued the first of its notices containing the per-visit and per-beneficiary limits for FY 1998. The

FY 1999 omnibus appropriations act made adjustments to the funding formulas established by BBA 97.

(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. Although a small portion of total Medicare outlays (approximately 1 percent in 1996), the benefit has grown in recent years. The number of Medicare-certified hospices has increased from 553 in 1988 to 2,154 in 1996. Medicare outlays for hospices has increased from $118.4 million in 1988 to $1.8 billion in 1995. Medicare beneficiaries receiving hospice services has increased from 40,356 in 1988 to 302,608 in 1995.

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, and any other item or service that is specified in the hospice plan for which Medicare payment may otherwise be made. Hospice services that are not necessary for the alleviation or management of terminal illness are not covered. The beneficiary must give up the right to have Medicare pay for any other Medicare services that are related to the treatment of the terminal condition. However, the custodial care and personal comfort items which are excluded from other Medicare services are included in the hospice benefit.

Beneficiaries may elect to receive hospice benefits for two 90-day periods, followed by an unlimited number of 60-day periods. A beneficiary may revoke a hospice care election before a period ends and thus become eligible for regular Medicare benefits. After having revoked an election, a beneficiary is free to re-elect hospice care.

Payments to providers for covered services are subject to a cap for each beneficiary served, which was $14,788 for the period November 1, 1997, through October 31, 1998. Enrollees are liable for limited copayments for outpatient drugs and respite care.

3. SOCIAL SERVICES BLOCK GRANT

Title XX of the Social Security Act authorizes reimbursement to states for social services, 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.

States receive allotments of SSBG funds on the basis of their population, within a Federal expenditure ceiling. Because there are no requirements on the use of funds, States decide how to use their funds to respond to the social services needs of the eligible population.

National data on the use of SSBG funds are scarce. States have been required to submit pre-expenditure reports to HHS on their planned use of funds, but these reports are not prepared in a uniform format and do not indicate the states' actual use of funds. In the Family Support Act of 1988 (P.L. 100–485), Congress required more detailed post-expenditure reports from states. An analysis of the state expenditure reports for FY1996 by the Congressional Research Service (CRS) showed that of the states' FY1996 funds of $2.4 billion, 11 percent was spent for home-based services for both adults and children, 7.9 percent for special services for the disabled, 1.6 percent was spent for adult day care services, and 0.6 percent was spent for home-delivered meals. Of the many services supported by the SSBG, the largest spending categories is for child day care (15 percent of FY1996 funds). Older persons with long-term care needs must compete with other eligible population groups for SSBG services.

Beginning in FY1996, funding for the SSBG was reduced from its peak amount of $2.8 billion (which was the funding level for fiscal years 1989–1995). Funding for fiscal year 1996 was $2.4 billion; fiscal year 1997, $2.5 billion; fiscal year 1998, $2.3 billion; and fiscal 1999, $1.9 billion. Annual funds for the SSBG will be permanently set at $1.7 billion, beginning in FY2001 under provisions of the Transportation Equity Act (P.L. 105–178 enacted on June 9, 1998.

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 (such as their own homes) so that institutionalization, often undesirable and costly, 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 models. 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. Private Long-Term Care Insurance

Long-term care insurance is rapidly growing market. Almost 5 million long-term care insurance policies were sold by 1996, as reported by Health Insurance Association of America (HIAA). This is almost a six-fold increase over the 800 hundred thousand policies sold by 1987.[16] In one year alone from 1995 to 1996 the number of policies sold increased by more than 600,000. From 1987 to 1996, the average annual rate of increase in policies sold was 22 percent.[17]

Although growth has been considerable in a short period of time, the private insurance industry has approached this market with caution. Insurers have been concerned about the potential for adverse selection for this product, where only those people who are likely to need care actually buy insurance. In addition, they point to the problem of induced demand for services that can be expected to be generated by the availability of new long-term care insurance. With induced demand, individuals decide to use more services than they otherwise would because they have insurance and/or will shift from nonpaid to paid providers for their care. In addition, insurers are concerned that, given the nature of many chronic conditions, people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

As a result of these risks, insurers have designed policies that limit their liability for paying claims. Policies are medically underwritten to exclude persons with certain conditions or illnesses. In addition, most plans provide indemnity benefits that pay only a fixed amount for each day of covered service. If these amounts are not updated for inflation, the protection offered by the policy can be significantly eroded by the time a person actually needs care. Today, policies generally offer some form of inflation adjustment, but only with significant increases in premium costs. HIAA reports that in 1996 the average annual base premium for leading long-term care insurers was $364 for persons at age 50, $980 for persons at age 65, and $3,907 for persons at age 79. The premium amounts increased rather substantially when inflation protection (of 5 percent) was added. Premiums increased to $802, $1,829, and $5,592, respectively.[18] These premiums assume $100/$50 for nursing home/home health coverage, 4 years of coverage, and a 20-day waiting period for benefits.

These design features of long-term care insurance have raised issues about the quality of coverage offered purchasers of policies. The insurance industry has responded to these concerns by offering new products that have provided broadened coverage and fewer restrictions. In addition, the National Association of Insurance Com-

[16] This is a cumulative total of policies sold; fewer persons would be covered, due to failure to pay premiums because of death, a change in income, a decision not to continue coverage, etc.

[17] Health Insurance Association of America (HIAA). Long-Term Care Insurance in 1996, by Susan Coronel. September 1998. Washington, DC p. 13.

[18] Ibid., p. 28.

missioners (NAIC) has established a model act and regulations for long-term care insurance products sold within their jurisdictions. Although all states have adopted at least some portion of these standards to protect purchasers of policies, adherence to all aspects of the NAIC model varies widely. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104–191) required long-term care policies to meet many of the standards specified in the NAIC model act and regulations, in order to receive favorable tax treatment. The HIAA analysis reports that 42 states are at least 60 percent compliant with HIPAA requirements.[19]

One of the key issues in expansion of the long-term care insurance market is affordability of the policies. As indicated above, premiums tend to be high especially when the policy includes an inflation adjustment. Many elderly people cannot afford these premiums. It is for this reason that some argued against tax code clarifications for long-term care insurance; they believe the clarifications would end up providing tax breaks to wealthy people who would probably buy coverage anyway.

The insurance industry believes that affordability of premiums can be greatly enhanced if the pool of those to whom policies are 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 build up reserves to cover future payments of benefits. In addition, group coverage has lower administrative expenses. HIAA reports that average premiums of the leading insurers have been decreasing over time; the average premium in 1996 decreased by, on average, 5 percent compared to 1995 premium rates. Competition and market experience have tended to keep premiums relatively stable.[20]

According to HIAA, employer-based activity has increased steadily over the years. By 1996, over 650,000 policies had been sold by 1,532 employers. Most of these plans require employees to pay all the costs of the premiums. 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 340,000 in 1996.

But just how broad-based employer interest is in a new long-term care benefit is unclear. Many employers currently face large unfunded liabilities for retiree pension and health benefits. Employers are also concerned about benefit costs for their labor force. The majority of employers sponsoring plans require that the employee pay the full premium cost of coverage.

[19] Ibid., p. 7.
[20] Ibid., p. 6.

Chapter 10

HEALTH BENEFITS FOR RETIREES OF PRIVATE SECTOR EMPLOYERS

A. BACKGROUND

Employer-based retiree health benefits were originally offered in the late 1940s and 1950s as part of collective bargaining agreements. Costs were relatively low and there were few retirees compared to the number of active workers. 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 late 1980s, however, retiree health benefits became more expensive for employers due to rising health care costs and changing demographics of the work force. The United States saw double-digit health care inflation and as employees retired earlier, employers experienced higher retiree-to-active worker ratios. Older Americans approaching or at retirement age consumed a higher level of medical services, and as a result, their health care was more expensive. With the increase in liability for health care costs, employers began to drop health care coverage for retirees.

As more workers and retirees moved into managed care and employers took other cost savings measures, health benefit costs experienced a period of almost flat growth from 1993 to 1997. The decline in access to retiree health care benefits and participation by retirees, continued, however, as employment shifted from manufacturing to service industries which are less likely to offer health insurance. According to the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, the percentage of large employers (500+ employees) that provide health coverage to retirees 65 or over has fallen from 40 percent in 1993 to 30 percent in 1998. For early retirees, not yet eligible for Medicare, coverage declined from 46 percent in 1993 to 36 percent in 1998. Also, the Department of Labor reported that fewer retirees were electing coverage when it is offered by employers because of the increased costs they are expected to share.

According to the GAO and the Employee Benefits Research Institute, other factors in the 1990s that may have contributed to employer decisions to modify or even eliminate retiree health benefits include downsizing, corporate takeovers, increased competitive pressures and the declining bargaining power of labor. Employers

have also become more conscious of retiree health plan costs since financial accounting standards, known as FAS106, began requiring recognition of post retirement benefit liabilities on their balance sheets.

In 1998, while fewer large employers are totally eliminating their retiree health benefit plans, a vast majority of companies have made numerous modifications to their retiree health benefits programs in an effort to reduce their overall liability for health care costs. Employers are asking retirees to pay an increasingly large share of the cost of coverage. According to the Mercer/Foster Higgins Survey, 41 percent of employers paid the full cost of premiums for early retirees in 1993, but only 36 percent covered the total amount in 1998. Additional cost-control measures include providing a fixed (defined) employer contribution toward the cost of retiree health insurance instead of paying the premiums for whatever plan coverage an employee has chosen; placing lower limits on total lifetime health care costs; changing age and length of service requirements for eligibility; and offering a Medicare-risk plan to their Medicare- eligible retirees.

Some of these curtailments have prompted class-action law suits from retirees who would face higher costs and restrictions on providers or who would have to obtain and pay for individual insurance policies. In order to avoid court challenges over benefit changes, almost all employers now explicitly reserve the right in plan documents to modify those benefits. Because of fear of litigation as well as ethical and public relations concerns, firms are also more likely to modify or terminate benefits for future rather than current retirees.

1. Who Receives Retiree Health Benefits?

Privately sponsored retiree health benefits are far from universal and retirees are increasingly expected to share in the costs. Employer plans are nevertheless a major source of health coverage and of significant value to many retirees. According to EBRI estimates of the March 1998 Current Population Survey, about 36 percent of early retirees (ages 55 to 64) have health benefits from prior employment, while about 20 percent have employment coverage through another family member. Almost 38 percent have another form of insurance such as private policies, veterans health care, and Medicaid; and about 17 percent are uninsured. For those age 65 and over in 1997, 96 percent were covered by Medicare or Medicaid, with 35 percent also covered by health benefits from prior employment. (Percentages totaled more than 100 percent as retirees may have more than one source of health insurance coverage.)

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.

The cost of purchasing an individual health care policy following retirement is often prohibitive for many retirees who are not yet eligible for Medicare. Average health care expenses of insured people in their early 60s are twice those of people in their 40s; and they are three times those of people in their early 20s. While employment-based insurance spreads these costs over all workers in the same plan, private non-group insurance premiums generally reflect the higher risk attributable to the policyholder's age and health status. It is not unusual for people in their late fifties and early sixties without group coverage to face annual premiums of $4,000 to $6,000. If they have not had recent insurance coverage, in most states they could be charged more or even denied coverage. For those 65 or older living on a fixed income, employer-based benefits may help fill coverage gaps in Medicare, such as deductibles and copayments or the lack of a prescription drug benefit.

2. Design of Benefit Plans

Employers that provide coverage for retired employees and their families in the company's group health plan may adjust their plans to take account of the benefits provided by Medicare once the retiree is eligible for Medicare at age 65. (If the employee continues to work once they are eligible for Medicare, the employer is required to offer them the same group health insurance coverage that is available to other employees. If the employee accepts the coverage, the employer plan is primary for the worker and/or spouse who is over age 65 and Medicare becomes the secondary payer.)

When the Medicare program was first implemented, the most popular method of integrating benefit payments with Medicare was referred to as "standard coordination of benefits" (COB). The employer plan generally paid what Medicare did not pay and 100 percent of the retiree's health care costs were covered. COB led to higher utilization of health care services, however, and a major change gradually occurred in how plans integrate their benefit payments with Medicare.

Today, two out of three large employers use the "carveout" method in which retirees have the same medical coverage as active employees with the same out-of-pocket costs. The employer plan calculates the retiree's health benefit under regular formulas as though Medicare did not exist and the Medicare payment is then subtracted or "carved out". A 1996 Hewitt Associates survey of major U.S. employers found that plan costs using the "carveout" approach are 40 to 60 percent of the cost of a plan using the "standard coordination of benefits" method.

In 1994, according to an earlier Foster Higgins Survey, 17 percent of employers with more than 500 employees offered at least one Medicare HMO plan to their Medicare-eligible retirees. Typically, enrollees in Medicare HMOs are provided with additional services such as routine physicals, immunizations, and prescription drug coverage not available through traditional Medicare. This may not be an option, however, for retirees who travel extensively or live for more than 90 days in an area not covered by the HMO. Medicare HMO and other managed care options may also become unavailable in areas as some HMOs choose to stop providing care under Medicare risk contracts. The 1998 Mercer/Foster Higgins

National Survey of Employer-Sponsored Health Plans indicated that only 10 percent of employers with 500 or more employees offered a Medicare managed care option in 1998.

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. The accounting rules (known as FAS 106) initially went into effect for publicly traded corporations with 500 or more employees for fiscal years beginning after December 15, 1992. Beginning in 1995, FAS 106 requirements became applicable to smaller firms. A similar requirement known as GASB–26 became effective for state and local governments in June 1996. The requirement does not apply to firms whose employees receive health benefits through a Taft-Hartley plan which are union-organized and provide health coverage under collectively bargained agreements.

While the new rules did not affect a company's cash flow by requiring employers to set aside funds to pay for future costs, it made employers much more aware of the potential liability of retiree health benefits. Investors are now able to determine whether a company could fund its retiree health plan and still earn competitive returns. Many companies cited FAS 106 as a reason for modifying retiree health benefits, including the phasing out of such coverage. Others have considered pre-funding retiree health benefits.

4. Pre-Funding

If a company could accumulate sufficient cash reserves that could be set aside in a fund dedicated solely to paying retiree health care costs, it would be able to finance the benefits out of the reserves as obligations are incurred rather than out of its operating budget. Such prefunding would also reduce the problem created by an unfavorable ratio of active workers to retirees where the actives subsidize the costs of the retirees through their premiums. Prefunding is not, however, a universal solution, as companies operating on the margins could not afford to put money aside.

The majority of retiree health benefit plans are funded on a pay-as-you-go basis and represent large unfunded liabilities to employers. According to a 1997 study of 612 Fortune 1000 companies by Watson Wyatt Worldwide, 83 percent of manufacturing companies and 61 percent of service companies provided some form of health

benefits for retirees. However, only 20 percent of the companies prefund these postretirement benefits. And in 1997 those companies had funded only 25 percent of their accumulated obligations of the retiree health benefits.

In contrast to the companies' funding of pension plans, there is no requirement that companies prefund retiree health benefits and there is little financial incentive for them to do so. Currently, there are two major tax vehicles for pre-funding retiree health benefits. Provided requirements are met, 401(h) trusts and voluntary employees benefit association plans (VEBAs) allow employers to make tax deductible contributions to health insurance benefits for retirees, their spouses, and dependents and tax-deferred contributions to retiree and disability benefits. 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 "subordinate" or "incidental" to the retirement benefits paid by the employer pension plan. This provision is interpreted to mean that employers are limited to contributing to the trust no more than 25 percent of the annual total contributions to retiree benefits, including pension benefits, a limit employers find too low to adequately fund liabilities for retiree health and other benefits. Section 401(h) funds also cannot be used to fund other costs in the pension plan.

VEBAs used to be the principal mechanism for prefunding retiree benefits. The tax code treated VEBAs like qualified pension plans, but imposed fewer restrictions on their use, thus providing more opportunities for abuse. Congress was also concerned that tax dollars being spent to fund retiree health and other employee benefit programs were not of benefit to most taxpayers. Strict limits on the use of VEBAs were included in the Deficit Reduction Act of 1984 (DEFRA) and, as a result, VEBAs lost much of their value as a prefunding mechanism.

Under the 1984 Act, deductions were 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. Earnings on VEBA assets beyond certain amounts may also 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.

B. BENEFIT PROTECTION UNDER EXISTING FEDERAL LAWS

1. ERISA

Nothing in federal law prevents an employer from cutting or eliminating health benefits and while ERISA protects the pension benefits of retired workers, it offers only limited federal safeguards to retirees participating in a firm's health plan.

The Employee Retirement Income Security Act (ERISA, P.L. 93–406) was enacted in 1974 to establish federal uniform requirements for employee welfare benefit plans, including health plans. While ERISA protects the pensions of retired workers, 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). The content and design of employer health plans was left to employers in negotiation with their workforce and there are no vesting and funding standards as there are for pensions. Retiree health benefits are also in a less-protected position as a result of ERISA's preemption of state laws affecting employer-provided plans. Under ERISA, states can regulate insurance policies sold by commercial carriers to employers, but they are prohibited or "preempted" from regulating health benefit plans provided by employers who self-insure.

ERISA does, however, require that almost all employer provided health benefit plans, including self-insured plans and those purchased from commercial carriers, 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 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. However, 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.

2. COBRA

Because losing access to employer-based coverage poses major challenges for retirees, Congress has allowed COBRA eligibility upon retirement and special COBRA extensions if employers file for chapter 11 bankruptcy. The Consolidated Budget Reconciliation Act of 1985 (COBRA, P.L. 99–272) included 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 retirement, termination of employment for reasons other than gross misconduct, or reduction in hours. 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 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. Thus COBRA coverage allows some individuals to retire at 63½ and continue with employer based group coverage until they become Medicare-eligible at age 65. 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. Those eligible for COBRA coverage may also have to pay the entire premium plus an additional 2 percent. For many individuals, the high cost of COBRA coverage is a shock because their employer may have been covering 70 to 80 percent of the premium before retirement.

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.

3. HIPAA

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. HIPAA requires that all individual policies be guaranteed renewable, regardless of the health status or claims experience of the enrollees, unless the policyholder fails to pay the premium or defrauds the insurer. It also requires that individuals who recently had group coverage be offered health insurance without restrictions for pre-existing conditions. However, the Act allows states to comply in a variety of ways. It does not limit what insurers may charge for these policies, leaving that regulatory authority to the states. Some states have

established high-risk pools for people who are hard to insure, but even their premiums can be adjusted for age, and they may be as high as two times the average premium charged for individual policies outside the risk pool.

C. OUTLOOK

Some employers recognize that retiree health benefits help attract and retain employees and can give the employer an advantage in a tight-labor market. According to the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, 3 percent of retiree medical plan sponsors actually offered retiree coverage for the first time in 1998, and another 9 percent are increasing the covered services they provide to retirees.

Many employers, however, question whether they can continue the current level of benefits in the face of health care costs which have once again started to increase and the fast approaching retirement of the baby-boom generation. In 1998, employer costs for Medicare- eligible retirees jumped by 5 percent according to a survey of large employer plans by the consulting firm Towers Perrin. Much of the increase was caused by rising prices for prescription drugs, which are not covered by Medicare and rising demand for services from an aging population. Responses to their 1999 survey indicated that costs for retirees age 65 and over will rise by an average of 10 percent in 1999. The survey also found that plan costs for early retirees (those under age 65) are anticipated to rise in 1999 by an average of 6 percent, compared with 4 percent in 1998.

The impact of potential Medicare reform on employer coverage of retiree health care is also uncertain. The National Bipartisan Commission on the Future of Medicare was established by the Balanced Budget Act of 1997 to review the long-term financial condition of Medicare and make recommendations about potential solutions. The Commission failed to reach agreement, however, and while President Clinton has released a plan to modernize and strengthen Medicare, it is not expected that sweeping changes will be agreed to between the Administration and Congress before the 2000 elections.

Employers want the Medicare program to provide more benefits such as full prescription drug coverage for all their retirees which would enable them to cut their expenses for retiree health coverage. Some suggest, however, that improved Medicare coverage might encourage employers to drop prescription drug coverage or all of their retiree health care coverage. To avoid this, President Clinton's proposal for Medicare reform includes an incentive to employers to retain drug coverage.

Employers are also concerned that reforms would raise the age of eligibility for Medicare enrollment from 65 to 67 and increase the gap between early retirement and receipt of Medicare benefits. While many employers now pay for health benefits until retirees qualify for Medicare, these early retirees are twice as expensive for employers to cover as older retirees who receive Medicare. According to the Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans, the cost of covering a pre-Medicare retiree averaged $4,984 in 1998, almost 25 percent higher than the average cost of covering an active employee, $4,037 per employee. The

cost of covering a Medicare-eligible retiree averaged $2,092 per retiree, less than half the cost of covering a pre-Medicare retiree.

To address gaps in coverage for early retirees, President Clinton has proposed and bills have been introduced in the 105th and 106th Congress that would allow people ages 62 through 64 to buy into Medicare if they do not have access to employer-sponsored or federal health insurance. In addition, retirees ages 55 and over whose former employers terminated or substantially reduced retiree health instance would be permitted to extend their COBRA coverage until age 65. However, the cost of buying into Medicare or continuing COBRA coverage may also exceed what most uninsured can afford and questions have been raised about whether Medicare buy-ins would result in costs to the federal government.

Others feel that the private sector should be encouraged to address health insurance needs, perhaps with the implementation of tax incentives rather than expanding a public program that is projected to face long-term financial problems. In the 106th Congress, both the House and Senate have approved a tax relief package with new deductions for health insurance for individuals who pay more than half of the premiums themselves and for prescription drug coverage for Medicare beneficiaries. It is not expected that President Clinton will sign the legislation, but the health tax measures should continue to be of interest to those concerned about declining health insurance coverage for American retirees and other workers.

Chapter 11

HEALTH RESEARCH AND TRAINING

A. BACKGROUND

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 prevalence 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.

Support of scientific and medical research, sponsored primarily by the National Institutes of Health (NIH), is crucial in the quest to control diseases affecting the elderly population. Fiscal year 1998 appropriations for NIH totaled $13.6 billion, a 7.0 percent increase over the fiscal year 1997 funding. In October 1998, Congress voted a 14.6 percent increase for fiscal year 1999, giving NIH $15.6 billion to spend this fiscal year.

The National Institute on Aging (NIA) is the largest single recipient of funds for aging research. Fiscal year 1999 NIA appropriations have increased 15.1 percent over fiscal year 1998 funding levels, from $518.3 million in fiscal year 1998 to $596.5 million in fiscal year 1999. This increase in aging research funding is significant not only to older Americans, but to the American population as a whole. Research on 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 apply 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, besides Alzheimer's research, 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.

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 on particular diseases, disorders, and conditions is collaborative, with different institutes investigating pathological aspects related to their specialties. At least 17 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 and Craniofacial 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 Institute of Child Health and Human Development
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 on Drug Abuse

National Institute of Alcohol Abuse and Alcoholism
National Institute of Nursing Research
National Center for Research Resources

(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, alleviate, 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. Recent NIA-sponsored research has led to discovery of genetic mutations linked to Alzheimer's disease, increased knowledge of the basic biology of cellular aging, especially the role of oxidative damage, and hope for future new approaches to treatment of such common conditions as osteoporosis, cancer, heart disease, and diabetes.

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. Started in 1958, the BLSA has entered into its fifth 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. In 1995, 80 percent of all persons in the U.S. who died of cancer were over 60 years of age.

The incidence of cancer increases with age. Although aging is not the cause of cancer, the processes are related. Over the past 20 years, mortality rates for many cancers have stayed steady or declined in people younger than 65 while increasing in people over 65. Meanwhile, cardiovascular mortality in those 65 and over has

declined from 45 percent of deaths in 1973 to 36 percent of deaths in 1995. Because cancer is primarily a disease of aging, longer life expectancies and fewer deaths from competing causes, such as heart disease, are contributing to the increasing cancer incidence and mortality for people aged 65 and over.

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 1997, approximately 1.2 million deaths were reported from all of the diseases under the purview of the Institute (half of the U.S. deaths that year). The projected economic cost in 1999 for these diseases is expected to be $424 billion.

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. In 1997, NHLBI took over administration of the Women's Health Initiative, a 15-year research project established in 1991 to investigate the leading causes of death and disability among postmenopausal women.

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 decline in stroke deaths and heart disease deaths since 1970.

(D) NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH

The National Institute of Dental and Craniofacial Research (NIDCR) supports and conducts research and research training in oral, dental, and craniofacial 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.

The Institute sponsors research on many conditions that affect older adults. Oral cancers, with an average age at diagnosis of 60 years, cause about 8,000 deaths each year and often involve extensive and disfiguring surgery. The Institute has ongoing collaborations with the National Cancer Institute and other institutes in studies of head and neck cancer. In several research areas, development of animal models has facilitated the study of the mechanisms of disease. These include salivary gland dysfunction, bone and hard tissue disorders, including osteoporosis, and arthritis.

(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 over 15 million Americans, of whom over 6 million are age 65 or older. Among Americans age 65 and older, over 18 percent have diabetes, with the highest prevalence in minority groups. The Institute is studying the genetic factors that contribute to development of diabetes, and methods of prevention of diabetes with diet, exercise, or medication.

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 incontinence and 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 neurological 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. Work is also ongoing on new-generation pneumococcal vaccines and on

vaccines to protect against often fatal hospital-associated infections, to which older persons are particularly vulnerable.

(H) NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

The National Institute of Child Health and Human Development (NICHD) supports research that has implications for the entire human lifespan. Examples of aging-related research include: The effect of maternal aging on reproduction; variation in women's transition to menopause; the use of hormone replacement therapy in women with uterine fibroids; treatments to improve motor function after stroke; the genetics of bone density; and the natural history of dementia in individuals with Down syndrome.

(I) 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. A particular focus is age-related macular degeneration, the leading cause of new blindness in persons over age 65. Research is exploring both the genetic basis of the disease and methods of preventing complications with laser treatments.

(J) 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. A number of diseases that impact the elderly have known or suspected environmental components, including cancer, immune disorders, respiratory diseases, and neurological problems.

Areas of NIEHS research include the genetic relationship of smoking and bladder cancer; environmental and genetic effects in breast cancer; suspected environmental components in autoimmune diseases such as scleroderma, multiple sclerosis, lupus, diabetes, and rheumatoid arthritis; and the role of environmental toxicants in Parkinson's disease, Alzheimer's disease, amyotrophic lateral sclerosis, and other neurodegenerative disorders.

(K) 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, the many forms of arthritis, and numerous diseases of joints, muscles, bones, and skin. The Institute supports 30 specialized and comprehensive research centers.

Over 40 million Americans are affected by 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.

The most common degenerative joint disease is osteoarthritis, which is predicted to affect at least 70 percent of people over 65. Among other approaches, NIAMS is sponsoring studies on the death of cartilage cells, on improved imaging techniques, and on the usefulness of alternative therapies such as glucosamine and chondroitin sulfate.

In rheumatoid arthritis research, scientists are studying clusters of genes that seem to influence susceptibility to rheumatoid arthritis and other autoimmune diseases. Progress is also being made on the goal to use gene therapy to treat rheumatoid arthritis.

(L) 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.

(M) NATIONAL INSTITUTE OF MENTAL HEALTH

The National Institute of Mental Health (NIMH) is involved in extensive research relating to Alzheimer's and related dementias, and the mental disorders of the elderly. NIMH is working 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 researchers have identified a new gene mutation that may help in understanding genetic and environmental factors in Alzheimer's.

Depression is a relatively frequent and often unrecognized problem among the elderly. Nearly five million elderly persons suffer from a serious and persistent form of depression. 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.

Clinical depression often leads to suicide. According to the Centers for Disease Control and Prevention, 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. It is particularly high among white males aged 85 and older—about six times the national U.S. rate.

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.

(N) NATIONAL INSTITUTE ON DRUG ABUSE

The National Institute on Drug Abuse (NIDA) researches science-based prevention and treatment approaches to the public health and public safety problems posed by drug abuse and addiction. For many people, addictions established in the younger years, notably nicotine addiction, may carry on into old age. NIDA-supported research has begun to clarify the biological mechanisms in the brain that underlie the process of addiction, leading to hope for future prevention and treatment. Other research has shown that nicotine and nicotine-like compounds may have beneficial effects in treating neurological diseases such as Parkinson's and Alzheimer's disease.

(O) 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, the highest rates of alcohol abuse and dependence have been reported among older white men.

(P) 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; the ethics of therapeutic decisionmaking; and end-of-life palliative care.

(Q) 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 short-term estrogen treatment is helpful in decreasing vascular stiffness and lowering blood pressure in older women. Another grantee discovered that many older people have too little vitamin D in their bodies, which can lead to fractures and other muscle and bone problems. Research studies on older monkeys have shown that many common geriatric diseases

appear to be caused by old age and predisposing genetic factors rather than environmental or lifestyle factors.

C. ISSUES AND CONGRESSIONAL RESPONSE

1. NIH APPROPRIATIONS

At $15.6 billion for FY 1999, NIH's budget represents about 40 percent of federal civilian (i.e., nondefense) spending for research and development. The agency has enjoyed strong bipartisan support from Congress, reflecting the interest of the American public in promoting medical research. Even in the face of pressure to reduce the deficit, Congress nearly doubled NIH's appropriation over the last decade. In real terms, from FY 1989 to FY 1998, the budget stayed about 24 percent ahead of inflation. For FY 1998, the President requested a 2.6 percent increase for NIH over FY 1997 compared with the estimated 3.1 percent biomedical inflation rate. Congress responded with a 7.0 percent increase to $13.6 billion. For FY 1999, the President reversed the practice of recent years by proposing a large increase for NIH, requesting a total of $14.8 billion, up 8.4 percent over FY 1998. The House and Senate Appropriations Committees responded by recommending increases of 9.1 percent and 14.4 percent, respectively. The final appropriation, incorporated into the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999 (P.L. 105–277), gave NIH an increase of nearly $2 billion or 14.6 percent, for a total of $15.6 billion.

With its increased appropriation, NIH plans to highlight six areas of research, cutting across all the institutes and centers, that offer particularly promising opportunities: the biology of brain disorders, including neurodegenerative disorders; new approaches to pathogenesis (disease origins and development); new preventive strategies against disease; new avenues for development of therapeutics; genetic medicine; and advanced instrumentation and computers in medicine and research. The six areas are a framework for initiatives on specific diseases, notably cancer research and diabetes research. Other types of funding receiving substantial increases are initiatives to enhance the research infrastructure, including increases for research training, shared instrumentation, new sequencing and imaging technologies, advanced computing, and clinical research. Funding is included for construction of the new Clinical Research Center, a new vaccine research facility, and for extramural facilities construction grants.

Appropriations levels for the NIH institutes, including estimates for aging research, are as follows:

FISCAL YEAR 1999 APPROPRIATIONS FOR NIH

[In millions of dollars]

Institute or Center	Fiscal year 1999 appropriation	Fiscal year 1999 aging research (estimates)
Aging	$596.5	$596.5
Cancer	2,927.2	46.6
Heart/Lung/Blood	1,793.7	90.8
Dental/Craniofacial Research	234.3	10.3
Diabetes/Digestive/Kidney	994.2	69.0

FISCAL YEAR 1999 APPROPRIATIONS FOR NIH—Continued

[In millions of dollars]

Institute or Center	Fiscal year 1999 appropriation	Fiscal year 1999 aging research (estimates)
Neurology/Stroke	903.3	83.6
Allergy/Infectious Diseases	1,570.1	68.5
General Medical Sciences	1,197.8	.....
Child Health/Human Development	751.0	9.5
Eye	395.9	77.6
Environmental Health	375.7	6.0
Arthritis	308.2	37.5
Deafness	229.9	9.3
Mental Health	861.2	71.9
Drug Abuse	603.3	1.2
Alcohol Abuse/Alcoholism	259.7	5.0
Nursing Research	69.8	9.7
Human Genome Research	264.9	.....
Research Resources	554.8	16.8
Fogarty International Center	35.4	.....
Library of Medicine	181.3	.....
Office of Director	306.6	.....
Buildings & Facilities	197.5	.....
Total, NIH	15,612.4	1,209.8

2. NIH Authorizations and Related Issues

Much of the congressional attention to NIH in the 105th Congress focused on budgetary and appropriations issues. Reauthorization legislation to extend provisions that expired in FY 1996 was not introduced, although a few of the expired authorities were extended in other health bills passed at the end of the Congress.

In giving NIH its $2 billion increase for FY 1999, Congress responded to calls to double the agency's budget in five years, a process that would require increases of about 15 percent per year. Various legislative proposals had been introduced, some focusing on NIH and others seeking to double the budgets of a number of R&D agencies over 10 to 12 years (requiring increases of about 6 percent per year). Several other bills were introduced that sought to provide extra funding for NIH beyond its annual appropriation by establishing research trust funds in the Treasury, to be supported by income tax checkoffs, health plan premium set-asides, or tobacco settlement money. No action was taken on any of these measures. Since health research has received much more substantial increases than other science funding in recent years, Congress must weigh whether continued large increases for NIH are sustainable in the face of other priorities.

Both the appropriations and the authorizing committees conducted considerable debate and several hearings on NIH priority setting and resource allocation. Congress is interested in overseeing how NIH can responsibly spend large increases in funding, and how funds are allocated among the NIH institutes, among various disease categories, and between laboratory and clinical research. The FY 1998 appropriations act mandated a study of NIH research priority setting, to be done by the Institute of Medicine of the National Academy of Sciences. The study, entitled Scientific Opportunities and Public Needs: Improving Priority Setting and

Public Input at NIH, was released July 8, 1998, and is available at [http://www.nap.edu/readingroom/books/nih/]. It made 12 recommendations relating to allocation criteria, the decisionmaking process, mechanisms for public input, and the impact of congressional directives. It particularly stressed that NIH needs to engage the public to a greater extent in informing the process of research priority setting. In response, NIH has established a Council of Public Representatives to advise the Director and an Office of Public Liaison in each institute and center. Additional scrutiny and oversight of NIH will continue in the 106th Congress.

Reauthorization legislation for various NIH programs was last enacted in 1993 (P.L. 103–43), with authorizations expiring in FY 1996. Potential issues for future legislation include clinical research, research facilities, alternative medicine, NIH administrative structure, establishing a trust fund for biomedical research, and research on women's health, bioengineering, genome sequencing, and prostate cancer. Related issues that may spark continued debate include stem cell research, the use of human fetal tissue or human embryos in research, and attempts to prohibit human cloning research.

3. Alzheimer's Disease

Alzheimer's disease (AD) is the most common cause of dementia among the elderly. Researchers are beginning to uncover the causes of AD, but there is no cure, nor is there a conclusive diagnostic test for AD. Physical, psychological, and neurological tests allow for a probable diagnosis with approximately 90 percent accuracy, but AD can only be confirmed through an autopsy. 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 AD. More than half of all Alzheimer's patients receive care at home, and the rest are in a variety of health care institutions. 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 AD. 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 AD can be emotionally, physically, and financially stressful. Researchers recently estimated the annual cost of caring for an Alzheimer's patient at more than $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 FY 1999, the National Institutes of Health (NIH) will spend an estimated $399.4 million on AD research. AD research funding more than tripled between FY 1987 and FY 1992, then remained flat (in real terms) until last year when it began to increase again. The National Institute on Aging (NIA) at NIH is the lead federal agency for AD research and accounts for more than two-thirds of NIH's Alzheimer's research funding. The Office of Alzheimer's Disease Research at 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 AD 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 Diseases (NIAID), and the National Institute of Nursing Research (NINR).

Since 1991, a series of important findings have pushed AD 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. Researchers have discovered four genes associated with AD. This, in turn, has led to an outpouring of findings about the sequence of events that leads to the formation of protein plaques and tangled nerve cells in the brains of Alzheimer's patients. 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.

NIH's Alzheimer's Disease Prevention Initiative, which was established at the instruction of Congress (FY 1999 House and Senate Appropriations Committees report language), aims to redouble efforts to build on the recent spate of research findings and find ways to arrest the development of AD and prevent future cases. Without effective preventive strategies, research is currently the only option for bringing AD under control.

Although an autopsy is still the only way to conclusively diagnose AD, scientists are making advances in diagnosing the disease while patients are still alive. A recent consensus statement by NIA and the Alzheimer's Association provides clinicians with guidelines for diagnosing AD. New brain-imaging technologies combined with genetic analysis may offer a way to establish early diagnosis, determine prognosis, monitor patients, and evaluate treatment efficacy.

Currently, there is no effective way to treat or prevent Alzheimer's disease. FDA has approved two drugs, Cognex and Aricept, that have been shown to produce modest improvements in cognitive ability in some patients with mild to moderate symptoms. Neither drug stops or reverses the progression of AD. Several clinical trials of compounds are underway, as scientists look for treatments that have no serious side effects and that can ease a broad range of symptoms and improve patients' activities of daily living and cognitive function. Researchers are studying the use of estrogen, anti-inflammatory drugs, and anti-oxidants in AD patients, determining which groups of people develop AD, and conducting several initiatives related to caregiving.

The NIA funds 27 Alzheimer's Disease Centers (ADCs) at major medical research institutions across the country. The ADCs provide clinical services to Alzheimer's patients, conduct basic and clinical research, disseminate professional and public information, and sponsor educational activities. Much of the success in AD research can be attributed to resources provided by NIA to the ADCs.

In 1990, the NIA began a program to link satellite diagnostic and treatment clinics to the existing ADCs. The aim 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. NIA also established the Consortium to Establish a Registry for Alzheimer's Disease (CERAD), a project to develop a national registry for standardized data on AD.

A variety of initiatives are underway to help caregivers manage the daily activities and stresses of looking after AD patients. A five-year NIA program will provide caregivers with support, skills, and information and will include a focus on African American and Hispanic families. NIA is also funding efforts to compare care and outcomes in special care units in nursing homes.

The Alzheimer's Disease Demonstration Grant to States program at the Administration on Aging provides funds to states to develop model practices for serving persons with AD and their families. A recent national evaluation of the program found that it had proven very successful in expanding support services to AD patients and family caregivers, especially hard-to-reach minority, low- income, and rural families.

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.

Alzheimer's advocates complain that the current health care system does not provide adequate care for people with dementia. Most people who get AD are Medicare beneficiaries, but the program is poorly structured to meet the health care needs of those with chronic illness and disability. Studies indicate that AD is very costly to Medicare, though much of the cost comes from preventable health care crises (e.g., falls, injuries, infections, malnutrition, medication mismanagement) that are a direct result of impaired memory, judgment, and capacity for self care.

Financing the high cost of long-term care is the issue of greatest concern to the families of Alzheimer's patients. At least 70 percent of AD patients live at home, where families provide most of the care at an average cost of more than $12,500. Many AD patients eventually have to be placed in a nursing home where the costs can exceed $40,000 a year. Medicaid, the only significant source of financial assistance for long-term care, now pays half of all nursing home costs in the country. Medicaid's nursing home spending is driven by its coverage of persons who spend down to Medicaid eligibility levels.

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 [www.alzheimers.org]. The Alzheimers Association also provides information and assistance to AD patients and their families through its nationwide network of local chapters, in addition to funding research [www.alz.org].

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 Institute of Allergy and Infectious Diseases, the National Institute of Dental and Craniofacial Disorders, the National Heart, Lung, and Blood Institute, and the National Institute on Aging, among others.

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 threat for an estimated 28 million Americans, 10 million of whom already have osteoporosis. Another 18 million have low bone mass and are at increased risk for the disease. The annual cost of osteoporosis was estimated at $14 billion in 1995. Medical costs will increase significantly as the population ages and incidence increases. Research holds the promise of significantly reducing these costs if drugs can be developed to prevent bone loss and the onset of osteoporosis, and to restore bone mass to those already affected by the disease.

Research initiatives to address osteoporosis are underway in several NIH institutes, and also involve other agencies through the Federal Working Group on Bone Diseases, coordinated by NIAMS. The NIH Women's Health Initiative is currently studying osteoporosis and fractures to determine the usefulness of calcium and vitamin D supplements. Other research is investigating the genes and molecules involved in the formation and resorption of bone, the role of estrogen as a bone protector, and the use of combinations of drugs as therapy for osteoporosis. The NIH Osteoporosis and Related Bone Diseases National Resource Center is a joint Federal-nonprofit sector effort to enhance information dissemination and education on osteoporosis to the public.

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 40 million Americans, one in seven persons, has some form of rheumatic disease, making it the Nation's leading crippler. That number is expected to climb to nearly 60 million, or 18 percent of the population, by the year 2020, due largely to the aging of the U.S. population. 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 20 million Americans. OA causes cartilage to fray, and in extreme 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. NIH scientists are 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. Other areas of research involve using animal models to study the very early stages of OA, work on diagnostic tools to detect and treat the disease earlier, genetic studies to elucidate the role of inheritance, and development of comprehensive treatment strategies.

Rheumatoid arthritis (RA), one of the autoimmune diseases, is a chronic inflammatory disease affecting more than 2.1 million Americans, over two-thirds of whom are women. RA causes joints to become swollen and painful, and eventually deformed. The cause is not known, but is the result of the interaction of many factors, such as a genetic predisposition triggered by something in the internal or external environment of the individual.

There are no known cures for RA, but research has discovered a number of therapies to help alleviate the painful symptoms. Current treatment approaches involve both lifestyle modifications, such as rest, exercise, stress reduction, and diet, as well as medications and sometimes surgery. To further their understanding of RA, researchers are studying basic abnormalities in the immune system of patients, genetic factors, the relationships among the hormonal, nervous, and immune systems, and the possible triggering role of infectious agents.

5. Geriatric Training and Education

The Health Professions Education Partnerships Act of 1998 amended the Public Health Service Act (PHSA) to consolidate and reauthorize current health professions and minority and disadvantaged health education programs. Section 753 of the PHSA authorizes the Secretary of the Department of Health and Human Services (DHHS) to award grants or contracts for: (1) Geriatric Education Centers (GECs); (2) Geriatric Training Regarding Physicians and Dentists; and (3) Geriatric Faculty Fellowships. The programs are administered by the Bureau of Health Professions at the Health Resources and Services Administration (HRSA) of DHHS.

Finally, the Secretary is authorized to make grants to GECs. A GEC is a program that: (1) improves the training of health professionals in geriatrics, including geriatric residencies, traineeships, or fellowships; (2) develops and disseminates curricula relating to treatment of health problems of elderly individuals; (3) supports the training and retraining of faculty to provide instruction in geriatrics; (4) supports continuing education of health professionals who provide geriatric care; and (5) provides students with clinical training in geriatrics in nursing homes, chronic and acute disease hospitals, ambulatory care centers, and senior centers.

With respect to the program for geriatric training for physicians and dentists, the Secretary may make grants to, and enter into

contracts with, schools of medicine, schools of osteopathic medicine, teaching hospitals, and graduate medical education programs, for the purpose of providing support (including residencies, traineeships, and fellowships) for geriatric training projects to train physicians, dentists and behavioral and mental health professionals who plan to teach geriatric medicine, geriatric behavioral or mental health, or geriatric dentistry.

The Secretary is authorized to establish a Geriatric Academic Career Awards program to provide fellowship awards to eligible individuals to promote the career development of such individuals to serve on school faculties as academic geriatricians.

HRSA reported in its Justification of Estimates for Appropriations Committees for FY1999 that the goal of the Geriatric Programs was to increase the supply of geriatric faculty and to improve the distribution and increase the supply of geriatric trained practitioners. To date the GECs have trained 335,000 practitioners in 27 health-related disciplines; trained 7,500 academic and clinical faculty in 170 health-related schools and 550 affiliated clinical sites. The GECs also have developed over 1,000 different curricular materials on topics such as adverse drug reactions, Alzheimer's disease, depression, elder abuse, ethnogeriatrics, and teleconferencing.

HRSA estimates the number of full-time primary care internists and family physicians needed by the year 2000 to provide geriatric care to be 30,000. There are 8,966 physicians currently trained in geriatrics and this is a declining number due to physician retirements. Currently, the GECs produce around 100 new fellowship-trained geriatricians each year which is not enough to replace those that die or retire.

There are 30 GECs in the national network and they have collectively formed an Ethnogeriatric Collaborative to formally link all minority related resources and activities. Though ethnic minorities are 40 percent of all GEC trainees, the numbers of minority faculty remains small for each discipline.

HRSA has awarded grants to train 52 faculty fellows in geriatric medicine, dentistry, and psychiatry to help reduce the unmet need for geriatric faculty.

Appropriations for FY1999 totaled $9.7 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 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. CONCLUSION

Within the past 50 years, there has been an outstanding improvement in various measures of the health and well-being of the American people. Some once-deadly diseases have been controlled or eradicated, and the mortality rates for victims of heart disease, stroke, and some cancers 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 spending for Alzheimer's disease research will approach the $400 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 1990's 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 106th Congress. Over the next 4 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 1999 the nearly 2 million units up for renewal will require budget authority of $9.6 billion, according to HUD. This will increase to 2.7 million units and $16.2 billion in fiscal year 2002. 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.

Housing reform bills.—In 1995, House and Senate conferees were unable to agree on a compromise version of housing authorization bills H.R. 2406 and S. 1260. In the 105th Congress, a new reform bill was introduced. This bill, H.R. 2, The Housing Opportunity and Responsibility Act of 1997, generally followed H.R. 2406, addressing public housing and project-based Section 8 admission pref-

erences—who should get priority. Currently, nearly 75 percent of assistance is given to extremely low-income households. There is now a desire to move toward more mixed-income rental buildings with role models. This will give more preference to the working poor rather than to the poorest of the poor. H.R. 2 included 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 matching Senate bill, S. 462, The Public Housing Reform and Responsibility Act of 1997, addressed 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. Conferees on the two bills began informal discussions on their differences, and by Fall of 1998, they believed they had worked out an acceptable compromise. To assure passage of this housing authorization bill, it was included in the VA-HUD Appropriations bill for fiscal year 1999 as Title V, The Quality Housing and Work Responsibility Act of 1998. The overall thrust of this new authorization bill is greater flexibility for local housing authorities, more demolitions of obsolete public housing units, and a merger of the Section 8 voucher and certificate programs.

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 restructuring 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. Final regulations for the restructuring program have been submitted to the HUD Office of General Counsel for clearance, and HUD has released the list of 52 state and local housing agencies that qualified to participate in the first phase of the program. HUD expects to publish the final regulations and handbook for the program in early Spring 1999.

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. In funding, 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 received 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. In an effort to move families from Welfare-to-Work, the HUD budget for fiscal year 1999 includes a provision of $283 million for 50,000 new vouchers to help families who are currently on welfare move closer to places of employment, and become self-sufficient.

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.

At the same time, HUD is taking on major commitments to reform itself and its programs. It has 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.

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 4.8 million assisted units available at the end of fiscal year 1998 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.

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 for 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 the 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 fiscal year 1998, there were approximately 20,000 Section 202 projects, comprised of approximately 224,000 units eligible for payment. The appropriations for fiscal year 1999 provide $660 million which, according to HUD, should finance 7,000 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 5-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 or 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 last appropriated funding directly for the Congregate Housing Program in fiscal year 1995. For FY1996 through FY1997, no appropriations were made, but the program was supported by carryovers in funding from previous years. In FY1998 and fiscal year 1999, the VA–HUD appropriations bills provided funding for congregate services and service coordinators for the elderly and disabled as a set-aside of the Community Development Block Grants (CDBG). In FY1998, at least $7 million was to be used for this purpose; in FY1999 at least $20 million was set-aside.

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 benefit from congregate housing services, this is one avenue of housing assistance that the States may want to explore more carefully.

Today there are approximately 100 projects serving nearly 3,500 elderly residents that receive 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 was evaluated by HUD in 1998 after the five-year expiration period had expired. A completed report on the program is expected to be released in the Spring of 1999.

3. PUBLIC HOUSING

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing, the Public Housing Program has burgeoned into a system that includes 1.3 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 hous-

ing. 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 passage of the FY1999 VA-HUD Appropriations Act, PHAs have the option of setting a minimum rent of $50 if they believe it is necessary for the maintenance of their projects, with exception made for families where this rent level would present a hardship. 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 persons 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 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.

Title V of the FY1999 VA–HUD Authorization Act (P.L. 105–276) makes many changes to the current public housing program. Some of these changes are: non-working, non-elderly or disabled persons residing in public housing will be required to perform 8 hours of community service a month; tenants are given opportunities for increased input in decisionmaking; PHA's have greater access to nation-wide police reporting services to screen applicants for criminal or drug activity before admitting them to public housing, and troublesome tenants can be evicted quickly.

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 1999, 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 in Title V of the VA–HUD Appropriations Act for FY1999 (P.L. 105–276) Congress included a provision which combines the two programs. Regulation for this new Sec. 8 program have not been discussed as yet, and preliminary regulations probably would not be presented before Summer of 1999.

In fiscal year 1999, Congress appropriated $10.1 billion for the Section 8 program: $9.7 billion for the renewal and amendment of contracts, and $434 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. The programs are administered by the Rural Housing Service. 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 of 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 (Section 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 responsibly 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.

The Section 538 program was a demonstration program whose authority expired on September 30, 1998. The program has been made permanent by Section 599C of the Quality Housing and Work Responsibility Act of 1998 (P.L. 105–276). The Act also amends the program to provide that the USDA may not deny a developer's use of the program on the basis of the developer using tax exempt financing as part of its financing plan for a proposed project.

7. Federal Housing Administration

The Federal Housing Administration (FHA) is an agency of the Department of Housing and Urban Development (HUD) which administers programs that insure mortgages on individual home purchases and loans on multifamily rental buildings. The loans are made by private lenders and FHA insures the lenders against loss

if the borrowers default. The FHA program is particularly important to those who are building or rehabilitating apartment buildings. The elderly are often the occupants of such buildings.

Of particular importance to the elderly is the revision that Congress made to Section 232 of the National Housing Act. This section authorizes FHA to insure loans for Nursing Homes, Intermediate Care Facilities, and Board and Care Homes. Section 511 of the Housing and Community Development Act of 1992 (P.L. 102–550) amended Section 232 to authorize FHA to insure loans for assisted living facilities for the frail elderly.

The term "assisted living facility" means a public facility, proprietary facility, or facility of a private nonprofit corporation that:

(1) Is licensed and regulated by the State (or if there is no State law providing for such licensing and regulation by the State, by the municipality or other political subdivision in which the facility is located);

(2) Makes available to residents supportive services to assist the residents in carrying out activities of daily living such as bathing, dressing, eating, getting in and out of bed or chairs, walking, going outdoors, using the toilet, laundry, home management, preparing meals, shopping for personal items, obtaining and taking medications, managing money, using the telephone, or performing light or heavy housework, and which may make available to residents home health care services, such as nursing and therapy; and

(3) Provides separate dwelling units for residents, each of which may contain a full kitchen or bathroom, and includes common rooms and other facilities appropriate for the provision of supportive services to residents of the facility.

The term "frail elderly" is defined as an elderly person who is unable to perform at least three activities of daily living adopted by HUD.

An assisted living facility may be free-standing, or part of a complex that includes a nursing home, an intermediate care facility, a board and care facility or any combination of the above.

The law also authorizes FHA to refinance existing assisted living facilities.

8. Low Income Housing Tax Credit

The Low Income Housing Tax Credit program (LIHTC), created by the Tax Reform Act of 1986, provides tax credits to investors who build or rehabilitate rental housing units that must be kept available to lower income households for long periods of time. Although initially approved for 3 years, and then annually, it was made permanent in 1993. This $3.5 billion a year program (which is expected to increase to $5.3 billion by 2003) is administered at the state level by housing finance agencies. Estimates vary, but the program may have helped create as many as 800,000 apartments since 1987. A significant but unknown number are occupied by lower-income elderly households. The tax credits, that are based on the amount spent to develop the subsidized units themselves, are claimed by both individual and corporate investors over a 10-year period. In return for the tax credits, investors must keep the units rented to households whose incomes are no more than 60 percent of the median income in the local area for up to 30 years and some-

times longer. In many cases, the tax credits do not provide enough financial support by themselves to make the project economically viable. This is particularly the case where 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 is 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 alternatives. Little is known about how much the units cost when all public subsidies are considered and how much rents are being reduced compared to similar unassisted apartments. There is some concern, based on the past experience of other assisted rental projects, that service to renters may deteriorate or that units will not be adequately maintained over the long run since investors receive most of their financial incentives during the first 10 years of the project's life. But housing advocates argue that for those with low-wage jobs, it is becoming increasingly difficult to find affordable housing and that the tax credit program is very important. They point to government figures showing that more than 5 million very-low income households have serious housing problems, most paying more than 50 percent of their income for shelter.[1] The formula for the allocation of tax credits, $1.25 per capita, has not been changed since the program's beginning in 1986, and thus, the benefits have been eroded by inflation. Housing organizations support legislation that has been introduced in the 106th Congress that would increase the credit limit to $1.75 per capita (a 40 percent increase), and adjust it each year for inflation.

B. PRESERVATION OF AFFORDABLE RENTAL HOUSING

1. INTRODUCTION

In addition to the expiration of Section 8 rental contracts, another current issue is 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

[1] See Housing the Poor: Federal Housing Programs for Low-Income Families. By Morton J. Schussheim. CRS Report 98–860 E. October 20, 1998.

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 loses 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 have to move elsewhere.

If excessively high rents and deteriorating conditions sound contradictory, they may be. HUD has 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

Title V of the VA–HUD Appropriations Act for fiscal year 1998 (P.L. 105–65) contains the latest restructuring plan for Section 8 contracts. This title establishes a mark-to-market program for restructuring FHA-insured mortgages for Section 8 project-based contracts, reduces the costs of oversubsidized Section 8 properties, gives HUD the authority to appoint participating administrative entities (PAEs) who would develop and administer a restructuring plan for the projects, seeks to minimize fraud and abuse in federally assisted housing, and creates the Office of Multifamily Housing Assistance Restructuring in HUD.

The Re-Engineering Program authorizes the Secretary of HUD to enter into portfolio restructuring agreements with housing finance agencies, capable public entities, and profit and non-profit organizations. These agencies are to notify applicants of their acceptance or rejection as PAEs, and they are to administer the restructuring of mortgages. The restructuring program is voluntary and owners have the option of not renewing their HUD Section 8 contracts. The PAEs are to screen owners interested in participating in the restructuring program to see if their properties are economically viable and in good physical condition. Owners of properties that are approved would then work with the PAE in developing a rental assistance plan for the project. If properties are in an advanced state of deterioration where rehabilitation would be too costly, the properties would be demolished or disposed of. Tenants in projects that do not have renewed contracts would be eligible for voucher assistance and would receive reasonable moving expenses.

Projects funded by Section 202 housing for the elderly, Section 811 housing for the disabled, or the McKinney Homeless Authorization Act, are exempt from the restructuring levels. These projects even if restructured, would operate on current rent levels with operating and adjustment factors being considered. Therefore, the elderly, disabled or previously homeless persons living in these projects would not be affected by a mortgage restructuring.

On September 11, 1998, HUD published proposed rules for the restructuring program in the Federal Register, and on October 11 interim rules were implemented. Final rules are expected by Spring 1999.

C. HOMEOWNERSHIP

1. Homeownership Rates

The 1998 homeownership rate reached a record high of 66.3 percent, with 69.1 million families owning their homes. This is an increase of more than 7 million during the past 5 years. The rate for households with heads age 65 or over stood at 79.2 percent at the end of 1998. A strong growth in jobs, and mortgage rates as low as they've been in 30 years, played an important part. Until a year or so ago, generally stable home prices in most markets also helped new buyers. This has been a particularly opportune time for minorities, lower-income households, and those living in neighborhoods often underserved by lenders, to apply for and receive a home mortgage. Homeownership rates for these groups have lagged, and still lag, considerably behind the national rate (see figures below), but vigorous enforcement of fair housing laws and the Community Reinvestment Act have made mortgage credit more available. In addition, homeownership efforts by the government-sponsored enterprises Fannie Mae and Freddie Mac, and a variety of affordable home lending initiatives by HUD, the real estate industry, and others have contributed to increased opportunities for lower-income buyers. While the rate for (non-Hispanic) whites went up 3.4 percent between 1993 and 1998, during this same period, the rate for blacks increased 9.8 percent and that for Hispanics, 13.5 percent.

Homeownership rates	1993	1998
Nationwide	64.0	66.3
White (non-Hispanic)	70.2	72.6
Black (non-Hispanic)	42.0	46.1
(Hispanic)	39.4	44.7
Central Cities	48.6	50.0
Suburbs	70.3	73.6

Source: U.S. Department of Housing and Urban Development.

Minorities, lower-income households, and recent immigrants should continue to benefit from the current extraordinarily favorable climate for home buyers. The Federal Housing Administration (FHA), an insurance program that is part of HUD, makes it possible for lower-income households with blemished credit records to purchase a home with as little as a 3 percent downpayment. The program has insured more than 5 million mortgages since 1993. Changes to the FHA program in 1998 now make it possible to get

insured loans of up to $208,800 in communities where housing costs are high. In addition, HUD has a new homeownership voucher program that will allow as many as 50,000 families to use their "Section 8" rental assistance vouchers to become first-time homebuyers.

Homeownership Rates by Age—4th Quarter 1998

Less than 35 year	39.6
35–44	67.6
45–54	74.9
55–64	81.7
65 years and over	79.2

Source: U. S. Census Bureau.

A coalition of 66 national groups, (the National Partners in Homeownership), established in 1995, including the housing industry, lenders, and non-profit groups, will also continue their commitment to make buying a home more affordable and easier. These efforts are being carried out by 153 local partnerships and include counseling sessions, home buying fairs, and help with locating homes.

As noted, the economic climate has been very favorable in recent years, but during a period of rising unemployment, many of the newest homebuyers could face difficulties. Many low-income buyers have been enticed to buy with very little downpayments and very little savings set aside to carry them through economic setbacks. Some wonder if there are adequate safety nets in place for when the economy turns downward. HUD's FHA insurance program does have a new "Loss Mitigation Program" to help borrowers retain their homes and cure a delinquency on their mortgage. Existing assistance for borrowers in trouble include special forbearance, mortgage modifications, pre-foreclosure sale and deed-in-lieu of foreclosure. The program has a new "partial claims" option that supports home buyers who can only partially recover from a financial difficulty.

2. Homeownership Tax Provisions

The largest Federal housing programs help exclusively upper-middle and upper income homeowners with their housing costs through the mortgage interest and property tax deductions. The Congressional Joint Committee on Taxation have estimated the cost of these two tax benefits for fiscal year 1999 to be $66.3 billion: $48.5 billion for the mortgage interest deduction and $17.8 billion for the deduction of property taxes. They are projected to increase to a total of $77.1 billion by the year 2003. These provisions are of little or no value to lower income households, or to most elderly homeowners who own their home without a mortgage. Three-quarters of the benefits go to households with incomes of $75,000 or more. By comparison, the 1999 fiscal year budget for HUD, whose programs serve low income households, was about $26 billion.

While the elderly have very high homeownership rates, and thus have not benefited as much from the home buying initiatives described above, there have been some important changes in the tax laws that have been particularly beneficial for those approaching

retirement age and beyond. Prior to 1997, homeowners could generally avoid paying a tax on the gain from the sale of their residence by purchasing a more expensive home, the "rollover provision" in the tax code. However, this often meant that households had to buy a more expensive home than they preferred. In addition, a small number of people who had to sell their home because of the loss of a job, a major medical expense, or a divorce, and thus could not buy a more expensive home, were often faced with a large tax on the sale of their home. Before 1997, there was also a tax provision that allowed many home sellers age 55 and above to exclude from taxation up to $125,000 of gain from the sale of a home.

The Taxpayer Relief Act of 1997 made major changes to the treatment of gains from the sale of a home, replacing the rollover and the $125,000 exclusion. The 1997 Act provides, instead, a $250,000 exclusion of gain from the sale of a principal residence ($500,000 for joint returns) that does not require a rollover and is not restricted to those over age 55. The exclusion can be used for one sale every 2 years and the amount of the exclusion is generally pro-rated for periods of less than 2 years. It is available for sales made after May 6, 1997. This change benefits homeowners such as those in divorce proceedings or facing a serious financial setback that forces them to sell their home. It also allows owners nearing retirement age to sell their home, and either purchase a smaller home (downsize) or become renters, without having to worry about the tax consequences of the sale.

In addition, most homeowners will no longer need to save a lifetime of financial documents on home purchases, sales, and spending on improvements.

There were also changes made in the 1997 Act that affect Individual Retirement Accounts and homes. Under the Act, the 10 percent penalty tax on IRA withdrawals before age 59½ will not apply to funds used for a qualified home purchase. (But IRA money for which a tax deduction has been taken, and earnings on such money, will be subject to tax upon withdrawal). Withdrawals must be used within 120 days for the home purchase expenses of the taxpayer or the taxpayer's spouse, child, grandchild, or ancestor, or the spouse's ancestor. This penalty-free withdrawal is limited to $10,000 less any qualified home buyer withdrawals made in prior years. The funds can be used to acquire, construct, or rebuild a residence and to pay for settlement, financing, and closing costs. The home must be a principal residence, and the purchaser must have had no ownership interest in a principal residence for 2 years before the purchase. This provision is effective for tax years beginning after December 31, 1997. 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.

3. Possible Changes to Residential Tax Provisions

There have been some suggestions for changes to the tax code that would allow losses from the sale of a home to be treated as a capital loss, the same as losses from the sale of stocks, bonds, and other investments. A number of other property related proposals are being examined by Congress: To provide a tax credit against income tax for the purchase of a principal residence by a

first time home buyer; to permit loans from individual retirement plans for first time homebuyers; to allow withdrawals (without the 10 percent penalty) from IRAs that are used to pay down home mortgage amounts; to provide a credit against income tax to individuals who rehabilitate historic homes for use as a principal residence; to allow indexing of homes for purposes of determining gain or loss so as to permit a larger exclusion amount; to amend the code so as to provide that the sale of a life estate or a remainder interest in a principal residence qualifies for the exclusion; and a suggestion to provide a tax credit for the purchase of a principal residence within an empowerment zone or enterprise community by a first time home buyer.

4. 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 1970's, 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 elderly 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 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 was marketing home equity conversion loans in California, New Jersey, and Pennsylvania. To qualify for this so-called "HouseMoney" plan, the borrower could own a one-to-four family home that is not a mobile home or cooperative. A manufactured home could qualify if it were 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.

Currently, the company is administering old loans, but no new loans are being written under the program.

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. (Currently, reverse mortgages are not being written in Texas, and the Home Keeper Mortgage is not available in Massachusetts.) 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 variant of the Home Keeper Mortgage may be used for home purchases by borrowers age 62 or more. A combination of personal funds (none of which may be borrowed) and proceeds from a Home Keeper Mortgage may be used to purchase the property. No payments are due on the loan until the borrower no longer occupies the property as a principal residence.

(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 healthy 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. In recent years, 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. Reportedly, 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.

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.

One of the estate planners obtained a restraining order to block HUD from enforcing the changes suggested in the Mortgage Letter. Basically, the court found that HUD had not followed required rulemaking procedures. The Mortgage Letter did not, for example, permit a period for public comment. In response, the Senior Homeowner Reverse Mortgage Protection Act (H.R. 1297) and the Senior Citizen Home Equity Protection Act (S. 562) were introduced in the 105th Congress. The bills were identical except for their titles. The provisions of these bills were amended and included in the fiscal year 1999 HUD Appropriations Act, P.L. 105–276.

Title V of P.L. 105–276 is cited as the Quality Housing and Work Responsibility Act. Section 593 of the Act amends the National Housing Act to prevent the funding of unnecessary or excessive costs for obtaining FHA-insured home equity conversion loans. The eligibility requirements for obtaining FHA insurance have been amended to require that borrowers receive full disclosure of costs charged to the borrower, including the costs of estate planning, financial advice, and other services that are related to the mortgage but that are not required to obtain the mortgage. The disclosure must clearly state which charges are required to obtain the mortgage and which charges are not required to obtain the mortgage. The loans must be made with such restrictions as HUD determines are appropriate to ensure that the borrower does not fund any unnecessary or excessive costs for obtaining the mortgage, including the costs of estate planning, financial advice, or other related services.

HUD is directed to expedite the change by promulgating an interim rule. Within 90 days of the enactment of P.L. 105–276 (October 21, 1998), HUD is directed to issue final regulations to be promulgated under standard procedures which provide notice and opportunity for public comment. The interim rule would be superseded by the final rule.

Section 593 requires that, in each of fiscal years 2000 through 2003, up to $1 million of any funds made available for housing counseling under Section 106 of the HUD Act of 1968, must be used for housing counseling and consumer education in connection with HUD home equity conversion mortgages. HUD is directed to consult with interested parties to identify alternative approaches to providing the consumer information that may be feasible and desirable for the FHA-insured reverse mortgage and for other reverse mortgage programs. HUD is given the discretion to adopt alternative approaches to consumer education that are developed through this consultation. HUD may only use alternative approaches if such approaches provide consumers with all the information specified in the law.

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 2,100 continuing care retirement communities with an estimated 625,000 residents, which represent about 2 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.

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 speci-

fied 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

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 source of 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 an 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 5-year demonstration program. HUD was to present Congress with a report on the ECHO demonstration program in 1998, but the report was never completed. HUD said that the report could not be done because they were unable to gather the necessary data for a report.

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 problems.

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 the issue 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 iden-

tifying 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 awarded 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 community, 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/aleristics:

Supportive Services only address the specific 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 service. 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., services 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 constraints), 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 10 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 single room units within a building of up to 100 units. Like the Shelter Plus Care program, it is designed to provide permanent housing. Unlike Shel-

ter Plus Care, however, the provision of supportive services is optional.

Congressional action resulted in a single appropriations for homeless assistance grants in fiscal years 1995–1999. The funding for homeless assistance in FY1995 was $1.12 billion. The funding was reduced to $823 million for FY1996, FY1997 and FY1998. For FY1999 the funding was increased to $975 million, at least 30 percent of the appropriated funds are to be used for permanent housing.

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 from 1997 show that households headed by those age 65 and over, who had an average income of $23,965 in 1997, spent $8,082 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 on mortgage interest drops sharply for households age 65 and over, other housing costs remain high. Even though household income falls significantly for the elderly, ($23,965 compared to the average household income of $39,926 in 1997), the amount of property taxes paid by the elderly is higher than that paid by the average household ($1060 in 1995 versus $971 for the average household). The elderly spend 4.4 percent of income for property taxes; the average household, about 2.4 percent. The elderly spend 9 percent of their income on utilities, including telephone, and water, compared to about 6 percent for the average household.

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, and they are far more physically 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 1995, only 19 percent of eligible households received those benefits.

As a proportion of total income, low-income households pay three to four times what all households combined pay for residential

home energy costs; approximately 12 percent versus 4 percent, respectively. For example, in fiscal year 1996 LIHEAP households spent $1,140 or 12.4 percent of their income on residential energy, as compared to $1,294, or 3.8 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 median income) spent $1,108, or 9.1 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 1994 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 Home 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, the Human Services Amendments of 1994, and the Human Services Reauthorization Act of 1998.

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 Energy 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. A new provision of the Human Services Reauthorization Act of 1998 added language stating that grantees should give priority for weatherization services to those households with the lowest incomes that pay a high proportion of their income for home energy.

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, Temporary Assistance to Needy Families, 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.

(A) PROGRAM DATA

The most recent estimates from HHS concerning LIHEAP are for fiscal year 1997. They indicate that States provided heating assistance to 4.1 million households in that year. Additionally, 762,490 households received winter crisis assistance, 124,103 received cooling assistance, 78,678 received weatherization assistance and 21,266 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 received help with heating costs in fiscal year 1997, as was the estimate in fiscal year 1996, compared with 5.5 million households in fiscal year 1995, and 6.0 million in fiscal year 1994.

In fiscal year 1997, grantees reported average annual LIHEAP benefits ranging from $42 to $381 for heating assistance, maximum winter crisis aid benefits ranging from $100 to $800, and benefits ranging from $37 to $540 for cooling assistance. The Department of Health and Human Services estimates that the fiscal year 1996 national annual benefit for households receiving heating and/or winter crisis aid was $180, a 9 percent decrease compared with fiscal year 1995. (Fiscal year 1997 estimate is not available.) Benefits accounted for 91 percent of LIHEAP spending in fiscal year 1996, with 9 percent for administration.

The Department of Health and Human Services used the March 1997 Current Population Survey data to arrive at estimates regarding the demographics of households receiving heating assistance during October 1996–March 1997. The CPS data indicate that of those households:

65 percent had incomes below 110 percent of poverty.
74 percent had incomes below 125 percent of poverty.
84 percent had incomes below 150 percent of poverty.
36 percent had at least one member 60 years or older.
44 percent received social security benefits.

The State-reported data for fiscal year 1995 indicate that 30 percent of LIHEAP heating assistance recipient households contained a person age 60 or older. Of households containing an individual age 60 or over and eligible for LIHEAP, 21 percent received heating assistance in fiscal year 1995. The percentage of all eligible households that received LIHEAP heating assistance in fiscal year 1995 was 26 percent.

The fiscal year 1996 LIHEAP Home Energy Notebook, prepared for the U.S. Department of Health and Human Services in March, 1998 revealed:

On average, residential energy expenditures for all households increased by 3.8 percent, from $1,247 in fiscal year 1995 to $1,294 in fiscal year 1996. LIHEAP recipient households increased their average residential energy expenditures by 4.7 percent, from $1,089 in fiscal year 1995 to $1,140 in fiscal year 1996;

Low-income households are more likely than non-low-income households to use liquefied petroleum gas (LPG) and kerosene as their main source of heat; LIHEAP recipient households are more likely than low-income households to use kerosene and LPG as their main fuel source. Low-income and LIHEAP households use natural gas at a lower rate than non-low-income households (51.3 percent and 45.6 percent versus 54.1 percent);

Average home heating expenditures for non-low-income households were about $441, 14 percent higher than the $380 average home heating costs for low-income households in fiscal

year 1996. Average home heating expenditures for LIHEAP recipient households were about $426;

Home heating expenditures represented a higher percentage of annual household income for low-income households (about 3.2 percent; 4.3 percent for LIHEAP recipient households) 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 in fiscal year 1996 for all households that cooled was about $144, and for LIHEAP recipients that cooled was about $92;

Cooling expenditures represented a higher percentage of average annual income for low-income households that cooled (0.8 percent) than for all households that cooled (0.3 percent).

(B) FUNDING

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 $1.1 billion in fiscal year 1999.

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. In fiscal year 1997, LIHEAP was funded at $1 billion, with a contingency fund of $420 million. In fiscal year 1998, Public Law 105–78 funded LIHEAP at the $1 billion level again, with a $300 million emergency fund. The fiscal year 1999 omnibus appropriations bill (Public Law 105–277), signed October 21, 1998, provides $1.1 billion in LIHEAP funding for fiscal year 1999, plus $300 million in emergency funding. The bill also includes $1.1 billion in advanced funding for fiscal year 2000.

According to the Department of Health and Human Services' most recent estimates of states' obligation of LIHEAP funds, in fiscal year 1996, $652.4 million were used for heating assistance, $14.5 million for cooling assistance, $138.4 million for crisis assistance, and $110.6 million for low-cost residential weatherization assistance or other energy-related home repair.

Contingency LIHEAP funds have been utilized in recent years for both cold and hot weather emergencies. From fiscal year 1994 through fiscal year 1998, the President has released emergency funds totaling $955 million on eight different occasions. During January 1997, President Clinton released $215 million in emergency LIHEAP funds, citing cold weather and a nationwide price hike in fuel costs. In fiscal year 1998, President Clinton released $160 million in emergency LIHEAP funds, the bulk of which was received by 11 states suffering from extreme heat waves.

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 Federal Energy Administration (FEA) became involved in 1976 with passage of Public Law 94–385. In October 1977, the newly formed Department of Energy (DOE) assumed the responsibilities of the FEA. 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 Temporary Assistance to Needy Families (TANF), Supplemental Security Insurance (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 to nonprofit agencies for purchasing and installing energy conserving materials, such as insulation, and for making energy-related repairs. Federal law allowed a maximum average expenditure of $2,002 per household in fiscal year 1998 ($2,032 in fiscal year 1999), unless a state-of-the-art energy audit shows that additional work on heating systems or cooling equipment would be cost-effective.

(A) PROGRAM DATA

Since its inception through fiscal year 1998, the weatherization program has served more than 5 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. 14,970 dwellings weatherized in that year were studied. The report revealed:

The Weatherization Assistance Program saved $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 represented approximately 18 percent of the total home heating bill of $640;

Energy savings through weatherization reduced 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 was particularly hard hit by home energy costs, spending 17 percent of income on residential energy. Elsewhere across the country, low-income people typically spent 12 percent of their income on energy, compared to only 3 percent for other income levels.

In 1996, the Department of Energy reported that the Weatherization Assistance Program's performance had improved significantly because of the implementation of many of the recommendations of the 1990 National Evaluation that was conducted under the supervision of the Oak Ridge National Laboratory. A 1996 "metaevaluation" of 17 state-level evaluations of the Weatherization Program concluded that improved practices had produced 80 percent higher average energy savings per dwelling in 1996 as compared to measured savings in 1989. These savings equal a 23.4 percent reduction in consumption of natural gas for all end uses.

(B) FUNDING

In fiscal year 1996, the appropriation for the Weatherization Assistance Program was $111.7 million. The fiscal year 1997 appropriation was $120.8 million. The fiscal year 1998 appropriation was $129 million, and the fiscal year 1999 appropriation was $133 million.

B. RECENT LEGISLATIVE ACTIVITY

Public Law 105–285 was enacted on October 27, 1998 and reauthorized LIHEAP for 5 years (through fiscal year 2004). On October 9, 1998 the Senate and House agreed to the conference report reauthorizing the program for 5 years at "such sums as may be necessary" for fiscal year 2000 and fiscal year 2001, and for $2 billion annually for fiscal years 2002–2004. Earlier House legislation had proposed a 2-year reauthorization. In addition to reauthorizing LIHEAP for 5 years, P.L. 105–285 contains provisions to:

Clarify the intent of Congress to provided funding for LIHEAP 1 year in advance;

Clarify the conditions under which the President may release energy emergency contingency funds. The new Section 303 "provides for release of LIHEAP funds in response to emergencies, including a natural disaster, any other event meeting criteria the Secretary determines appropriate, or a significant increase in: home energy supply shortages or disruptions; the cost of home energy; home energy disconnections; participation in a public benefit program such as the food stamp program; or a significant increase in unemployment or layoffs."

Add an emphasis on giving priority for weatherization services to those households with the lowest incomes that pay a high proportion of their income for home energy;

Direct the General Accounting Office to conduct an evaluation of the Residential Energy Assistance Challenge (REACH) grant program; and

Increase from $250,000 to $300,000 the amount of annual LIHEAP appropriations that may be reserved by the Secretary to provide training and technical assistance.

The appropriation for LIHEAP was a topic of debate between the House and Senate in the 105th Congress. On July 20, 1998, the House Labor/HHS/Education Appropriations Committee reported H.R. 4274 (H. Rept. 105–635), which would have rescinded the $1.1 billion in advanced fiscal year 1999 funding, but restored $1.1 billion for fiscal year 2000. The Senate's reported bill, S. 2440 (S. Rept. 105–300) would have maintained the funding level of $1.1 billion plus $300 million in emergency funds for fiscal year 1999, and maintained the same $1.1 million in advanced funding for fiscal year 2000. The fiscal year 1999 omnibus appropriations bill (P.L. 105–277), signed October 21, 1998 included the Senate's recommended $1.1 billion in LIHEAP funding for fiscal year 1999, plus $300 million in emergency funding, and $1.1 billion in advance funding for fiscal year 2000.

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 services 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. 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 benefitting low-income older persons and is a source of Federal funding for training, research, and demonstration activities in the field of aging. It authorizes funds for supportive and nutrition services for older Native Americans and Native Hawaiians and 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 ad-

ministers 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 thirteen times since the original legislation was enacted. During the 1970s, 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 1972, Congress established the national nutrition program for the elderly. In 1973, the area agencies on aging (AAAs) 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.

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).

Increased funding during the 1970s 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 1980s 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.

Until the 104th Congress, there had been widespread bipartisan congressional support of OAA programs, especially the nutrition and senior community service employment program. The 104th Congress marked the beginning of controversy over a number of proposals that surfaced as part of the Act's reauthorization. This controversy continued through the 105th Congress (see discussion below). The Act's authorization expired at the end of FY1995, but funding has continued through appropriations legislation.

A. THE OLDER AMERICANS ACT TITLES

The following is a brief description of each Title of the Older Americans Act:

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.

TITLE II. ADMINISTRATION ON AGING (AOA)

Title II of the Older Americans Act establishes AoA, within the Department of Health and Human Services (DHHS), as the chief Federal agency advocate for older persons. It also authorizes the Federal Council on Aging, whose purpose is to advise the President and the Congress on the needs of older persons. However, the last time the Council received funding was in FY1995. The FY1999 Omnibus Appropriations Act contains a permanent provision prohibiting the expenditure of funds for the Council.

TITLE III. GRANTS FOR STATES AND COMMUNITY PROGRAMS ON AGING

Title III authorizes grants to State and area agencies on aging to act as advocates on behalf of, and to coordinate programs for, the elderly. The program supports 57 State agencies on aging, 660 area agencies on aging, and over 27,000 service providers and currently funds six separate service programs. States receive separate allotments of funds for supportive services and centers, congregate and home-delivered nutrition services, U.S. Department of Agriculture (USDA) commodities or cash-in-lieu of commodities, disease prevention and health promotion services, and in-home services for the frail elderly. Three other programs—assistance for special needs, school-based meals and multigenerational activities, and supportive activities for caretakers—are not funded.

Title III services are available to all persons aged 60 and over, but are targeted to those with the greatest economic and social need, particularly low-income minority persons. Means testing is prohibited. Participants are encouraged to make voluntary contributions for services they receive.

Funding for supportive services, congregate and home-delivered nutrition services, and in-home services for the frail elderly is allocated to States by AoA based on each State's relative share of the total population of persons aged 60 years and over. States are required to award funds for the local administration of these programs to area agencies on aging. USDA provides commodities or cash-in-lieu of commodities to States, in conjunction with the AoA nutrition programs.

The Title III nutrition program is the Act's largest program. FY1999 funding of $626 million represents 43 percent of the Act's total funding and 66 percent of Title III funds. Most recent data show that the program provided 240 million meals to over 3 million older persons. About half of total meals served were provided in congregate settings, such as senior centers and schools, and half were provided to frail older persons in their homes.

Data from a national evaluation of the nutrition program show that, compared to the total elderly population, nutrition program 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. The report found the program plays an important role in participants' overall nutrition and that meals consumed by participants are their primary source of daily nutrients. The evaluation also indicated that for every Federal dollar spent, the program leverages on average $1.70 for congregate meals, and $3.35 for home-delivered meals.[1]

The supportive services and centers program provides funds to States for a wide array of social services and activities of approximately 6,400 multipurpose senior centers. The most frequently provided services are transportation, information and assistance, home care, and recreation. In FY1996, the program provided about 40 million rides, responded to over 13 million requests for information and assistance, and provided about 15 million home care services (i.e., personal care, homemaker, or chore services).

TITLE IV. RESEARCH, TRAINING, AND DEMONSTRATION PROGRAM

Title IV of the Act authorizes the Assistant Secretary for Aging to award funds for 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 has supported a wide range of projects, including community-based long-term care, support services for Alzheimer's disease, and career preparation and continuing education in the field of aging.

TITLE V. SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

Title V of the Act authorizes a program to provide opportunities for part-time employment in community service activities for unemployed, low-income older persons who have poor employment prospects. The program has three goals: to provide employment opportunities for older persons; to create a pool of persons who provide community services; and to supplement the income of low-income older persons (income below 125 percent of the Federal poverty level). Enrollees work in a variety of community service activities and are paid the higher of the national or State minimum wage or the local prevailing pay for similar employment. The program, which is not considered a job training program, supports over 61,500 jobs in program year (PY) 1998–1999 (July 1, 1998–June 30, 1999).

Title V is administered by the Department of Labor (DOL), which awards funds to ten national organizations and to all States. National organizations that receive funds are Asociacion 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.

[1] U.S. Department of Health and Human Services. Office of the Assistant Secretary for Aging. Serving Elders at Risk: The Older Americans Act Nutrition Programs, National Evaluation of the Elderly Nutrition Program, 1993–1995. June 1996.

Funding is distributed using a combination of factors, including a "hold harmless" for employment positions held by national organizations in 1978, and a formula based on States' relative number of persons aged 55 and over and per capita income. Appropriations Committee directives in recent years have required that funds be distributed so that national organizations receive 78 percent of the total appropriation, and States receive 22 percent.

TITLE VI. GRANTS FOR SERVICES FOR NATIVE AMERICANS

Title VI authorizes funds for supportive and nutrition services to older Native Americans. Funds are awarded directly by AoA to Indian tribal organizations, Native Alaskan organizations, and nonprofit groups representing Native Hawaiians.

TITLE VII. VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES

Title VII authorizes five separate vulnerable elder rights protection activities. States receive separate allotments of funds for the long-term care ombudsman program and elder abuse prevention activities. Three other authorized programs—elder rights and legal assistance, Native Americans elder rights program, and outreach, counseling, and assistance—are not funded. Funding for vulnerable elder rights protection activities is allotted to States based on the States' relative share of the total population age 60 and older. State agencies on aging may award funds for these activities to a variety of organizations for administration, including other State agencies, area agencies on aging, county governments, nonprofit services providers, or volunteer organizations.

The largest elder rights protection program is the long-term care ombudsman program, whose purpose is to investigate and resolve complaints of residents of nursing facilities, board and care facilities, and other adult care homes. It is the only Older Americans Act program that focuses solely on the needs of institutionalized persons and is authorized under both Title III (supportive services and centers) and Title VII. State and other non-Federal funds represent a significant amount of total funds for the program. In FY1996, about $42 million in Federal and non-Federal funding was devoted to support this program. About 62 percent of the program effort was supported by Older Americans Act sources; non-Federal and other funds represented about 38 percent of the total program support.

B. SUMMARY OF MAJOR ISSUES IN THE 105th CONGRESS

Authorizations of appropriations for the Older Americans Act expired at the end of 1995. The 105th Congress, like the 104th Congress, did not reauthorize the Act. Appropriations legislation for the last four years—FY 1996 through FY 1999—has continued the program.

In the past, the Act has received bipartisan congressional support. However, beginning with the 104th Congress, and continuing through the 105th Congress, Members of Congress have differed about certain provisions that were under discussion as part of the reauthorization. Although the House Economic and Educational Opportunities Committee and the Senate Labor and Human Re-

sources Committee reported bills to reauthorize the Act in 1996, these bills were not acted upon by either chamber.

In June 1998, the Chairman of the Subcommittee on Early Childhood, Youth and Families of the House Education and the Workforce Committee (which has responsibility for the Act) introduced H.R. 4099, the Older Americans Act Amendments of 1998. The bill revisited issues that remained in controversy at the end of the 104th Congress, and modified proposals that were contained in the House Committee-reported 104th Congress bill. H.R. 4099 would have reduced the 20 currently authorized programs to eight, made structural changes in the community service employment program, and modified the formula for distributing funds, among other things. The Chairman of the Subcommittee on Aging of the Senate Labor and Human Resources Committee, which has responsibility for the Act, did not introduce legislation in the 105th Congress.

1. Activity During the 105th Congress

Although many Members of Congress and many aging organizations were concerned about the delay in enactment of reauthorization legislation, ultimately the 105th Congress did not take final action. The controversy raised by certain proposals in the 104th Congress bills, and devising ways to modify approaches to these proposals, were major factors in the delay in the 105th Congress.

H.R. 4099 revisited certain issues that remained in controversy at the end of the 104th Congress, and modified proposals that were contained in the House Committee-reported 104th Congress bill. These issues included proposals to (1) consolidate authorizations of appropriations for certain programs under the Act; (2) restructure the community service employment program; (3) change the interstate formula for distribution of Title III funds for supportive and nutrition services; (4) revise certain requirements to target supportive and nutrition services to low-income minority older persons that are in current law, while retaining an overall requirement to target services to these persons; and (5) impose cost-sharing requirements for certain services so that participants contribute toward their costs. The Chairman of the Subcommittee on Aging of the Senate Labor and Human Resources Committee, which has responsibility for the Act, did not introduce legislation in the 105th Congress.

By early summer 1998, some Members of Congress were concerned that there appeared to be no action on reauthorization. In response to rising criticism from constituents and constituent organizations about the lack of action, two bills were introduced that would have reauthorized the Act through FY2001. Senator McCain introduced S. 2295 on July 13, 1998, and Representative DeFazio introduced a companion bill, H.R. 4344, on July 29, 1998. The bills would have simply reauthorized the Act, and made no substantive program changes. They received substantial congressional support—S. 2295 had 67 co-sponsors, and H.R. 4344 had 188 co-sponsors.

Other reauthorization proposals were introduced. These were S. 390, Older Americans Act Amendments of 1997 (Mikulski), and H.R. 1671, Older Americans Act Amendments of 1997 (Martinez). These bills were similar to the reauthorization proposals suggested

by the Administration during the 104th Congress. They differed from H.R. 4099 and bills reported by the House and Senate Committees during the 104th Congress in a number of ways. For example, they would not have consolidated authorizations of appropriations for the Act's programs, nor would have made major structural changes in the community service employment program.

Other 105th Congress bills included S. 948, the Pension Assistance and Counseling Act of 1997, introduced by Senator Grassley, with a companion bill in the House,H.R. 2167, introduced by Representative Schumer. These bills would have amended the research, training, and demonstration program authorized under Title IV of the Act to create a toll-free telephone number for individuals who are seeking information and assistance regarding pension and other retirement benefits, among other things. No final action was taken on these bills.

2. Issues in Reauthorization

Issues that continued to be in controversy in the 105th Congress included proposals to: restructure the Act's programs and reduce the number of authorizations of appropriations; restructure the community service employment program; impose cost-sharing requirements on participants toward services they receive; revise the formula for distributing funds for nutrition and supportive services to States; and change provisions that target services to low income minority older persons. The following discusses issues that were raised as part of the reauthorization:

(A) CONSOLIDATION AND RESTRUCTURING OF OLDER AMERICANS ACT PROGRAMS

Similar to the 104th Congress House and Senate Committee reported bills, H.R. 4099 would have consolidated and restructured certain Older Americans Act programs, and given more flexibility to States in the operation of aging service programs. Current law authorizes twenty separate programs under the Act (although some have never been funded). H.R. 4099 would have reduced the number of separately authorized programs to eight.

While the bill proposed major changes in the structure of the Act, it would have preserved core functions of the State and area agency on aging programs under Title III. These include responsibilities of these agencies to plan and coordinate service programs on behalf of older persons, and to advocate for programs and services on their behalf. Current law requirements that State and area agencies develop State and area plans on aging, taking into consideration the needs of older persons with the greatest social and economic need, would have remained intact. Similar to the 104th Congress legislation, H.R. 4099 would have eliminated a number of specific plan requirements that were viewed as burdensome to State and area agencies.

H.R. 4099 would have consolidated the authorization of appropriations for the congregate and home-delivered nutrition programs, now under two separate authorities. Under this approach, States would have received one allotment of funds for congregate and home-delivered meals, but would have been expected to assess

the need for both types of nutrition services. The bill would have retained a separate authorization of appropriations for the U.S. Department of Agriculture portion of the nutrition program.

(B) RESTRUCTURING THE COMMUNITY SERVICE EMPLOYMENT PROGRAM

The senior community service employment program, authorized under Title V of the Act, provides opportunities for part-time employment in community service activities for unemployed, low-income older persons who have poor employment prospects. The program is funded at $440 million in FY1999, representing 30 percent of Older Americans Act funds. It is administered by the Department of Labor (DoL), which awards funds directly to national sponsoring organizations [2] and to States.

H.R. 4099 would have made 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. Like the 104th Congress Committee-reported bills, H.R. 4099 would have restructured the program, in part, to respond to a 1995 General Accounting Office (GAO) report. That report reviewed certain administrative issues related to the program, including DoL's method of awarding funds, formula allocation of funds, and grantee use of funds.[3] H.R. 4099 would have given States more control of the administration of the program and introduced competition for funds among prospective grantee organizations.

In addition, H.R. 4099 would have retained the community service employment program as a separate Older Americans Act title, and retained DoL as the Federal administrative authority. The 104th Congress legislation would have eliminated the separate title and moved the program to AoA.

Distribution of Community Service Employment Funds by the Federal Government.—Currently, 78 percent of funds are awarded by DoL directly to ten national organizations on a non-competitive basis; 22 percent of funds is distributed to States. The 104th Congress bills would have transferred all funds now administered by national organizations to States. In contrast, H.R. 4099 would have transferred only a portion of funds now administered by national organizations to States, so that by FY2003, 50 percent of total funds would have been distributed to national organizations and 50 percent to States. The national organizations' share of total funds would have decreased from 78 percent of the total to 50 percent by FY2003, and the States' share would have increased from 22 percent to 50 percent.[4] In addition, the bill would have required that funds to national organizations be awarded on a competitive basis.

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[2] The ten national organizations are: American Association of Retired Persons; Asociacion Nacional Por 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.

[3] General Accounting Office. Senior Community Service Employment Program Delivery Could Be Improved Through Legislative and Administrative Actions. GAO/HEHS–96–4. November 1995.

[4] Despite requirements in the authorizing statute that States are to receive a larger portion of funds, appropriations law for many years has stipulated that 78 percent of funds be distributed to national organizations, and 22 percent to States. This has been a long-standing issue.

This approach was, in part, based on a goal of reducing the number of national organizations that operate in each State, and of giving States more control in the administration and coordination of the program. National organizations receive funds to administer the program in all but three States; in many States, multiple national organizations administer programs in addition to a designated State agency. Some State agencies have been concerned about the duplication of national organizations' activities that affect the distribution of employment positions within a State. In its report, GAO noted that there is inequitable distribution of funding within some States as well as duplication of effort among national and State sponsors.

Proponents of the approach to equalize funds for national organizations and States indicate that costs of program administration and duplication of effort within States would decrease since there would be fewer organizations that would administer the program in some States. Proponents also say that giving States more leverage in funding decisions would increase coordination of effort among all grantees in States.

The restructuring of the senior community service employment program generated substantial controversy during both the 104th and 105th Congresses. Some existing national grantees expressed concern that their continued existence would be threatened if more program funding were to be shifted to States, and if States, rather than the Federal Government, were to make decisions about which organizations would be grantees. They were also concerned that restructuring could result in disruption of jobs for some existing enrollees.[5] A number of organizations and some Members of Congress indicated that the program has operated well under the national organizations' administration, and that, because of the long-standing association of some of the organizations with the program, they have expertise to continue administering the majority of funds.

Formula Allocations to Grantees.—Tile V 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 FY 1998, 57 percent of funds were distributed according

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In the 1978 reauthorization of the Older Americans Act, the Senate Labor and Human Resources Committee expressed concern about the "circumvention" by the Appropriations Committee of the authorizing committee formula.

In more recent action on the funding split, for FY1997 the House Appropriations Committee proposed to increase the amount of funding allocated to States to 35 percent of the total, thereby reducing funds to national organizations to 65 percent. This action was taken in part based on recognition that the House authorizing committee was moving toward transferring all Title V funding to the states. However, in final action on FY1997 appropriations (P.L. 104–208), Congress continued to stipulate the 78 percent/22 percent split for national organizations and States, as it had done in the past.

[5] The modifications to the program were debated during markup of the bills by the House EEO Committee and the Senate Labor and Human Resources Committee in the 104th Congress, with certain members of the Committees voicing objections to the proposed restructuring. Some Members were concerned about the bills' approach to completely turn over the program to the States and that such a transition could be disruptive to enrollees. There was also concern that there would be a loss of the national organizations' expertise in administering the program.

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. Senator Mikulski stated that the restructuring of the Title V program would be revisited when S. 1643 reached the Senate floor. A similar amendment was proposed by Representative Kildee during the markup of H.R. 2570, but was also rejected by the EEO Committee.

to the hold harmless provision ($252 million out of $440.2 million for July 1, 1998–June 30, 1999 program year); the balance was distributed according to each State's relative population of persons aged 55 and over 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 of funds based on relative measures of age and per capita income. 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.

The formula in H.R. 4099 built upon the current methodology, but it would have moved the hold harmless amount to 1998. The bill would have required that funds for FY1999–FY2003 be distributed to States based on the share of funds they received in FY1998; any funds appropriated in excess of the FY1998 level would have been distributed on the basis of States' relative share of persons age 55 and over and per capita income. Funds would have then been distributed to national organizations and to State agencies as described above.

Use of Funds for Enrollee Wages/Fringe Benefits, Administration, and Other Enrollee Costs.—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" that, under current DoL regulations, may include recruitment and orientation of enrollees and supportive services for enrollees, among other things. In its review, GAO found that most national organizations and some State sponsors had budgeted administrative costs in excess of the statutory limit by inappropriately classifying them as "other enrollee costs."

H.R. 4099 would have established a new minimum amount of grant funds that must be used for enrollee wages and fringe benefits, specify a limit on "other enrollee costs," and redefine such costs. First, it would have required that a minimum of 85 percent of a grantee's funds be used for enrollee wages and fringe benefits compared to 75 percent in DOL regulations). Of these funds, up to 5 percent could be used for "other enrollee costs." The bill would have defined these as costs for employment-related counseling, supportive services, and transportation. This approach was designed to limit funds for administration by prohibiting funds categorized as "other enrollee costs" to be used for administration.

The bill would have retained the same limit on administrative costs as in current law, that is, up to 13.5 percent of a grantee's funds (with a waiver up to 15 percent, if approved by the Secretary). Under this approach, grantees would have paid for enrollee assessments and training from their administrative costs.

Performance Standards.—H.R. 4099 would have required the Secretary of Labor to publish regulations establishing performance standards.[6] The standards would have included requirements that:

- At least 20 percent of participants are placed in unsubsidized employment, and that they remain in unsubsidized jobs for at least four months after placement;
- There be a specific percentage reduction in participants' dependency on public assistance, as a result of program participation;
- A specific percentage of participants receive employment and training through other Federal, State and local training programs; and
- There be a specific percentage increase in employment opportunities in underserved areas.

The bill also specifies penalties and adjustment to grants if grantees fail to meet the standards.

(C) INTERSTATE FUNDING FORMULA FOR SUPPORTIVE AND NUTRITION SERVICES

The way in which AoA distributes nutrition and supportive funds to States continued to be at issued during the 105th Congress as it had during the 104th Congress. Current law requires the Administration on Aging (AoA) to distribute Title III funds for supportive and nutrition services to States based on their relative share of the population aged 60 and older. In addition to specifying certain minimum funding amounts, the law contains a "hold harmless" provision requiring that no State receive less than it received in FY1987.

AoA distributes funds for supportive and nutrition services in the following way. First, States are allotted funds in an amount equal to their FY1987 allocations, which were based on estimates of States' relative share of the total U.S. population in 1985.[7] Second, the balance of the appropriation is allotted to States based on their relative share of the population aged 60 and over as derived from the most recently available estimates of State population. And third, State allotments are adjusted to assure that the minimum grant requirements are met. The effect of this methodology is that the majority of funds are distributed according to population estimates that do not reflect the most recent population trends. For example, for FY1998, 84 percent of total Title III funds were distributed according to the FY1987 "hold harmless." The remainder of funds appropriated was distributed according to 1996 population data.

The method that AoA uses to meet the 1987 "hold harmless" provision has received some scrutiny. In a 1994 report, GAO concluded that Title III funds are not distributed according to the require-

[6] Development of performance standards for the program was also discussed during the 104th Congress. During markup of the Senate bill by the Committee on Labor and Human Resources, Senator Mikulski introduced an amendment that would have established certain performance standards for the program.

[7] There is usually a two-year time lag in availability of estimates of State population from the U.S. Census Bureau; therefore, for example, 1998 funding allotments relied on 1996 State population estimates.

ments of the statute.[8] GAO concluded that the method employed by AoA does not distribute funds proportionately according to States' relative share of the older population, based on the most recent population data and, therefore, negatively affects States whose older population is growing faster than others. GAO recommended that AoA revise its method to allot funds to States, first, on the basis of the most current population estimates, and then adjust the allotments to meet the hold harmless and statutory minimum requirements.

H.R. 4099 would have followed the GAO recommendation by requiring that funds be distributed, first, according to the most recent data on States' relative share of persons sixty years and older. The bill then stipulated that no State would receive less than it received in FY1998, thereby creating a 1998 hold harmless requirement. The intent of this approach was to have more of total funding distributed according to the most recent population data as total funding increases over the FY1998 level, but at the same time assuring that States allotments would not go below their FY1998 levels. The actual effect of this approach in FY1999 would have been that States would have generally received approximately the same amount as they received in FY1998 because funding for nutrition and supportive services did not increase between those years.

H.R. 4099 differed from the 104th Congress House Committee-reported bill, which would have gradually eliminated the 1987 hold harmless requirement over a period of years. Some States were concerned about this approach, indicating that without a hold harmless provision, they would have lost funds. H.R. 4099's hold harmless provision may have ameliorated concerns of some States that would have lost funds under the 104th Congress bill.[9]

(D) TARGETING OF SERVICES TO LOW-INCOME MINORITY OLDER PERSONS

Targeting of services to low-income minority older persons continued to be a subject of review during the 105th 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 to 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 providers 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.

The House bill, as introduced in the 104th Congress, would have retained requirements that the Title III program focus on older

[8] U.S. General Accounting Office. *Older Americans Act. Title III Funds Not Distributed According to Statute.* GAO/HEHS–94–37. January 1994.

[9] The Senate Committee-approved bill would have taken a different approach to changing the formula. It would have based allotments for supportive and nutrition services on two factors: a composite measure that attempts to capture the relative size of a State's relative "elderly in-need" (EIN) percentage; and, a measure of a State's relative total taxabale resources compared to the State's relative EIN.

persons who have the greatest social and economic need, but would have deleted a number of provisions on specific targeting on low-income minority older persons that are in current law. These deletions were debated during markup of the bill by the EEO Committee; an amendment to the bill that would have restored certain targeting requirements contained in current law was rejected.

H.R. 4099 contained targeting provisions that are similar to those contained in the 104th Congress House Committee-reported bill, but also contains other references that were not in the Committee-reported bill. It would have required that (1) State agencies develop a formula to distribute funds within the state, taking into account the geographical distribution of older individuals with greatest social or economic need; (2) preference be given to providing services to older individuals with greatest social and economic need, with particular attention to low-income minority older individuals; (3) State and area agencies evaluate the need for services by older individuals with the greatest social and economic need, with particular attention to low-income older individuals; and (4) State and area agencies conduct outreach to older individuals with the greatest social and economic need, and to low-income older individuals.

The bill did not contain all references to low-income minority older individuals that are in current law. Therefore, the targeting issue continued to be debated during the 105th Congress.

(E) COST-SHARING FOR SERVICES BY OLDER PERSONS

One of the most frequent issues to arise in past reauthorization legislation has been whether the Act should allow mandatory cost sharing for certain social services. Under current law and regulations, mandatory fees are prohibited, but nutrition and supportive services providers are allowed to solicit voluntary contributions from older persons toward the costs of services. Older persons may not be denied a service because they will not or cannot make a contribution. Funds collected through voluntary contributions are to be used to expand services. In the past, Congress has resisted any attempts to allow Older Americans Act programs to charge fees for services.

H.R. 4099 would have allowed States to apply cost sharing to most Title III services on a sliding scale basis. It would have prohibited cost sharing for certain services—these are information and assistance, outreach, benefits counseling, case management, and ombudsman and other protective services. It would have prohibited States from imposing cost sharing on individuals with low income (as defined by the State, but no lower than 125 percent of the Federal poverty level), and would have required that incomes of older persons be determined on a self-declaration basis. It 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. This cost-sharing provision is the same as that in the 104th House Committee-approved bill. The Administration's bill for the 104th Congress also proposed a new provision on cost-sharing. It contained some of the same elements as the House and Senate-Com-

mittee approved bills, but would have also exempted nutrition services from cost-sharing.

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 1987 and 1992 reauthorizations of the Act, Congress considered, but ultimately rejected, proposals to change the current voluntary contributions policy.

C. OLDER AMERICANS ACT APPROPRIATIONS, FY1998–FY1999, and FY2000 BUDGET REQUEST

1. FY1999 FUNDING

On October 21, 1998, the President signed P.L. 105–277, the Omnibus Consolidated Appropriations Act, 1999, completing the FY1999 funding cycle. FY1999 funding for programs under the Older Americans Act totals $1.456 billion,[10] $11 million more than in FY1998, resulting in less than a 1 percent increase. A substantial portion of this increase ($8 million) was for Title IV activities, training, research, and discretionary projects and programs.

The Administration's FY2000 budget request includes funding of $1.632 billion for the OAA programs, a 12 percent increase in funding over FY1999. The request includes $125 million for a new National Family Caregiver Support program under Title III.

See Table 1 for FY1998–FY1999 funding and the Administration's FY FY2000 funding.

TABLE 1. OLDER AMERICANS ACT AND ALZHEIMER'S DEMONSTRATION PROGRAM, FY1998–FY1999 FUNDING AND FY2000 BUDGET REQUEST

[In millions of dollars]

	FY1998 approp.	FY1999 Omnibus approp.	FY2000 President's request
Title II: Administration on Aging	$14.795	$14.795	$16.830
Federal Council on Aging	.....	.....	.....
AoA program administration	14.795	14.795	16.830
Title III: Grants for State and Community Programs on Aging	961.798	952.617	1122.617
Supportive services and centers	309.500	300.319	310.082
Preventive health	16.123	16.123	16.123
Nutrition services	626.412	626.412	671.412
Congregate meals	(374.412)	(374.412)	(374.412)
Home-delivered meals	(112.000)	(112.000)	(147.000)
USDA commodities	(140.000)	(140.000)	(150.000)
School-based meals/multigenerational activities	.....	.....	.....
National Family Caregiver Support	.....	.....	125.000

[10] 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 (L–HHS–ED). Funding for the USDA commodities program is included in appropriations legislation for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies.

TABLE 1. OLDER AMERICANS ACT AND ALZHEIMER'S DEMONSTRATION PROGRAM, FY1998–FY1999 FUNDING AND FY2000 BUDGET REQUEST—Continued

[In millions of dollars]

	FY1998 approp.	FY1999 Omnibus approp.	FY2000 President's request
In-home services for the frail elderly	9.763	9.763	[1]
Assistance for special needs	.....	.....	.....
Supportive activities for caretakers	.....	.....	[1]
Title IV: Training, Research, and Discretionary Projects and Programs	10.000	18.000	22.000
Health Disparities Intervention Grants	.....	.....	(4.000)
Title V: Community Service Employment	440.200	440.200	440.200
Title VI: Grants for Native Americans	18.457	18.457	18.457
Title VII: Vulnerable Elder Rights Protection Activities	([2])	[3] 12.181	12.181
Long-term care ombudsman program	.....	(7.449)	([4])
Elder abuse prevention	.....	(4.732)	([4])
Elder rights and legal assistance	.....	.....	([4])
Outreach, counseling, and assistance	.....	.....	([4])
Native Americans elder rights program	.....	.....	.....
Total—Older Americans Act Programs	1,445.250	1,456.250	1,632.285
Alzheimer's Demonstration Grants	[5] 5.999	[5] 5.999	[5] 5.970

[1] The Administration has proposed a National Family Caregiver Support program to replace the authorization of appropriations for In-home services for the frail elderly and Supportive activities for caretakers.

[2] No separate funding provided. The House Appropriations Committee included an unspecified amount for ombudsman and elder abuse prevention under supportive services and centers. The conference committee earmarked $4.449 for ombudsman services and $4.732 for elder abuse prevention in the supportive services program.

[3] For FY1999, Title VII activities received a separate appropriation.

[4] The Administration proposes consolidating funding for the long-term care ombudsman program; the elder abuse prevention program; the elder rights and legal assistance program; and the outreach, counseling and assistance program.

[5] The FY1999 Omnibus Consolidated Appropriations Act (P.L. 105–277/H.R. 4328) transferred the administration of the program from the Health Resources and Services Administration to AoA. The program is still authorized under Section 398 of the Public Health Service Act.

2. The Older Americans Act

(A) INTRODUCTION

The Older Americans Act (OAA) provides funding to State agencies on aging and area agencies on aging for a wide range of home and community-based services. Although funding under the Older Americans Act is small compared to Federal funding available under the Medicare and Medicaid programs, many state and area agencies have been leaders in the development of a system of home and community-based services in their respective states and communities.

The OAA does not focus exclusively on long-term care, but 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 coordinated 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. 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.

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. In some cases, OAA funds may be used to assist persons whose Medicare benefits have been exhausted or who are ineligible for Medicaid.

The role of the OAA in providing congregate and home-delivered meals to the elderly is an important contribution to the long-term care system. 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. Currently, the number of meals served to older persons in their homes is almost equal to the number provided in community settings under the congregate nutrition program.

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) GROWTH IN THE HOME-DELIVERED MEALS PROGRAM

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. Appropriations for Title III in FY1999 is $952 million. (The Older Americans Act chapter contains detailed information on funding.)

The total number of meals served under the nutrition program has increased by 41 percent through the period 1980 through 1996 (the latest available data). Home-delivered meals accounted for the largest share of that growth, increasing by 227 percent during that period, compared to an actual decline of 41 percent in meals served in congregate settings.

There are a number of reasons for this enormous growth in home-delivered meals. Funding for home-delivered nutrition services has increased more rapidly than for congregate meal services. From 1980 to 1999, funding for home-delivered meals increased by 124 percent, compared to an increase of only 39 percent for the congregate program. In addition, states have increasingly transferred funds allotted for congregate meals to their home-delivered meals programs in order to meet the increasing demand of the growing older population. Persons in the oldest age categories are more likely to need more in-home services, such as home-delivered meals. Moreover, States' efforts to develop comprehensive home and community-based long-term care systems have had an impact on this growth, as States have implemented policies to provide services to enable frail older persons to remain in their own homes, rather

than in institutions. Finally, earlier discharge of elderly patients from the hospital 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 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 established statutory authority for the program in the 1978 amendments to 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 to (1) investigate and resolve complaints made by or on behalf of residents of nursing homes and board and 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 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 ombudsman can become well-acquainted with the residents, the employees, and the workings of the facility.

In FY1996, there were about 570 local ombudsmen program with about 850 paid staff (full-time equivalents). However, the program relies heavily on volunteers to carry out ombudsman responsibilities—about 13,000 volunteers assisted paid staff in fiscal year 1996.

In fiscal year 1996, ombudsman investigated 127,000 new cases and closed 116,000 cases. These cases involved almost 180,000 complaints. About 81 percent of complaints involved care in nursing facilities, and 19 percent in board and care homes and other settings. About two-thirds of complaints related to resident care and rights; the remainder had to do with other issues, such as facility administration and quality of life.

About $41.5 million was spent on ombudsman activities from all sources in FY1996. About 62 percent was from the OAA. Nonfederal sources represent a significant portion of total ombudsman funding—$15.2 million, representing 37 percent of total funds. A small additional amount was supplied by other federal sources.

The 1992 OAA amendments required the Assistant Secretary for Aging to evaluate the program. The evaluation, conducted by the Institute of Medicine (IOM), concluded that the program serves a vital public interest, and that it is understaffed and underfunded to carry out its broad and complex responsibilities of investigating and resolving complaints of the over 2 million elderly residents of nursing homes and board and care facilities. The report recommended increased funding to allow states to carry out the program as stipulated by law and to provide for greater program accountability.

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.—[Note to Committee staff—this paragraph should be rewritten to reflect current circumstances.]

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 SSBG program is permanently authorized by Title XX of the Social Security Act as a "capped" entitlement to States. 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 the former Aid to Families with Dependent Children (AFDC) program. The welfare reform law originally allowed States to transfer no more than 10 percent of their TANF allotments to the SSBG. This will be reduced to 4.25 percent, effective in FY2001. These transferred funds may be used only for children and families whose income is less than 200 percent of the Federal poverty guidelines. Moreover, notwithstanding the SSBG prohibition against use of funds for cash pay-

ments 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 1-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. 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 this provision to ensure program continuity and viability.

In 1984, Congress made the 90-percent pass-through requirement permanent and applicable to all States under Public Law 98–558. Currently, about 1,134 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 1995. Among the principal findings were: (1) 91 percent of CSBG funds are received by local agencies eligible for the congressionally mandated pass-through; (2) 80 percent of such eligible agencies are Community Action Agencies (CAA's); (3) approximately 71 percent of the funds received by CSBG-funded agencies come from Federal programs other than CSBG; (4) approximately 14 percent of funds received by CSBG-funded agencies come from State and local government sources; and (5) CSBG money constitutes only 6 percent of the total funds received by CSBG-funded agencies.

Local agencies from 50 States provided detailed information about their uses of CSBG funds. Those agencies used CSBG money in the following manner: emergency services (22 percent), linkages between and among programs (22 percent), nutrition programs (11 percent), education (9 percent), employment programs (9 percent), income management programs (5 percent), housing initiatives (8 percent), self-sufficiency (9 percent), health (3 percent), and other (2 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 has signed legislation to reauthorize the program twice, in 1994 and in 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 individuals served under the SSBG. However, an analysis by the Congressional Research Service found that in

FY1995, states spent approximately 10 percent of their SSBG funds for home-based services.

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 Administration, 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 1995 CSBG funds, discussed above, provides some interesting clues. Although the survey was voluntary, all but two 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 50 States show expenditures for employment services, which includes job training and referral services for the elderly, accounted for 9 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 22 percent of CSBG expenditures in fiscal year 1995. Data submitted by 38 states indicated that 19 percent of CSBG clients in fiscal year 1995 were age 55 or older, and 8 percent were older than 70.

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 and remains available for expenditure for 10 years. 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 communities 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 was scheduled to 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. Congress appropriated $2.3 billion for the program in fiscal year 1998 and $1.9 billion in fiscal year 1999, although the entitlement ceilings for those years was $2.38 billion. In addition, transportation legislation enacted in 1998 (P.L. 105–178) will reduce the entitlement ceiling to $1.7 billion, beginning in fiscal year 2001.

(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 five times: in 1984 (P.L. 98–558), in 1986 (P.L. 99–425), in 1990 (P.L. 101–501), in 1994 (P.L. 103–252), and in 1998 (P.L. 105–277). In addition to the CSBG itself, the Act authorizes various discretionary activities, including community economic development activities, rural community development activities, community food and nutrition programs, and the National Youth Sports Program.

In fiscal year 1999, appropriations are as follows: $500 million for the CSBG; $30 million for community economic development; $3.5 million for rural community facilities; $15 million for national youth sports; and $5 million for community food and nutrition. In addition, $10 million has been appropriated for a newly authorized Assets for Independence program, which will enable low-income individuals to accumulate assets in individual development accounts.

B. ADULT EDUCATION AND LITERACY

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 quality, and to address selected national education priorities.

While many strong arguments exist for the importance of formal and informal educational opportunities for older persons, such opportunities have traditionally been a low priority in education policymaking. Public and private resources for the support of edu-

cation 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.

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."

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.

Statistics on educational attainment reveal cause for concern. According to the Statistical Abstract for the United States for 1998, there are an 171 million persons who were 25 years old and over in 1997; of these, 17.9 percent (31 million) attained less than 12 years of school (Table 262). As might 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, in contrast to the 17.9 percent rate of non-completion of high school for all adults 25 years old and older, almost twice that proportion, 34.5 percent, of those 65 years old and older did not graduate from high school (Table 50). 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 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. The 102d Congress considered a number of alternatives to implement this strategy, but reached no final agreement. However, the 103d Congress reached agreement, and President Clinton signed the Goals 2000: Educate America Act into law (P.L. 103–227) on March 31, 1994, thereby enacting into law the national educational goals.

2. Program Description

The U.S. Department of Education (ED) is authorized under the Adult Education and Family Literacy Act (AEFLA) to make grants to states to provide annual educational assistance to approximately 4 million adults. These services help adults become literate and obtain educational skills needed for employment, provide parents with skills necessary for the education of their children, and assist adults complete a secondary school education. The FY1999 appropriation for Federal adult education and literacy programs is $377 million; $958 million is the estimated FY1998 contribution from state and local sources for these programs. Similar activities were previously authorized under the Adult Education Act (AEA) and the National Literacy Act of 1991 (NLA), both of which were repealed by the AEFLA in 1998.

Under the AEFLA State Grants program, allocations are made to states by formula. States in turn make discretionary grants to eligible providers for the provision of adult education instruction and services. Adults are defined as those at least 16 years of age or otherwise beyond the age of compulsory school attendance. Adult education includes services or instruction below the college level for adults who: are not enrolled in secondary school and not required to be enrolled; lack mastery of basic educational skills to function effectively in society; have not completed high school or the equivalent; and are unable to speak, read, or write the English language. Adult education services include: adult basic education and literacy; adult secondary education and high school equivalency; English-as-a-second-language; and assistance for parents to improve the educational development of their children.

With certain exceptions, the AEFLA requires state and local funds to support at a minimum 25 percent of total expenditures for adult education activities. Most states spend more than the minimum, and many spend significantly more. For FY1998, the Federal appropriation for the State Grant program was $345 million. The estimated total of Federal, state, and local expenditures related to the State Grants Program was $1.3 billion. Of this amount, states and localities spent an estimated $958 million, or 73 percent of all adult education expenditures.

In the latest year for which state enrollment data are available from all states (1996), 4.0 million adults participated in federally supported adult education and literacy programs. Of this total, 1.56 million participated in adult basic education programs, 1.56 million in English-as-a-second-language programs, and 0.93 million in adult secondary education activities. The Division of Adult Edu-

cation and Literacy at ED has estimated the adult education target population from the 1990 Census to be more than 44 million adults, or nearly 27 percent of the adult population.[1] These adults are persons 16 years and older, who have not graduated from high school or the equivalent, and who are not currently enrolled in school.

3. Legislation in the 105th Congress

P.L. 105–220, the Workforce Investment Act of 1998 (WIA), was signed into law by the President on August 7, 1998. The intent of the legislation was to extend, coordinate, and consolidate Federal programs for employment and job training, adult education and literacy, and vocational rehabilitation. Title II of WIA is the Adult Education and Family Literacy Act (AEFLA), which repealed the Adult Education Act (AEA) and the National Literacy Act of 1991, P.L. 102–73 (NLA), but amended and extended major provisions for adult education and literacy through FY2003.

Most of the programs and activities that were authorized by the AEA and funded in FY1998 are continued by the AEFLA and funded in FY1999. However, the AEFLA significantly augments previous AEA requirements through the implementation of a performance accountability system, including core indicators of performance. This system is to be used to measure program effectiveness and progress at the state and local levels and to award state incentive grants; performance results are to be considered in making local awards. In addition, the AEFLA:

- Expands the purpose of the adult education and literacy programs formerly authorized by the AEA specifically to include assistance for parents to improve the educational development of their children;
- Continues 3 out of 4 programs for adult education that were funded in FY1998, but repeals the Literacy for Incarcerated Individuals program. In addition, it authorizes a fourth program, Incentive Grants, for states exceeding expected levels of performance for specific education and job training programs;
- Authorizes to be appropriated annually from FY1999 through FY2003 such sums as may be necessary for adult education and literacy programs;
- Makes minor changes to the state allocation formula, including a 90 percent hold harmless provision for state grants;
- Terminates the eligibility of for-profit entities for receiving substate awards for conducting adult education and literacy activities;
- Simplifies the provisions for the allocation of funds within states, but authorizes a new reservation of funds (12.5 percent) at the state level for "state leadership activities";
- Clarifies that the state administrative agency must be designated consistent with state law, and repeals the AEA requirement for a state advisory council;

[1] U.S. Department of Education. Office of Vocational and Adult Education. Adult Education and Literacy Fact Sheet. Washington, January 1998.

• Simplifies the AEA provisions for national programs, and no longer requires the Secretary of Education to estimate the number of illiterate adults in the Nation every 4 years; and

• continues the National Institute for Literacy with only minor changes from the AEA provisions.

As already noted, the 105th Congress funded adult education and literacy programs at a level of $377 million for FY1999, under the provisions of P.L. 105–277, the Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999.

C. THE DOMESTIC VOLUNTEER SERVICE ACT (CHAPTER 15)

1. BACKGROUND

The purpose of the Domestic Volunteer Service Act of 1973 (DVSA), "is to foster and expand voluntary citizen service in communities throughout the Nation in activities designed to help the poor, the disadvantaged, the vulnerable, and the elderly." (42 U.S.C. 4950) The Act authorizes four major volunteer programs: the Retired and Senior Volunteer Program (RSVP), the Foster Grandparent Program, the Senior Companion Program, and the Volunteers in Service to America (VISTA) program. These programs are administered by the Corporation for National and Community Service. The Corporation was created in 1993 by The National and Community Service Trust Act of 1993 (P.L. 103–82), which combined two independent federal agencies—the Commission on National and Community Service, which administered National Community Service Act (NCSA) programs, and ACTION, which administered DVSA programs. The Corporation is administered by a chief executive officer and a bipartisan 15-member board of directors appointed by the President and confirmed by the Senate.

Funding for DVSA programs are contained in the Labor-HHS-ED appropriations act. Authorization of appropriations for the DVSA programs expired at the end of FY1996, but the programs continue to be funded through appropriations legislation for Labor-HHS–ED.

(A) NATIONAL SENIOR VOLUNTEER CORPS

Formerly known as the "Older American Volunteer Programs", the Corps consists primarily of the Foster Grandparent Program (FGP), the Senior Companion Program (SCP), the Retired and Senior Volunteer Program (RSVP). The premise of the Senior Volunteer Corps is that seniors through their skills and talents can help meet priority community needs and have an impact of national problems of local concern. In all three programs, project grants for the Corps' programs are awarded to public agencies, such as state, county, and local governments, and to private nonprofit organizations. These entities apply to the Corporations' state offices for funds to recruit, place, and support the senior volunteers.

(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. RSVP is designed to provide a variety of volunteer opportunities for persons 55 years and older. 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. 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.

In FY1997, 453,300 volunteers served in 751 projects. Roughly 86 percent were white, 9 percent were black, 4 percent were Hispanic, and 2 percent were Asian/Pacific Islanders or American Indian/Alaskan Natives. Persons under the age of 65 accounted for 17 percent of the volunteers, those between 65 and 84 accounted for 74 percent, and those 85 and older accounted for 10 percent. Women made up 75 percent of the volunteers. For FY1999 $43 million was appropriated.

(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.

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.

In general, to serve as a foster grandparent, an individual must have an income that does not exceed 125 percent of the poverty line, or in the case of volunteers living in areas determined by the Corporation to be of a higher cost of living, not more than 135 percent of the poverty line. Volunteers receive stipends of $2.55 an hour. The Domestic Volunteer Service Act exempts stipends from taxation and from being treated as wages or compensation. In an effort to expand volunteer opportunities to all older Americans, the 1986 amendments to DVSA (P.L. 99–551) permitted non-low-income persons to become foster grandparents. The non-low-income volunteers are reimbursed for out-of-pocket expenses only.

The number of active volunteers on June 30, 1997 was 25,300, of which roughly 48 percent were white, 37 percent were black, 10 percent were Hispanic, and 6 percent were Asian/Pacific Islanders or American Indian/Alaskan Natives. Persons under the age of 70 accounted for 31 percent of the volunteers, those between 70 and

79 accounted for 51 percent, and those 80 and older accounted for 18 percent. Women made up 90 percent of the volunteers.

Of the children served by the foster grandparents for FY1997, 44 percent were 5 years of age or under, 40 percent were between 6 and 12 years of age, and 16 percent were 13 and older. Over 70 percent of the volunteers served children in four "volunteer stations." The sites were public/private schools (33 percent), head start (15 percent), pre-elementary day care (14 percent), and residential long term care (10 percent). Nearly a quarter of the children had learning disabilities and nearly a fifth were developmentally delayed or disabled. Approximately 10 percent were abused or neglected. For FY1999, $93.3 million was appropriated.

(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 Omnibus Budget Reconciliation Act of 1981 (P.L. 97–35) amended section 211 of the Act to create a separate Part C containing the authorization for the Senior Companion Program.

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.

The number of active volunteers on June 30, 1997 was 13,900, of which roughly 51 percent were white, 33 percent were black, 11 percent were Hispanic, and 6 percent were Asian/Pacific Islanders or American Indian/Alaskan Natives. Persons under the age of 70 accounted for 35 percent of the volunteers, those between 70 and 79 accounted for 51 percent, and those 80 and older accounted for 14 percent. Women made up 85 percent of the volunteers.

Of the clients served by the senior companions for FY1997, 14 percent were between 22 and 44 years of age, 24 percent were between 65 and 74, 36 percent were between 75 and 84, and 26 percent were 85 and older. Over 50 percent of the volunteers served clients in five "volunteer stations." The sites were residential long-term care (12 percent), multi-purpose centers (12 percent), nursing/convalescent (12 percent), non-profit home health care (11 percent), and non-profit area agencies on agency (10 percent). Nearly half of the clients were frail elderly and nearly 10 percent had Alzheimer's disease. For FY1999, $36.6 million was appropriated.

(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. To the maximum extent possible, they live among and at the economic level of the people they serve. Volunteers receive a living allowance in FY1999 of approximately $8,730, and either a lump sum stipend that accrues at the rate of $100 for each month of service, or an educational award. In FY1997, 58 percent of the VISTA members chose the educational award. The educational award for a full time term of service (i.e. 1700 hours in a period of generally 10 to 12 months) is $4,725 and half of that amount (approximately $2,362) per part time term of service. Although individuals can serve a maximum of three terms, they can earn only a maximum of two full or partial educational awards. Awards are made at the end of the service term in the form of a voucher that must be used within 7 years after successful completion of service. Awards are paid directly to qualified postsecondary institutions or lenders in cases where participants have outstanding loan obligations. Awards can be used to repay existing or future qualified education loans or to pay for the cost of attending a qualified college or graduate school or an approved school/work program. Educational awards are taxed as income in the year they are used. Members also receive health insurance, child care allowances, liability insurance, and eligibility for student loan forbearance (i.e., postponement.) Travel and relocation expenses can also be paid to members serving somewhere other than in their own community.

In FY1997, 4,468 members completed VISTA service. Based on a random sample of members, 57 percent were white, 26 percent were African-American, 11 percent were Hispanic, and 6 percent were Asian/Pacific Islanders, American Indian or "other." Persons under the age of 30 accounted for 45 percent of the members, those between 30 and 45 accounted for 33 percent, and those 45 and older accounted for 22 percent. Women made up 80 percent of the volunteers. By statute, the Corporation is required to encourage participation of those age 18 to 27 years of age and those 55 and older. As of January, 1999, approximately 11 percent of the members were 55 and older. For FY1999, $73 million was appropriated.

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.

2. Federal Response

Three strategies have marked the Federal Government's role in providing transportation services to the elderly: direct provision (funding capital and operating costs for transit systems or other transportation services); reimbursement for transportation costs; and fare reduction. The major federally-sponsored transportation programs that provide assistance to the elderly and persons with disabilities are administered by the Department of Transportation (DOT) and by the Department of Health and Human Services (HHS).

(A) DEPARTMENT OF TRANSPORTATION PROGRAMS

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 (now known as Section 5310), 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 5310 of UMTA declares a national policy that the elderly and people with disabilities have the same rights as other persons to utilize mass transportation facilities and services. Section 5310 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 5310 programs is to provide assistance in meeting the transportation needs of the elderly and people with disabilities where public transportation services are unavailable, insufficient, or inappropriate. 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 (now known as Section 5311) 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 5311 projects due to their social and geographical isolation and thus greater need for transportation assistance. Section 5311 has received annual appropriations of approximately $65 to $75 million through 1991. Section 5311 appropriations have increased significantly for 1992 through 1998, averaging $117 million annually.

The STAA of 1982 (P.L. 97–424) established Section 5307 in its amendments to the UMTA Act. Section 5307 provides assistance to the public in general, but two of its provisions are especially important to the elderly and persons with disabilities. Section 5307 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 5307 to the Section 5311 program. Each year, between $10 million and $20 million of Section 5307 funds have been transferred to the Section 5311 program. State and local governments also have the choice of using some of the Federal highway funds for transit. In fiscal 1997, flexible highway funds of $19.7 million was transferred to Section 5311.

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. Funding for RTAP has totaled more than $4 million annually since fiscal year 1987.

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 transpor-

tation 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 funded 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 including 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 5310 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 the costs of contracting for services. Equally important, both Sections 5310 and 5311 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.

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 renamed UMTA the Federal Transit Administration FTA), provided a substantial increase in funding for programs benefitting elderly and disabled persons. Specifically, the law authorized the Section 5310 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 5311, the bill authorizes $106.1 mil-

lion 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 (now known as Section 5309) capital funding for transportation projects that specifically address the needs of elderly and disabled persons; (2) establishing a rural transit set-aside of 5.5 percent of Section 5309 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 5310 or Section 5311 to use vehicles, under certain restrictions, for meal delivery service for homebound persons.

The 105th Congress enacted the Transportation Equity Act for the 21st Century (TEA–21, P.L. 103–178). The legislation substantially increased total mass transit funding, including Section 5310 and 5311, for the fiscal years 1998 through 2003. The TEA–21 average annual Section 5310 authorization level is $196 million, compared to the previous ISTEA authorization level of $156.1 million. The average annual authorization level of Section 5311 increased to $76.1 million from the previous average annual authorization level of $71.4 million. The TEA–21 also allows for the use of up to 10 percent of the urbanized formula funds (Section 5307) for ADA demand response transit service.

(B) DEPARTMENT OF HEALTH AND HUMAN SERVICES PROGRAMS

The passage of the OAA of 1965 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 supportive services funds on three categories: access services (transportation and other supportive services); in-home, and legal services. In 1996, 2.6 million one-way assisted transportation trips, and 36.9 million non-assisted one-way transportation trips for older persons were provided by Title III. In 1996 (the latest year for which data are available), $156.8 million, representing about 8 percent, of Title III expenditures, was spent for transportation services. This funding level does not take into consideration the mix of State and local resources which also fund transportation support services.

In addition to the Older Americans Act, other programs administered by HHS support transportation services for the older persons. These include the Social Services Block Grant (SSBG) and the Community Services Block Grant (CSBG) programs. The Medicaid program supports medically-related transportation.

3. ISSUES IN TRANSPORTATION SERVICES FOR OLDER PERSONS

Transportation in Rural Areas. 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 in-

comes 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.

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.

Transportation in Suburban Areas. 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.

The 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.

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 suburban wide services, and are generally viewed as penalizing low-in-

come elderly most in need of transportation services in the community.

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.

Challenges Associated With Some Older Drivers. U.S. demographics, the availability of a modern highway system, and the lack of extensive mass transportation in some regions of the country, will result in many older Americans continuing to depend upon the automobile for their basic means of transportation. Americans like to drive, and the American automobile has become more than a tool for transportation, it has become an extension of our personalities and a status symbol. Particularly for older persons, the automobile can be a symbol of independence, security, and dignity. Establishing criteria for determining which of the elderly are safe to drive is an extremely complex issue involving States' rights, privacy rights, and Federal/State/local funding.

Older persons, however, constitute an ever growing segment of the driving public. The largest increase in this population group could come around the year 2010, when large numbers of baby boomers reach retirement age. Using 1996 data from the Department of Transportation's Fatality Analysis Reporting System, the Insurance Institute for Highway Safety (IIHS) concluded that while persons 65 years and older represented 13 percent of the population in 1996, they account for 17 percent of motor vehicle deaths. However, IIHS avoided using these data to predict any positive relationship between longevity and highway deaths.

Some claim that older drivers are unsafe. They cite newspapers stories about older drivers getting lost on the highways, driving on sidewalks, striking pedestrians at intersections, and driving in oncoming traffic lanes. Indeed, some statistics suggest that older drivers have higher rates of fatal crashes than any other age group other than young drivers. In its analysis, IIHS indicated that:

- Drivers aged 70 and older have more motor vehicle deaths per 100,000 people than other groups except people younger than 25;
- Per mile driven, drivers 75 years and older have higher rates of fatal motor vehicle crashes than drivers in other age groups except teenagers; and

- Per licensed driver, fatal crash rates rise sharply at age 70 and older.

Statistics suggest that the greatest percentage of these accidents may have been caused by an inability to make quick decisions, or to react to rapidly changing traffic conditions. They involve eye, hand, and foot coordination, the reflexes most likely to be impaired with aging. The driving instincts and experience of some older drivers may be compromised by declining motor skills or cognitive ability.

Programs to identify and address the problems of elderly drivers have been initiated in both the public and private sectors. At the Federal level, the National Highway Traffic Safety Administration (NHTSA) has studied the problems and may use its National Driving Simulator to replicate the most hazardous situations for elders. Some States require more frequent testing of the skills and abilities of elders behind the wheel. Some also provide refresher courses for any drivers receiving citations. Unfortunately, there is little uniformity in State policies. Some require re-examination every 2 years while others allow license renewal through the mail, without any examination.

In the private sector, organizations like the Insurance Institute for Highway Safety (IIHS), the American Psychological Association (APA), and TransSafety, Inc. have likewise analyzed data, looking for common denominators that may cause older drivers to be at higher risk. Both APA and TransSafety have targeted vision loss (especially the "useful field of view") as an important risk factor.

American Association for Retired Persons (AARP) has addressed problems experienced by some older drivers. Beginning in 1979, AARP has sponsored a course entitled 55 Alive: A Mature Driving Program. The course provides eight-hour safe-driver training which, when satisfactorily completed, entitles the participant to receive a certificate, redeemable with some insurance companies for a discount. Since its inception, over six million people, of all ages, have completed the course.

Through their research, a number of these organizations have identified additional factors that might lead to driving hazards. Included among these are:

- Medications that could cause impairment or confusion;
- Reduced reflexes unable to cope with imminent traffic situations;
- Road rage caused by mixing older, slower-driving persons with younger, more impetuous drivers.

Conversely, there are factors that may mitigate the hazards to older drivers.

These include:

- Longer life spans with associated better health;
- Telecommunication advances such as e-mail and video conferencing, that provide social opportunities without requiring the use of automobiles;
- Construction of elder communities, that provide recreation, transportation, and other on-site services; and
- A willingness of some elder drivers to recognize their risks and voluntarily "turn in" their keys, or to engage in safer driv-

ing habits, such as driving at other than peak traffic hours or only in the daytime.

Concerns associated with some elder drivers are actually components of a larger issue: securing transportation for an aging population. Solving the problem may require the development of short-term and long-term strategies. A short-term approach should identify those changes that can be made quickly and without extensive disruption to existing transportation infrastructure. They might include the following activities:

- Assessing key medical problems of older drivers and their potential impact on safety;
- Providing relevant medical information to licensing bureaus;
- Requiring that licensing include tests for hand, foot, and eye coordination (including useful field of view);
- Developing graduated licensing programs (similar to those now applied to new drivers);
- Offering insurance incentives (similar to those provided in the AARP program) to get elders to study their driving habits, capabilities, and difficulties;
- Changing the characteristics of traffic lights and road signs (longer caution lights at intersections and larger letters on traffic signs); and
- Promoting the development of new automotive technologies such as "night vision," to provide time to react to rapidly changing traffic situations in poor light.

In the long term, Federal and State transportation authorities may need to refocus their programs towards the needs of older drivers. Approaches could include further development and deployment of intelligent vehicles, the construction of more comprehensive mass transit systems throughout the United States, and individual financial incentives (such as Federal/State tax credits or lower fares) for using mass transit.

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 Presi-

dent. 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 about 60 percent are lawyers admitted to a State bar. In 1997, LSC funded 269 local programs. Together they served every county in the nation, as well as the U.S. territories.

Legal services provided through Corporation funds are available only in civil matters and to individuals with incomes less than 125 percent of the federal poverty guidelines. 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."

Under the appropriations statute for fiscal year 1999 (P.L. 105–277), LSC grantees may not: "engage in partisan litigation related to redistricting; attempt to influence regulatory, legislative or adjudicative action at the federal, state or local level; attempt to influence oversight proceedings of the LSC; initiate or participate in any class action suit; represent certain categories of aliens, except that nonfederal funds may be used to represent aliens who have been victims of domestic violence or child abuse; conduct advocacy train-

ing on a public policy issue or encourage political activities, strikes, or demonstrations; claim or collect attorneys' fees; engage in litigation related to abortion; represent federal, state or local prisoners; participate in challenges to federal or state welfare reforms; represent clients in eviction proceedings if they have been evicted from public housing because of drug-related activities; or solicit clients.

In addition, LSC grantees may not file complaints or engage in litigation against a defendant unless each plaintiff is specifically identified, and a statement of facts is prepared, signed by the plaintiffs, kept on file by the grantee, and made available to any federal auditor or monitor. LSC grantees must establish priorities, and staff must agree in writing not to engage in activities outside these priorities.

Grantees also are required to maintain time-keeping records and account for any nonfederal funds received. The appropriations law contains extensive audit provisions. The Corporation is prohibited from receiving nonfederal funds, and grantees are prohibited from receiving non-LSC funds, unless the source of funds is told in writing that these funds may not be used for any activities prohibited by the Legal Services Corporation Act or the appropriations law. However, grantees may use non-LSC funds to comment on proposed regulations or respond to written requests for information or testimony from federal, state, or local agencies or legislative bodies, as long as the information is provided only to the requesting agency and the request is not solicited by the LSC grantee.

(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 amendments 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 residents 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.

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. Today, OAA funds support over 600 legal programs for the elderly in greatest social and economic need.

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. According to state data for FY1996, a very small amount (0.3 percent) of SSBG funds were used for legal services.

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 ex-

ample, 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. It is estimated that older clients represent about 11 percent of the clients served by the legal services program.

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 1974, 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 representation 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—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.

(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 serv-

ices 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. 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.

On June 15, 1998, the Supreme Court issued a decision that may affect the extent to which IOLTA funds will be available for legal services in the future. These funds represent interest earned on sums that are deposited by legal clients with attorneys for short periods of time. A substantial amount of these funds $57 million in 1997, according to the LSC are used to help fund legal services programs. In *Phillips* v. *Washington Legal Foundation,* the Court ruled that these funds are the private property of clients, and returned the case to the lower court to determine whether the state (Texas, in this case) was required to compensate the clients for "taking" these funds.

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; sim-

plification 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.

Chapter 16

CRIME AND THE ELDERLY

A. VIOLENT CRIME

1. BACKGROUND

Although violence experienced by all Americans, including the elderly, has declined in the United States since 1991, the crime rate remains higher than that reported in the early 1980s. According to the 1997 Uniform Crime Reports (UCR), in the United States there is one violent crime every 19 seconds, one murder every 29 minutes, one forcible rape every five minutes, one robbery every minute, and one aggravated assault every 31 seconds.

Recent polls show that a significant number of older Americans continue to fear criminal victimization. A 1997 Time/CNN/Yankelovich Partners telephone poll found that 50 percent of respondents aged 50 to 64 years and 40 percent of those 65 years and over reported that they were personally worried about being victims of crime. A 1997 Princeton Survey Research Associates telephone poll found that 70 percent of respondents aged 50 to 59 years, 69 percent of those aged 60 to 69 years, and 62 percent of those 70 years and over reported concern about becoming crime victims.

The Federal Bureau of Investigation's (FBI's) 1997 UCR crime data, released in December 1998, suggest that the fears of many of these Americans may be unfounded. UCR statistics show that the 1.6 million violent crimes reported in 1997 declined 3.2 percent from the previous year. In November 1997, the Bureau of Justice Statistics (BJS) released a report, entitled Criminal Victimization 1996, that presents data from the National Crime Victimization Survey, including the rate of victimization per 1,000 persons aged 12 years or older. The survey data suggest a relatively low victimization rate for older Americans, with those aged 50 to 64 years having a 15.7 rate of victimization for all crimes of violence, and those 65 years and older having a 4.9 victimization rate. By comparison, youth aged 12 to 19 years had a victimization rate for violent crime 20 times higher than those age 65 years and older.

While these data appear to provide encouraging news, special problems may arise when an older person falls victim to crime. The impact of crime on the lives of older adults may be greater than on the other population groups, given their vulnerabilities. They are more likely to be injured, take longer to recover, and incur greater proportional losses to income. About 60 percent of the elderly 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 many

seniors live on social security and other fixed income, and as retirees, may not have health insurance coverage through their former place of employment, crime can devastate them financially. Crime victimization of the elderly also can wreak emotional havoc on them.

The victimization of the elderly through telemarketing fraud remains one of the leading areas of concern in the fight to combat crime against older Americans. On February 5, 1998, the Senate Appropriations Commerce, Justice, State, and Judiciary Subcommittee held a hearing, "Regarding Telemarketing Scams." Helen Boosalis, chairperson of the Board of Directors of the American Association of Retired Persons (AARP), testified that, "Telemarketing fraud is a major concern for AARP because of the severe effects it has on our members, who are victimized in disproportionate numbers." Two years after a 1993 undercover FBI operation found that older Americans constituted the single largest group of people specifically targeted by fraudulent telemarketers, AARP sponsored a major survey of telemarketing fraud victims. Ms. Boosalis reported:

> The purpose of the survey was to learn more about how this crime affects older Americans. We found that older people are victimized much more frequently than young people are. More than half of the victims of telemarketing fraud are over age 50, although only 36 percent of the population is in this age group. While only 7 percent of the population are age 75 or older, 14 percent of victims are in that age bracket.
>
> AARP's survey found that victims typically are not the socially isolated, ill-informed, confused people described anecdotally. In fact, victims are just as likely to be relatively affluent, well-educated and informed. They are active in their communities and express many of the same attitudes towards telemarketers as do non-victims. * * * Additional AARP qualitative research revealed that though older consumers knew telemarketing fraud was wrong, they found it hard to believe that it was a crime.

Ms. Boosalis stated that AARP had joined with the FBI, the National Association of Attorneys General (NAAG), the U.S. Postal Inspection Service, and other agencies in December 1996 to initiate "Operation Unload," a project to alert consumers that they might be targeted by illegal telemarketers."

2. Congressional Response

During the 105th Congress (1997–1998), several bills were introduced in both houses of Congress that focused on crime and the elderly. Congress enacted the Telemarketing Fraud Prevention Act (P.L. 105–184). Introduced on June 10, 1997, the measure (H.R. 1847/Goodlatte) passed the House, amended, on July 8, 1997, and passed the Senate with an amendment in the nature of a substitute on November 9, 1997. Signed into law on June 23, 1998, the act enhances penalties for persons convicted of telemarketing fraud; provides for the forfeiture of property used in the offense, or

gained by the offender, in the commission of the crime; and clarifies mandatory restitution provisions that the offender must meet.

On July 2, 1998, Senator Judd Gregg introduced the Commerce, Justice, State Appropriations bill for FY1999 (S. 2260). On July 23, Senator Richard Durbin offered an amendment (S. Amdt. 3312) to the bill to amend the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103–322) to ensure greater protection of elderly women from domestic violence under the Violence Against Women Act grant program. Authorized by the Violence Against Women Act of 1994 (P.L. 103–322), the program provides funding to address the needs and concerns of women who have been, or might be, victimized by violence. Grant programs also provide technical assistance to state and tribal government officials in planning new criminal justice efforts in this area. Stating that several research studies have concluded that elder abuse is the most underreported crime in the family, Senator Durbin remarked:

> Those who perpetrate violence against their family members do not desist because the family member grows older. In fact, in some cases, the abuse may become more severe as the victim ages, becoming more isolated from the community with their removal from the workforce. Other age-related factors, such as increased frailty, may increase a victim's vulnerability. It also is true that older victims' ability to report abuse is frequently confounded by their reliance on their abuser for care or housing.

The amendment would have made the Violence Against Women Act grant program more sensitive to the needs of elderly women suffering from domestic violence. Though the Senate approved the amendment, it did not appear in the final version of the bill included in the Omnibus Consolidated and Emergency Supplemental Appropriations Act (P.L. 105–277).

Like Senator Durbin's amendment, two other bills introduced in the 105th Congress would have amended the Violence Against Women Act grant program to protect older women. On April 1, 1998, Representative Carolyn Maloney introduced the Older Women's Protection from Violence Act of 1998 (H.R. 3624). The bill would have amended the Violence Against Women Act of 1994 to direct the Attorney General to provide grants to law school clinical programs to fund the inclusion of cases, including issues of elder abuse, neglect, and exploitation; and to develop curricula and provide for the offering of training programs regarding such issues for law enforcement officers, prosecutors, and relevant federal, state, and local court officials. On May 22, 1998, Senator Durbin introduced a companion bill (S. 2114).

On March 19, 1998, Representative John Conyers, ranking member of the House Judiciary Committee, introduced an omnibus measure, the Violence Against Women Act of 1998 (H.R. 3514), containing a provision similar to that in H.R. 3624/S. 2114. None of these bills received approval in the respective chambers.

B. ELDER ABUSE

1. BACKGROUND

Elder abuse affects hundreds of thousands of older persons annually, yet remains largely a hidden problem. The National Center on Elder Abuse (NCEA) (within the American Public Human Services Association) has identified a number of types of abuse: physical, sexual, emotional or psychological abuse, financial or material exploitation, abandonment, self-neglect, or neglect by another person. According to the Administration on Aging (AoA), the most common forms of elder abuse are physical and psychological abuse, financial exploitation, and neglect.

The NCEA has been collecting data on reports of domestic elder abuse since 1986. Until recently, data on national trends in elder abuse have been based on the results of surveys of state adult protective services agencies and state agencies on aging. However, a groundbreaking study, completed by the NCEA in 1998, assessed the incidence of elder abuse nationwide. The study was completed in collaboration with Westat, Inc. for the Administration for Children and Families, and AoA, in the Department of Health and Human Services (HHS).[1]

This study found that almost 550 thousand persons aged 60 and over experienced various forms of abuse, neglect, and/or self-neglect in domestic settings in 1996. Based on an estimate of unreported incidents, the study concluded that almost four to five times more new incidents of elder abuse, neglect, and/or self-neglect were unreported in 1996. Generally, elder abuse is difficult to identify due to the isolation of older persons and reluctance of older persons and others to report incidents. Underreporting of abuse represents what some researchers have called the "iceberg" theory, that is, the number of cases reported is simply indicative of a much larger societal problem. According to this theory, the most visible types of abuse and neglect are reported, yet a large number of other, less visible forms of abuse go unreported.

Victims of elder abuse are more likely to be women and persons in the oldest age categories. Abusers are more likely to be male and most are related to victims. The NCEA study indicated that adult children represent the largest category of abusers.

According to AoA, state legislatures in all states have enacted some form of legislation that authorizes states to provide protective services to vulnerable adults. In about three-quarters of the states, these services are provided by adult protective service (APS) units in state social services agencies; in the remaining states, state agencies on aging carry out this function. Most states have laws that require certain professionals to report suspected cases of abuse, neglect and/or exploitation. In 1996, 23 percent of all domestic elder abuse reports came from physicians, and another 15 percent came from service providers. In addition, family members, neighbors, law enforcement, clergy and others made reports.

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[1] The National Elder Abuse Incidence Study. Final Report. National Center on Elder Abuse, American Public Human Services Association. In collaboration with Westat, Inc. September 1998. http://www.aoa.gov/abuse/report/

2. Federal Programs

The primary source of federal funds for elder abuse prevention activities are the Social Services Block Grant (SSBG) and the Older Americans Act (OAA) program. The SSBG (along with state funds) support activities of APS units in all states. The Older Americans Act supports a number of activities including training for APS personnel, law enforcement personnel, and others; coordination of state social services systems, including the use of hotlines for reporting; technical assistance for service providers; and public education activities.

C. CONSUMER FRAUDS AND DECEPTIONS

1. Background

According to the 1990's national census figures, 70 percent of the wealth of our country is owned by persons fifty-five and older. In addition, the age 65 and over market is a lucrative source of consumers who spend over $60 billion annually. These facts, 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 amount of money being fleeced, primarily from those over fifty-five, is immense: $40 billion a year from telemarketing scams alone according to the FBI. In addition, health fraud is costing the elderly about $25 billion a year in phoney health products. Unfortunately, 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 cures for ailments; to the healthy, they offer attractive vacation deals; and to those who are fearful of the future, they offer a confusing array of useless insurance plans.

Congress has held numerous hearings in recent years 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 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.

Congress and the Federal Trade Commission have 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 has also imposed tougher penalties on telemarketers who intentionally target senior citizens.

At the end of 1998, the Justice Department completed 2½ years of its Operation Double Barrel, a massive federal and state sting operation designed to catch telemarketers who fraudulently promise people prizes or other special items in return for a fee. The victims, mostly elderly, typically pay by credit card, but the prizes never arrive. To stop this illegal activity, the FBI and 35 state attorneys general used police and senior citizen volunteers to field phone calls from unsuspecting, dishonest telemarketers. To date, nearly 1,000 people have been charged with violating federal or state fraud laws, and 150 have been convicted.

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. Elderly consumers are frequently the least able to rebound from being victimized.

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. In addition, older citizens are often trusting and willing to talk to strangers, and often lack the skills to end a potentially fraudulent phone call.

Con artists are well organized, sophisticated, and effective. Police authorities report that it is not uncommon for a con artist, upon leaving one successful location, to exchange the addresses of his easiest victims with another con artist who is just moving into the area. To avoid being caught, con artists 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 frequently used by fraudulent marketeers is the so-called "sweepstakes" or "free giveaways" scheme. 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.

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. To this end, there has been increased coordination on the federal and state levels, as well as an emerging public-private partnership designed to promote public awareness among the elderly of consumer fraud scams and how to avoid them.

SUPPLEMENT 1

BRIEF SYNOPSIS OF HEARINGS AND WORKSHOPS HELD IN 1997 AND 1998

The Senate Special Committee on Aging, convened 19 hearings, 6 field hearings, and 8 forums during the 105th Congress.

HEARINGS

March 6, 1997—Retiring Baby Boomers: Meeting the Challenge
April 10, 1997—Improving Accountability in Medicare Managed Care: The Consumers Need for Better Information
April 29, 1997—Torn Between Two Systems: Improving Chronic Care in Medicare and Medicaid
May 19, 1997—Medicare Payment Reform: Increasing Choice and Equity
June 16, 1997—Shortchanged: Pension Miscalculations
July 28, 1997—JACKPOT: Gaming the Home Health Care System
September 23, 1997—Hearing on Prostate Cancer: The Silent Killer
February 10, 1998—A Starting Point for Reform: Identifying the Goals of Social Security
March 9, 1998—The Cash Crunch: The Financial Challenge of Long-Term Care for the Baby Boomer Generation
March 16, 1998—Equity Predators: Stripping, Flipping and Packing their way to Profits
March 31, 1998—Access to Care: The Impact of the Balanced Budget Act on Medicare Home Health Services
April 22, 1998—The Stock Market and Social Security: The Risks and the Rewards
May 6, 1998—Choosing a Health Plan: Providing Medicare Beneficiaries with the Right Tools
June 2, 1998—Preparing Americans for Retirement: The Roadblocks to Increased Savings
June 8, 1998—The Graying of Nations: Productive Aging Around the World
July 15, 1998—Living Longer, Retiring Earlier: Rethinking the Social Security Retirement Age
July 27 and 28, 1998—Betrayal: The Quality of Care in California Nursing Homes
September 10, 1998—Everyday Heroes: Family Caregivers Face Increasing Challenges in an Aging Nation
September 14, 1998—Crooks Caring for Seniors: The Case for Criminal Background Checks

FIELD HEARINGS

August 25, 1997—2010 and Beyond: Preparing Medicare for the Baby Boomers, Sioux City, IA

August 26, 1997—2010 and Beyond: Preparing Social Security for the Baby Boomers, Omaha, NE
January 12 and 13, 1998—The Many Faces of Long-Term Care: Today's Bitter Pill or Tomorrow's Cure, Las Vegas, NV and Reno, NV
February 18, 1998—Preparing for the Retirement of the Baby Boom Generation, Baton Rouge, LA
April 27, 1998—Elder Care Today and Tomorrow, Columbus, OH
June 30, 1998—Preserving America's Future Today, Bala Cynwyd, PA

FORUMS

July 25, 1997—Preparing for the Baby Boomers Retirement: The Role of Employment
June 24, July 8, July 15, and July 22, 1997—Medicaid Managed Care: The Elderly and Others with Special Needs
October 22, 1997—The Risk of Malnutrition in Nursing Homes
May 13, 1998—Transforming Health Care Systems for the 21st Century Issues and Opportunities for Improving Health Care
May 20, 1998—Living Longer, Growing Stronger: The Vital Role of Geriatric Medicine
July 16, 1998—Older Americans and the Worldwide Web: A New Wave of Internet Users
September 10, 1998—Easing the Family Caregiver Burden: Programs Around the Nation
September 18, 1998—Can We Rest in Peace? The Anxiety of Elderly Parents Caring for Baby Boomers with Disabilities

RETIRING BABY BOOMERS: MEETING THE CHALLENGES, WASHINGTON, DC, MARCH 6, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Gail Wilensky, chair, Physician Payment Review Commission
David M. Walker, partner, Global Managing director, Arthur Andersen LLP
Dallas L. Salisbury, president, Employee Benefit Research Institute; chair, American Savings Education Council; member, National Commission on Retirement Policy
Madelyn Hochstein, president and co-founder, DYG, Inc
Barry Bosworth, senior fellow, Economics Studies, Brookings Institution
Olivia Mitchell, professor of Insurance and Risk Management, Wharton School, University of Pennsylvania
Dr. Robert N. Butler, M.D., professor5 of Geriatrics, director, International Longevity Center, Mount Sinai Medical Center; vice chairman, Alliance for Aging Research
H. James Towey, president, Commission on Aging with Dignity

SYNOPSIS

This hearing sought to provide an overview of the mounting challenges facing older Americans today. It will look at the affects of the impending Baby Boomer retirement on society, the public per-

ception of this demographic shift, and ways in which to meet this change.

IMPROVING ACCOUNTABILITY IN MEDICARE MANAGED CARE: THE CONSUMER'S NEED FOR BETTER INFORMATION, WASHINGTON, DC , APRIL 10, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Irvin Stuart, Medicare Beneficiary, Bronx, NY
Diane Archer, executive director, Medicare Rights Center, New York, NY
William Scanlon, director, Health Financing and Systems Issues, General Accounting Office
Helen Darling, manager, Healthcare Strategy and Programs, Xerox Corporation, representing the Institute of Medicine
Margaret Stanley, assistant executive officer, Health Benefits Service, California Public Employees Retirement System CalPERS)

SYNOPSIS

This hearing examined how access to information about Medicare managed care plans can affect consumer decision making. The Committee will seek to determine if standardized information should be made available to beneficiaries and, if so, what are the best methods for providing the information.

TORN BETWEEN TWO SYSTEMS: IMPROVING CHRONIC CARE IN MEDICARE AND MEDICAID, WASHINGTON, DC, APRIL 29, 19974, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Karin von Behren, volunteer, Orange County Alzheimer's Association
Sue Paul, Augusta, ME
Richard Bennett, M.D., executive medical director for long term care, John Hopkins Geriatrics Center
Lucy Nonnenkamp, project director, Medicare Plus II, Kaiser Permanente
Jeanne Laily, vice president, Continuum Services and Chronic Care, Fairview Hospital and Healthcare Services
William Scanlon, director, Health Financing and Systems Issue, Health, Education and Human Services Division, U.S. General Accounting Office
Bruce Bullen, commissioner, Massachusetts Division, of Medical Assistance
Pamela Parker, director, Minnesota Seniors Health Options, St. Paul, MN
Barbara Markham Smith, senior research staff, Center for Health Policy Research, Washington, DC

SYNOPSIS

The Committee examined the treatment received by chronically ill persons who are eligible for both Medicare and Medicaid. The lack of coordination in treating these dual eligibles can lead to a deterioration on their quality of life and waste scarce health care

dollars. The Committee will look for ways to restructure the chronic health care delivery system in order to better serve persons currently thrown back and forth between Medicare and Medicaid.

MEDICARE PAYMENT REFORM: INCREASING CHOICE AND EQUITY, WASHINGTON, DC, MAY 19, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Hans Running, Medicare Beneficiary
William Scanlon, director, Health Financing and Systems Issue, Health, Education and Human Services Division, U.S. General Accounting Office
Steve Brenton, president and CEO, Association of Iowa Hospitals and Health Systems
Doug Dillon, Medicare Program Executive, Providence Health Plans
Susan Foote, president, Coalition for Fairness in Medicare
David Colby, Ph.D., deputy director, Physician Payment Review Commission
Kenneth Thorpe, Ph.D., professor, Department of Health Systems Management; director, Institute for Health Services Research; Tulane University School of Public Health and Tropical Medicine

SYNOPSIS

The Committee examined the current Medicare payment system, focusing on managed care payment. People have expressed concern that the lack of equity within the system denies many "low payment area" Medicare beneficiaries the same choice of joining a managed care plan that "high payment area" beneficiaries enjoy. Medicare managed care plans usually offer benefits, such as pharmaceuticals and lower co-pays, not available to standard fee-for-service enrollees. The Committee will look for ways to restructure the current payment system to bring equity and choice to all beneficiaries.

SHORTCHANGED: PENSION MISCALCULATIONS, WASHINGTON, DC JUNE 16, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Edwin Witgort, retired from Castle Metals
Paul Francione, retired from Pan Am Airlines
Edgar Pauk, deputy director, Legal Services for the Elderly
Allen Engerman, National Center for Retirement Benefits, Inc
Trip Reid, coordinator of Technical Assistance Projects, Pension Rights Center
Thomas Walker, president, Associated Benefits Corporation

SYNOPSIS

The Committee sought to expose the problem of pension miscalculations. Currently, few people check to make sure the pension they receive is correct. The Committee will look for ways to expose this hidden problem, educate people on the steps they can take to

protect themselves, and empower people with the tools they need to protect their pension benefits.

PREPARING FOR THE BABY BOOMERS' RETIREMENT: THE ROLE OF EMPLOYMENT, WASHINGTON, DC JULY 25, 1997

WITNESSES

Alan Reynolds, director of Economic Research at the Hudson Institute
John Rother, director of Legislation and Public Policy for the American Association of Retired Persons
Michael Barth, executive VP of ICF Kaiser International's Consulting Group
Richard Burkhauser, professor of economics at Syracuse University and at the Maxwell School
Colin Gillion, director of Social Security at the International Labor Organizations in Geneva, Switzerland
Scott Bass, Dean of the Graduate School and Vice Provost for Research at the University of Maryland-Baltimore County

SYNOPSIS

This forum discussed the possibility that Baby Boomers may have to remain in the workforce longer than their parents. Some questions addressed were: What impact will older workers have on the job market? How will the job market respond to older workers? Are Baby Boomers ready to delay retirement from the workforce? Will the situation lead to stress between Baby Boomers and younger generations?

JACKPOT: GAMING THE HOME HEALTH CARE SYSTEM, WASHINGTON, DC, JULY 28, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Jeanette G. Garrison, convicted Home Health Care Felon
George F. Grob, Deputy Inspector General for Evaluation and Inspections, Office of the Inspector General, Department of Health and Human Services
Leslie G. Aronovitz, Associate Director, Health Financing and Systems Issues, Health, Education and Human Services Division, U.S. General Accounting Office
Mary L. Ellis, vice president for Medicare, Wellmark, Inc
Bobby P. Jindal, secretary, Louisiana Department of Health and Hospitals

SYNOPSIS

The Committee sought to examine the depth of fraud in the home health care system, schemes used to defraud the health care system, and deficiencies in the current home health care systems; and potential solutions available. The committee will look for ways to reduce the amount of fraud in home health and for ways to get citizens involved in identifying and deterring fraud, waste, and abuse in health care.

MEDICAID MANAGED CARE: THE ELDERLY AND OTHERS WITH SPECIAL NEEDS, WASHINGTON, DC, JUNE 24, 1997, JULY 8, 1997, JULY 15, 1997, AND JULY 22, 1997, MS. SUSAN CHRISTENSEN, PRESIDING

WITNESSES

Tony Young, policy associate, United Cerebral Palsy Association
Alfonso V. Guida, Jr., vice president, National Mental Health Association
Kathleen H. McGinley, assistant director for Governmental Affairs,
Nancy Leonard, Care Manager, Connecticut Community Care on behalf of the Alzheimer's Disease and Related Disorders Association
Donald Minor, client advocate, Caremark on behalf of the National Association of People with AIDS

William J. Scanlon, director, Health Financing and Systems Issue Area, U.S. General Accounting Office
Barbara Markham Smith, Senior Research Staff Scientist, Center for Health Policy Research, The George Washington University
Patricia A. Riley, vice president of Government Programs, Policy and Planning for Allina Health System, Medica Health Plans

William J. Scanlon, director, Health Financing and Systems Issue Area, U.S. General Accounting Office
A. Michael Collins, deputy executive director, Center for Health Program Development and Management, University of Maryland at Baltimore County
John Ware, Jr., senior scientist and director, The Health Institute at New England Medical Center
Trish MacTaggart, director, Quality and Performance Management, Center for Medicaid and State Operations, Health Care Financing Administration

William J. Scanlon, director, Health Financing and Systems Issue Area, U.S. General Accounting Office
Barbara Shipnuck, deputy secretary for Health Care Policy, Finance and Regulation, State of Maryland Department of Health and Mental Hygiene
Peggy L. Bartels, director, Division of Health, Bureau of Health Care Financing, Wisconsin Medicaid Program
Jane Horvath, director Special Initiatives, National Academy for State Health Policy
Stephen A. Somers, president, Center for Health Care Strategies, Inc

SYNOPSIS

The Senate Special Committee on Aging held a series of four forums: people with special needs, state of the industry, quality and outcome measures, and the state of the states, designed to examine the ability of managed care programs to serve the elderly and others with special needs. The purpose of the forums is to give Congress an understanding of these challenges as states are seeking more flexibility in mandating Medicaid managed care.

2010 AND BEYOND: PREPARING MEDICARE FOR THE BABY BOOMERS, SIOUX CITY, IA, AUGUST 25, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Joseph R. Antos, assistant director for Health and Human Resources, Congressional Budget Office
Merton C. Bernstein, Walter D. Coles Professor of Law Emeritus, Washington University in St. Louis
Robert E. Moffit, Ph.D., deputy director of Domestic Policy Studies, The Heritage Foundation
John C. Goodman, president, National Center for Policy Analysis

2010 AND BEYOND: PREPARING SOCIAL SECURITY FOR THE BABY BOOMERS, OMAHA, NE, AUGUST 26, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Stephen C. Goss, deputy chief actuary, Social Security Administration
C. Eugene Steuerle, Ph.D., senior fellow, The Urban Institute
Helen Boosalis, board chair, American Association of Retired Persons
Sylvester J. Schieber, Ph.D., vice president, Watson Wyatt Worldwide

SYNOPSIS

The Committee examined the financing challenges facing Social Security and Medicare following the year 2010 when the large Baby Boom generation begins to retire. The Aging Committee helped to start a national dialog on these issues so that a national consensus can be formed and implemented well before the crisis of program bankruptcy becomes a reality. The hearing will seek input from Americans on the future of the two vitally important programs.

HEARING ON PROSTATE CANCER: THE SILENT KILLER, WASHINGTON, DC, SEPTEMBER 23, 1997, the Honorable Charles Grassley, Presiding

WITNESSES

Hon. Robert Dole, former U.S. Senator from the State of Kansas
Len Dawson, NFL Hall of Fame Quarterback
Mr. and Mrs. Bob Watson, General Manager, New York Yankees
Hon. Robert Miller, Governor, State of Nevada
E. David Crawford, M.D., University of Colorado Health Sciences Center
Col. David G. McLeod, M.D., chief, Urology Service, Walter Reed Army Medical Center
Richard J. Babaian, M.D., the University of Texas
Thomas V. Holohan, M.D., F.A.C.P., Chief Patient Care Services Offices, Veterans Health Administration, Department of Veterans Affairs
Harold Sox, M.D., Dartmouth Medical School

SYNOPSIS

The Committee sought to raise public awareness of prostate cancer, examine the different screening and treatment options, and address the debate over when treatment is appropriate. Prostate cancer is the second leading cause of male cancer deaths. The American Cancer Society predicts more than 330,000 new cases will be diagnosed in the United States this year.

THE RISK OF MALNUTRITION IN NURSING HOMES, WASHINGTON, DC, OCTOBER 22, 1997, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

L. Gregory Pawlson, M.D., M.P.H. director, Institute for Health Policy Outcomes and Human Values, George Washington University
Jeanie Kayser-Jones, Ph.D., professor, Physiological Nursing and Medical Anthropology, University of California at San Francisco
Ilene Henshaw, family member of Nursing Home Resident
Joseph Malloy, family member of Nursing Home Resident
Eric Tangalos, M.D., Head of Geriatrics, Mayo Clinic
Catherine Hawes, Ph.D., director of Program on Aging and Long-Term Care, Research Triangle Institute
Susan Flagge, Training Coordinator, Providence Mount St. Vincent, Seattle, WA
Susan Misiorski, vice president of Nursing, Apple Health Care
Loretta Grover, regional dietitian, Genesis Health Ventures

SYNOPSIS

This forum was designed to examine malnutrition in nursing homes and highlight the "best practices" to reduce the chances for malnutrition to occur. The forum was a balanced and constructive discussion about nutrition in nursing homes, with particular attention to the causes, extent and consequences of malnutrition. The Committee also focused discussion on ways to improve nutrition in nursing homes.

THE MANY FACES OF LONG-TERM CARE: TODAY'S BITTER PILL OR TOMORROW'S CURE, LAS VEGAS, NV, JANUARY 12, 1997, AND RENO, NV, JANUARY 13, 1997, THE HONORABLE HARRY REID, PRESIDING

WITNESSES

Jeanette Takamura, Assistant Secretary for Aging
Charles Bernick, M.D., Department of Internal Medicine Division of Neurology, University of Nevada School of Medicine
Josephine George, Las Vegas resident
Frankie Sue Del Papa, Attorney General, State of Nevada
Carla Sloan, Administrator, Division for Aging Services, Department of Human Resources
Rick Panelli, Chief, Bureau of Licensure and Certification, Nevada State Health Division
Lawrence J. Weiss, Ph.D., Director, Sanford Center for Aging, University of Nevada

Margaret McConnell, R.N., Administrator, Charleston Retirement and Assisted Living
Winthrop Cashdollar, Executive Director of the Nevada Health Care Association
Lea Mason, R.N., Secretary, Home Health Care Association of Nevada
Steven L. Phillips, M.D., C.M.D., Medical Director, Social Health Maintenance Organization, Senior Dimensions, Sierra Health Services, Inc

Hon. James A. Gibbons, A Representative in Congress from the State of Nevada
Jeanette Takamura, Assistant Secretary for Aging
Charles Bernick, M.D., Department of Internal Medicine Division of Neurology, University of Nevada School of Medicine
Carol Hunter, mother of Janet Hunter, A Nursing Home Resident
Frankie Sue Del Papa, Attorney General, State of Nevada
Carla Sloan, Administrator, Division for Aging Services, Department of Human Resources
Rick Panelli, Chief, Bureau of Licensure and Certification, Nevada State Health Division
Lawrence J. Weiss, Ph.D., Director, Sanford Center for Aging, University of Nevada
Wendy Van Curen Simons, Administrator, Park Place, Assisted Living Residential Neighborhood for Seniors
Winthrop Cashdollar, Executive Director of the Nevada Health Care Association
Donna J. Shilinksy, R.N., M.S., Community Care Associates
Steven L. Phillips, M.D., C.M.D., Medical Director, Social Health Maintenance Organization, Senior Dimensions, Sierra Health Services, Inc

SYNOPSIS

The Committee examined current issues facing long-term care such as patient safety, quality of care, options of care, and accountability in the delivery of long-term care. It also took a look into the future and discussed how the nation and the individual states can ensure that Americans have available and affordable quality care.

A STARTING POINT FOR REFORM: IDENTIFYING THE GOALS OF SOCIAL SECURITY, WASHINGTON, DC, FEBRUARY 10, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Ken Apfel, Commissioner, Social Security Administration
Hon. Tim Penny, Fiscal Fellow, CATO Institute, former Representative in Congress from the State of Minnesota
Joseph Perkins, President-elect American Association of Retired Persons
Fidel Vargas, Member, 1994–1995 Advisory Council on Social Security
Jane Ross, Director for Income Security, U.S. General Accounting Office

SYNOPSIS

The Committee will identify the core goals that a public retirement program should try to achieve and the priority that should be given to these goals. By focusing on the objectives that Americans expect reform to achieve, the Committee hopes to promote an understanding of the different objectives different groups advocate in their approaches to social security reform. The reform process can advance more effectively if the public and policy makers focus first on reaching agreement on the goals that must be achieved by the social security system.

PREPARING FOR THE RETIREMENT OF THE BABY BOOM GENERATION, BATON ROUGE, LA, FEBRUARY 18, 1998, THE HONORABLE JOHN BREAUX, PRESIDING

WITNESSES

Hon. Ken Apfel, Commission of Social Security
Hon. Nancy-Ann Min DeParle, Administrator Health Care Financing Administration
Jeanette C. Takamura, Assistant Secretary for Aging, Department of Health and Human Services
David M. Walker, Partner, Global Managing Director Arthur Andersen LLP
Kenneth E. Thorpe, Vanselow Professor of Health Policy, and Director, Institute for Health Services Research, Tulane University School of Public Health and Tropical Medicine
Al From, president, Democratic Leadership Council

SYNOPSIS

The purpose of the hearing was to raise awareness about major challenges facing Social Security and Medicare. The rapidly aging population has brought the reform of these programs to the top of the national policy agenda.

THE CASH CRUNCH: THE FINANCIAL CHALLENGE OF LONG-TERM CARE FOR THE BABY BOOMER GENERATION, WASHINGTON, DC, MARCH 9, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Donna Harvey, executive director, Hawkeye Valley Area Agency on Aging
Lynda Gormus
William J. Scanlon, Ph.D., director, Health Financing and Systems Issues, General Accounting Office
Mathew Greenwald, Ph.D., Mathew Greenwald and Associates
Samuel Morgante, vice president, Product Development and Government Relations, GE Capital Assurance Company, and chair, Health Insurance Association of America Long-Term Care Committee
JaneMarie Mulvey, Ph.D., director, Economic Research, American Council of Life Insurance
Barbara Stucki, Ph.D., senior research analyst, American Council of Life Insurance

Joshua M. Wiener, Ph.D., principal research associate, The Urban Institute
Roger Auerbach, administrator, Senior and Disabled Services Division, Oregon Department of Human Resources
Alan Lazaroff, M.D., director of Geriatric Medicine, Centura Senior Life Center
Mark J. Schulte, president and chief executive officer, Brookdale Living Communities, Inc

SYNOPSIS

The Committee plans to raise awareness of the risk to retirement income posed by the need for long term care services and to review public and private initiatives that might make long-term care more available and affordable for older Americans. Of particular interest was the examination of how retirement of the baby boomer generation will impact the demand for long-term care, the ability of public budgets to provide those services, and the projected retirement income of baby boomers.

EQUITY PREDATORS: STRIPPING, FLIPPING AND PACKING THEIR WAY TO PROFITS, WASHINGTON, DC, MARCH 16, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Helen Ferguson
Gael Carter
Vireta Jackson Arthur
Jim Dough, former employee of a predatory lender
Gene A. Marsh, professor of law, University of Alabama Law School
Jodie Bernstein, director, Bureau of Consumer Protection, Federal Trade Commission
William J. Brennan, Jr., director, Home Defense Program, Atlanta Legal Aid Society

SYNOPSIS

This hearing focused specifically on predatory lending practices and their impact on seniors. The purpose of the hearing is to expose these predatory lending practices, to educate seniors on how to spot problems before they sign a loan or mortgage, and to empower seniors with information sot that they can avoid these practices in the future.

ACCESS TO CARE: THE IMPACT OF THE BALANCED BUDGET ACT ON MEDICARE HOME HEALTH SERVICES, WASHINGTON, DC, MARCH 31, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Nancy-Ann Min DeParle, administrator, Health Care Financing Administration
Barbara Markham Smith, senior research staff, Center for Health Policy Research, George Washington University Medical Center
Cindi Slack, executive director, Sioux Valley Hospital Visiting Nurses Association

David J. Martin, administrator and co-owner, Apple Home Healthcare, Inc., and co-owner, Metro Preferred Health Care, Inc
William A. Dombi, vice president, National Association for Home Care
Linda Fanton, administrator/owner, Eastern Iowa Visiting Nurses and Home Health Care
James C. Pateidl, Third vice president, National Association of Surety Bond Producers

SYNOPSIS

The Committee examined three important policy changes that will impact seniors' access to home health care. The changes came through the Balanced Budget Act of 1997 at the urging of the Federal Home Care Financing Administration. The Committee will explore the effects of these policy changes and urge a resolution of the unintended problems that affect seniors' access to home health care.

THE STOCK MARKET AND SOCIAL SECURITY: THE RISKS AND THE REWARDS, WASHINGTON, DC, APRIL 22, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Barbara Bovbjerg, associate director, Income Security Issues, General Accounting Office
Bruce MacLaury, chairman, subcommittee on Social Security Reform, Committee for Economic Development
Alicia Munnell, former member, Council of Economic Advisors, Boston College
Olivia S. Mitchell, co-chair, Social Security Advisory Council Technical Panel, Wharton School of the University of Pennsylvania
James Phalen, managing director, Retirement Investment Services; executive vice president, State Street Global Advisors
Louis Enoff, former commissioner, Social Security Administration, Enoff Associates

SYNOPSIS

The Committee examined whether the stock market could have a role in saving Social Security. The Committee released a General Accounting Office (GAO) report that examines the issue and heard testimony from experts on which stock investing approach would be best.

ELDER CARE TODAY AND TOMORROW, WASHINGTON, DC, APRIL 27, 1998, THE HONORABLE JOHN GLENN, PRESIDING

WITNESSES

Bernadine P. Healy, M.D., dean, The Ohio State University College of Medicine and Public Health
Robert N. Butler, M.D., chairman and CEO, International Longevity Center
Bonnie S. Kantor, SC.D., director, Office of Geriatrics and Gerontology, The Ohio State University College of Medicine and Public Health

Connie M. Schmitt, director, TriHealth SeniorLink
Martin Janis, senior consultant
Matt Ottiger, legislative liaison, Ohio Department of Aging
Cindy Farson, director, Central Ohio Area Agency on Aging

SYNOPSIS

This field hearing highlighted successful aging research and geriatric training programs in Ohio. It focused on programs to provide medical and social support to older Americans in their homes and communities.

CHOOSING A HEALTH PLAN: PROVIDING MEDICARE BENEFICIARIES WITH THE RIGHT TOOLS, WASHINGTON, DC, MAY 6, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Michael Hash, Deputy Director, Health Care Financing Administration
William J. Scanlon, Director, Health Finance and System Issues Area, General Accounting Office
Susan Kleimann, Ph.D., Kleimann Communications Group, LLC
Geraldine Dallek, MPH project director, Institute for Healthcare Research and Policy, Georgetown University
David S. Abernethy, senior vice president, Public Policy and Regulatory Affairs, HIP Health Plans

SYNOPSIS

The Committee listened to how the government plans to give Medicare beneficiaries more information to help them sort through the increased number of health care options they face. The committee released a new General Accounting Office (GAO) report on the disenrollment of beneficiaries from Medicare managed care plans.

TRANSFORMING HEALTH CARE SYSTEMS FOR THE 21ST CENTURY ISSUES AND OPPORTUNITIES FOR IMPROVING HEALTH CARE, WASHINGTON, DC, MAY 13, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Andrea S. Gerstenberger, SC.D., Senior Program Officer, California Healthcare Foundation
Richard Bringewatt, president and CEO, National Chronic Care Consortium
Myrl Weinberg, president, National Health Counsel
Susan Denman, M.D., vice president for Medical Affairs, Philadelphia Geriatric Center and Temple University Health System
Gerard Anderson, professor, Johns Hopkins University
Mark Meiners, Ph.D., director, Robert Wood Johnson Foundation Medicare/Medicaid Integration Program

SYNOPSIS

Meeting the needs of a growing chronically-ill population in the United States will place tremendous strain on our current health care financing systems. The five participants in this forum outlined a policy framework for identifying the problems within our current system, as well as highlighted innovative solutions. Four issues drove the discussion: demographics, financing, structure of delivery systems and regulation.

LIVING LONGER, GROWING STRONGER: THE VITAL ROLE OF GERIATRIC MEDICINE, WASHINGTON, DC, MAY 20, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Violet Cosgrove, Older Consumer
John Murphy, M.D., associate professor and residency director, Division of Geriatrics, Department of Family Medicine, Brown University
Susan Klein, HM, DNSC, RN, Bureau of Health Professions, Health Resources and Services Administration
Steven L. Phillips, M.D., C.M.D., senior dimensions
Neeraj Kanwal, M.D., executive medical director, Government Programs Anthem Blue Cross and Blue Shield
Steve L. Anderson, executive director, Donald W. Reynolds Foundation
William L. Minnix, Jr., D. Min., president and chief executive officer, Wesley Woods Center on Aging, Emory University

SYNOPSIS

This forum addressed the importance of geriatric medicine and the shortage of geriatricians our national faces. Expert panelists examined possible solutions to this problem and allowed time for audience questions.

PREPARING AMERICANS FOR RETIREMENT: THE ROADBLOCKS TO INCREASED SAVINGS, WASHINGTON, DC, JUNE 2, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Jan Owens
Dennis L. Stone, owner, Western Manufacturing Corporation
Dallas Salisbury, president and chief executive officer, Employer Benefit Research Institute
Sharon Dillon Robinson, dean, Center for Retirement Education, Variable Annuity Life Insurance Company
Olena Berg, assistant secretary, Pension and Welfare Benefits Administration, United States Department of Labor

SYNOPSIS

The hearing identified retirement savings barriers for individuals and ways to educate individuals about the importance of saving. The committee and the subcommittee released a new nationwide survey showing why many small businesses do not offer their em-

ployees retirement savings plans and what would encourage them to do so.

THE GRAYING OF NATIONS: PRODUCTIVE AGING AROUND THE WORLD, WASHINGTON, DC, JUNE 8, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Dr. Jeanette Takamura, Assistant Secretary of Aging, Department of Health and Human Services
Richard Hodes, M.D., director, National Institute on Aging
Robert N. Butler, M.D., president and CEO, International Longevity Center
Lady Sally Greengross, director General of Age Concern England and director of the International Longevity Center-UK
Yuzo Okamoto, M.D., professor of Health Science and Welfare Economics, Kobe City College of Nursing
A.H.B. de Bono, M.D., director of the International Institute on Aging-Malta
Francoise Forette, M.D., director of International Longevity Center-France
Alvar Svanborg, M.D., Ph.D., professor emeritus, University of Gothenburg, Sweden and University of Illinois

SYNOPSIS

The hearing is the third in a series, prior hearings were held in 1977 and 1985, that focuses on the international trend of increased life expectancy. This hearing explored international programs, policies and research that encourage active aging.

PRESERVING AMERICA'S FUTURE TODAY, BALA CYNWYD, PA, JUNE 30, 1998, THE HONORABLE RICK SANTORUM, PRESIDING

WITNESSES

Patricia DeMarco
Joseph P. Sirbak II
Meredith Keiser, Foundation for International Responsibility and Social Trust
Carl Helstrom, Third Millennium
Sam Beard, Economic Security 2000
Michael Tanner, director of Health and Welfare Studies, CATO Institute
Marshall E. Blume, Wharton School of Business, University of Pennsylvania
David Langer, David Langer Company, Inc

SYNOPSIS

The Committee hosted field hearings to explore public sentiments on Social Security. The purpose was to gather information, educate the public on Social Security issues, and discuss proposals to fix the program's problems.

LIVING LONGER, RETIRING EARLIER: RETHINKING THE SOCIAL SECURITY RETIREMENT AGE

WITNESSES

Barbar D. Bovberj, Associate Director, Income Security Issues, Health, Education, and Human Services Division, U.S. General Accounting Office
David A. Smith, director of Public Policy, American Federation of Labor-Congress of Industrial Organizations (AFL–CIO)
Gary Burtless, Ph.D., senior fellow, Brookins Institution
Donna L. Wagner, Ph.D., director, The Center for Productive Aging, Towson University
Paul R. Huard, vice president of Policy and Communications, National Association of Manufacturers
Carolyn J. Lukensmeyer, executive director, Americans Discuss Social Security Project

SYNOPSIS

This hearing explored how an increase in the retirement age will affect the solvency of the Social Security system, the impact on workers, and how employers may adjust to an increase in the number of older workers.

OLDER AMERICANS AND THE WORLDWIDE WEB: THE NEW WAVE OF INTERNET USERS, WASHINGTON, DC, JULY 16, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Mary Furlong, CEO, ThirdAge Media
Micki Gordon, chairperson, Center for Productive Aging, Jewish Council for the Aging
Herb Ernst, retired professor and Internet User
Jeanne Hurley Simon, chairperson, U.S. National Commission on Libraries and Information Science
Craig D. Spiezle, director, Market Development and Corporate Marketing, Microsoft Corporation
Michael McMullan, deputy director, Center for Beneficiary Health Services, Health Care Financing Administration

SYNOPSIS

This forum examined older Americans' increasing use of the Internet, including the tremendous possibilities of social interaction, cultural enrichment, professional development and information about health care choices via the worldwide web.

BETRAYAL: THE QUALITY OF CARE IN CALIFORNIA NURSING HOMES, WASHINGTON, DC, JULY 27 AND 28, 1998 THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Ellen Curzon
John Davis
Leslie Oliva

Kathleen Duncan, certified nurse assistant, activities director, Social Services designee, admissions director
Patricia Lloyd, former licensed vocational nurse
Kathryn Locatell, M.D.,
Florence N., registered nurse

Charlene Harrington, professor, Department of Social and Behavioral Services, University of California
William J. Scanlon, Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, United States General Accounting Office
Andrew M. Kramer, M.D., research director, Center on Aging, University of Colorado, Health Services Center
Michael Hash, Deputy Administrator, Health Care Financing Administration
Sheldon L. Goldberg, president, American Association of Homes and Services for the Aging
Dennis Stone, M.D., on behalf of the California Association of Health Facilities
Paul R. Willging, executive vice president, American Health Care Association

SYNOPSIS

This hearing addressed the quality of care in California Nursing homes. The first day of the hearing included testimony from the family members of former nursing home residents and nursing home employees. The second day of the hearing featured the release of a General Accounting Office (GAO) reported requested by the Committee.

EVERYDAY HEROES: FAMILY CAREGIVERS FACE INCREASING CHALLENGES IN AN AGING NATION, WASHINGTON, DC, SEPTEMBER 10, 1998, THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Former First Lady Rosalynn Carter, president, Rosalynn Carter Institute
Gail Gibson Hunt, executive director, National Alliance for Caregiving
Peter S. Arno, professor, Albert Einstein College of Medicine
Carol Levine, director, Families and Health Care Project, United Hospital Fund
Mary S. Mittelman, Alzheimer's Disease Center, New York University Medical School
Dr. David Levy, chairman and chief executive officer, Franklin Health Inc., Upper Saddle River, NJ, and Carol Weinrod, registered nurse, Franklin Health
Myrl Weinberg, president, National Health Council

SYNOPSIS

This hearing sought to define family caregivers and explore the challenges they face.

EASING THE FAMILY CAREGIVER BURDEN: PROGRAMS AROUND THE NATION, WASHINGTON, DC, SEPTEMBER 10, 1998,

WITNESSES

Susan R. Friedman, executive director, The Grotta Foundation
Kathleen A. Kelly, executive director, Family Caregiver Alliance
Susan Reinhard, RN, Ph.D., deputy commissioner, New Jersey Department of Health and Senior Services
Bentley Lipscomb, secretary, Department of Elder Affairs
Richard Browdie, secretary of Aging, Department of Aging
Leah Eskenazi, manager of Senior and Community Programs, Legacy Health Systems
Connie Ford, RN, MPA, vice president, Product Development and Services, Adultcare

SYNOPSIS

This forum will focus on how to strengthen and increase programs for family caregivers. Currently, more than 25 million Americans care for an aging or ailing family member. The personal and financial contributions made by these individuals is enormous, and with a growing number of older Americans, that contribution only will increase.

CROOKS CARING FOR SENIORS: THE CASE FOR CRIMINAL BACKGROUND CHECKS, WASHINGTON, DC, SEPTEMBER 14, 1998 THE HONORABLE CHARLES GRASSLEY, PRESIDING

WITNESSES

Richard A. Meyer
Claudia Stine, director of Ombudsman Services
Thomas D. Roslewicz, Deputy Inspector General for Audit Services, Office of the Inspector General, Department of Health and Human Services
Kim Schmett, director, Iowa Department of Inspections and Appeals
Lee Bitler, director of Human Resources, Country Meadow, Inc
Richard Reichard, executive director, National Lutheran Home for the Aged; on behalf of the American Association for Homes and Services for the Aging
Melissa Putnam, certified nurse aide, Beverly Manor; on behalf of the Service Employees International Union

SYNOPSIS

This hearing explored the need for a national system to check the criminal backgrounds of nursing home workers.

CAN WE REST IN PEACE? THE ANXIETY OF ELDERLY PARENTS CARING FOR BABY BOOMERS WITH DISABILITIES, WASHINGTON, DC, SEPTEMBER 18, 1998, JACKIE GOLDEN, JOSEPH P. KENNEDY FOUNDATION FELLOW, PRESIDING

WITNESSES

Lorraine Sheehan, chairperson, Governmental Affairs Committee, The Arc
James Cumberpatch, parent
David Braddock, Ph.D., professor of Human Development, and head, Department of Disability and Human Development, University of Illinois
Thomas Nerney, co-director, National Program Office on Self-Determination, Institute on Disability, University of New Hampshire
Sue Swenson, Commissioner, Administration on Developmental Disabilities, Administration for Children and Families, U.S. Department of Health and Human Services
Diane Coughlin, director, Developmental Disabilities Administration

SYNOPSIS

This forum examined the hardships faced by aging parents of baby boomers with disabilities. The Committee will explore better ways to manage care, to use public resources and to improve the circumstances of the individuals with disabilities.

SUPPLEMENT 2

COMMITTEE STAFF MEMBERS

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Patricia Hameister, *Chief Clerk*

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SUPPLEMENT 3

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(202) 512–1800

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.*
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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.*
Developments in Aging: 1983—Volume 2, Report No. 98–360, February 1984.*
Developments in Aging: 1984—Volume 1, Report No. 99–5, February 1985..*
Developments in Aging: 1984—Volume 2, Report No. 99–5, February 1985.*
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.*
Developments in Aging: 1987—Volume 3—The Long-Term Care Challenge, Report No. 100–291, February 1988.*
Developments in Aging: 1988—Volume 1—Report No. 101–4, February 1989.*
Developments in Aging: 1988—Volume 2—Appendixes, Report No. 101–4, February 1989.*
Developments in Aging: 1989—Volume 1—Report No. 101–249, February 1990.*
Developments in Aging: 1989—Volume 2—Appendixes, Report No. 101–249, February 1990.*
Developments in Aging: 1990—Volume 1—Report No. 102–28, February 1991.*
Developments in Aging: 1990—Volume 2—Appendixes, Report No. 102–28, February 1991.*
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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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Developments in Aging: 1996—Volume 1—Report No. 105–36, June 24, 1997.*

Developments in Aging: 1996—Volume 2—Report No. 105–36, June 24, 1997.*

Developments in Aging: 1996—Volume 3—Report No. 105–36, April 30, 1998.*

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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]

Employment Aspects of the Economics of Aging, committee print, December 1969.* [1]

1970

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, committee print, January 1970.* [1]

The Stake of Today's Workers in Retirement Security, committee print, April 1970.* [1]

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[1] Working paper incorporated as an appendix to the hearing.

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Legal Problems Affecting Older Americans, committee print, August 1970.* [1]

Income Tax Overpayments by the Elderly, Report No. 91–1464, December 1970.*

Older Americans and Transportation: A Crisis in Mobility, Report No. 91–1520, December 1970.*

Economics of Aging: Toward a Full Share in Abundance, Report No. 91–1548, December 1970.*

1971

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.*

The Nation's Stake in the Employment of Middle-Aged and Older Persons, committee print, July 1971.*

The Administration on Aging—Or a Successor?, committee print, October 1971.*

Alternatives to Nursing Home Care: A Proposal, committee print, October 1971.*

Mental Health Care and the Elderly: Shortcomings in Public Policy, Report No. 92–433, November 1971.*

The Multiple Hazards of Age and Race: The Situation of Aged Blacks in the United States, Report No. 92–450, November 1971.*

Advisory Council on the Elderly American Indian, committee print, November 1971.*

Elderly Cubans in Exile, committee print, November 1971.*

A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92–505, November 1971.*

Research and Training in Gerontology, committee print, November 1971.*

Making Services for the Elderly Work: Some Lessons From the British Experience, committee print, November 1971.*

1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, Document No. 92–53, December 1971.*

1972

Home Health Services in the United States, committee print, April 1972.*

Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans, committee print, May 1972.*

Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print, May 1972.*

Action on Aging Legislation in 92d Congress, committee print, October 1972.*

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.*

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1973

The Rise and Threatened Fall of Service Programs for the Elderly, committee print, March 1973.*

Housing for the Elderly: A Status Report, committee print, April 1973.*

Older Americans Comprehensive Services Amendments of 1973, committee print, June 1973.*

Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.*

Economics of Aging: Toward a Full Share in Abundance, index to hearings and report, committee print, July 1973.*

Research on Aging Act, 1973, Report No. 93–299, committee print, July 1973.*

Post-White House Conference on Aging Reports, 1973, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, September 1973.*

Improving the Age Discrimination Law, committee print, September 1973.*

1974

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, February 1974.*

Developments and Trends in State Programs and Services for the Elderly, committee print, November 1974.*

Nursing Home Care in the United States: Failure in Public Policy:*

- Introductory Report, Report No. 93–1420, November 1974.*
- Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print, December 1974.*
- Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print, January 1975.*
- Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print, February 1975.*
- Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print, April 1975.*
- Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print, August 1975.*
- Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print, September 1975.*
- Supporting Paper No. 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)," committee print, March 1976.*

Private Health Insurance Supplementary to Medicare, committee print, December 1974.*

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1975

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1975.*
Senior Opportunities and Services (Directory of Programs), committee print, February 1975.*
Action on Aging Legislation in 93d Congress, committee print, February 1975.*
The Proposed Fiscal 1976 Budget: What It Means for Older Americans, committee print, February 1975.*
Future Directions in Social Security, Unresolved Issues: An Interim Staff Report, committee print, March 1975.*
Women and Social Security: Adapting to a New Era, working paper, committee print, October 1975.*
Congregate Housing for Older Adults, Report No. 94–478, November 1975.*

1976

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1976.*
The Proposed Fiscal 1977 Budget: What It Means for Older Americans, committee print, February 1976.*
Fraud and Abuse Among Clinical Laboratories, Report No. 94–944, June 1976.*
Recession's Continuing Victim: The Older Worker, committee print, July 1976.*
Fraud and Abuse Among Practitioners Participating in the Medicaid Program, committee print, August 1976.*
Adult Day Facilities for Treatment, Health Care, and Related Services, committee print, September 1976.*
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Witness Index and Research Reference, committee print, November 1976.*
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Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1976.*

1977

The Proposed Fiscal 1978 Budget: What It Means for Older Americans, committee print, March 1977.*
Kickbacks Among Medicaid Providers, Report No. 95–320, June 1977.*
Protective Services for the Elderly, committee print, July 1977.*
The Next Steps in Combating Age Discrimination in Employment: With Special Reference to Mandatory Retirement Policy, committee print, August 1977.*
Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1977.*

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1978

The Proposed Fiscal 1979 Budget: What It Means for Older Americans, committee print, February 1978.*

Paperwork and the Older Americans Act: Problems of Implementing Accountability, committee print, June 1978.*

Single Room Occupancy: A Need for National Concern, committee print, June 1978.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1978.*

Action on Aging Legislation in the 95th Congress, committee print, December 1978.*

1979

The Proposed Fiscal 1980 Budget: What It Means for Older Americans, committee print, February 1979.*

Energy Assistance Programs and Pricing Policies in the 50 States To Benefit Elderly, Disabled, or Low-Income Households, committee print, October 1979.*

Witness Index and Research Reference, committee print, November 1979.*

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Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1980.*

The Proposed Fiscal 1981 Budget: What It Means for Older Americans, committee print, February 1980.*

Emerging Options for Work and Retirement Policy (An Analysis of Major Income and Employment Issues With an Agenda for Research Priorities), committee print, June 1980.*

Summary of Recommendations and Surveys on Social Security and Pension Policies, committee print, October 1980.*

Innovative Developments in Aging: State Level, committee print, October 1980.*

State Offices on Aging: History and Statutory Authority, committee print, December 1980.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1980.*

State and Local Government Terminations of Social Security Coverage, committee print, December 1980.*

1981

The Proposed Fiscal Year 1982 Budget: What It Means for Older Americans, committee print, April 1981.*

Action on Aging Legislation in the 96th Congress, committee print, April 1981.*

Energy and the Aged, committee print, August 1981.*

1981 Federal Income Tax Legislation: How It Affects Older Americans and Those Planning for Retirement, committee print, August 1981.*

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Omnibus Budget Reconciliation Act of 1981, Public Law 97–35, committee print, September 1981.*

Toward a National Older Worker Policy, committee print, September 1981.*

Crime and the Elderly—What You Can Do, committee print, September 1981.*

Social Security in Europe: The Impact of an Aging Population, committee print, December 1981.*

Background Materials Relating to Office of Inspector General, Department of Health and Human Services Efforts To Combat Fraud, Waste, and Abuse, committee print, December 1981.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1981.*

A Guide to Individual Retirement Accounts (IRA's), committee print, December 1981, stock No. 052–070–05666–5.*

1982

Social Security Disability: Past, Present, and Future, committee print, March 1982.*

The Proposed Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, March 1982.*

Linkages Between Private Pensions and Social Security Reform, committee print, April 1982.*

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Aging and the Work Force: Human Resource Strategies, committee print, August 1982.*

Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, committee print, September 1982.*

Congressional Action on the Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, November 1982.*

Equal Employment Opportunity Commission Enforcement of the Age Discrimination in Employment Act: 1979 to 1982, committee print, November 1982.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1982.*

1983

Consumer Frauds and Elderly Persons: A Growing Problem, committee print, February 1983.*

Action on Aging Legislation in the 97th Congress, committee print, March 1983.*

Prospects for Medicare's Hospital Insurance Trust Fund, committee print, March 1983.*

The Proposed Fiscal Year 1984 Budget: What It Means for Older Americans, committee print, March 1983.*

You and Your Medicines: Guidelines for Older Americans, committee print, June 1983.*

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Heat Stress and Older Americans: Problems and Solutions, committee print, July 1983.*
Current Developments in Prospective Reimbursement Systems for Financing Hospital Care, committee print, October 1983.*
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1984

Medicare: Paying the Physician—History, Issues, and Options, committee print, March 1984.*
Older Americans and the Federal Budget: Past, Present, and Future, committee print, April 1984.*
Medicare and the Health Cost of Older Americans: The Extent and Effects of Cost Sharing, committee print, April 1984.*
The Supplemental Security Income Program: A 10-Year Overview, committee print, May 1984.*
Long-Term Care in Western Europe and Canada: Implications for the United States, committee print, July 1984.*
Turning Home Equity Into Income for Older Americans, committee print, July 1984.*
The Employee Retirement Income Security Act of 1974: The First Decade, committee print, August 1984.*
The Costs of Employing Older Workers, committee print, September 1984.*
Rural and Small-City Elderly, committee print, September 1984.*
Section 202 Housing for the Elderly and Handicapped: A National Survey, committee print, December 1984.*
Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1984.*

1985

Health and Extended Worklife, committee print, February 1985.*
Personnel Practices for an Aging Workforce: Private-Sector Examples, committee print, February 1985.*
10th Anniversary of the Employee Retirement Income Security Act of 1974, committee print, April 1985.*
Publications list, committee print, April 1985.*
Compilation of the Older Americans Act of 1965 and Related Provisions of Law, committee print, Serial No. 99–A, June 1985.*
America In Transition: An Aging Society, 1984–85 Edition, committee print, Serial No. 99–B, June 1985.*
Fifty Years of Social Security: Past Achievements and Future Challenges, committee print, Serial No. 99–C, August 1985.*
How Older Americans Live: An Analysis of Census Data, committee print, Serial No. 99–D, October 1985.*
Congressional Briefing on the 50th Anniversary of Social Security, committee print, Serial No. 99–E, August 1985.*

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1986

Protecting Older Americans Against Overpayment of Income Taxes, committee print, Serial No. 99–F, January 1986.*

The Cost of Mandating Pension Accruals for Older Workers, committee print, Serial No. 99–G, February 1986.*

The Impact of Gramm-Rudman-Hollings on Programs Serving Older Americans: Fiscal Year 1986, committee print, Serial No. 99–H, February 1986.*

Alternative Budgets for Fiscal Year 1987: Impact on Older Americans, committee print, Serial No. 99–I, May 1986.*

Nursing Home Care: The Unfinished Agenda, committee print, Serial No. 99–J, May 1986.*

Hazards in Reuse of Disposable Dialysis Devices, committee print, Serial No. 99–K, October 1986.*

The Health Status and Health Care Needs of Older Americans, committee print, Serial No. 99–L, October 1986.*

A Matter of Choice: Planning Ahead for Health Care Decisions, committee print, Serial No. 99–M, December 1986.*

Hazards in Reuse of Disposable Dialysis Devices—Appendix, committee print, Serial No. 99–N, December 1986.*

1987

Helping Older Americans To Avoid Overpayment of Income Taxes, committee print, Serial No. 100–A.*

Publications List, committee print, March 1987, Serial No. 100–B.*

Older Americans Act Amendments of 1987: A Summary of Provisions, committee print, December 1987, Serial No. 100–C.*

1988

Helping Older Americans To Avoid Overpayment of Income Taxes, committee print, January 1988, Serial No. 100–D.*

Publications List, committee print, February 1988, Serial No. 100–E.*

Compilation of the Domestic Volunteer Service Act of 1973, April 1988, Serial No. 100–F.*

The President's Fiscal Year 1989 Budget Proposal: How it Would Affect Programs for Older Americans, committee print, April 1988, Serial No. 100–G.*

Home Care at the Crossroads, committee print, April 1988, Serial No. 100–H.*

Health Insurance and the Uninsured: Background and Analysis, joint committee print, May 1988, Serial No. 100–I.*

Legislative Agenda for an Aging Society: 1988 and Beyond, joint committee print, June 1988, Serial No. 100–J.*

Medicare Physician Reimbursement: Issues and Options, committee print, September 1988, Serial No. 100–L.*

Medicare's New Prescription Drug Coverage: A Big Step Forward, But Problems Still Exist, committee print, October 1988, Serial No. 100–M.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Rural Health Care Challenge, committee print, October 1988, Serial No. 100–N.*

Insuring the Uninsured: Options and Analysis, joint committee print, December 1988, Serial No. 100–O.*

Costs and Effects of Extending Health Insurance Coverage, joint committee print, December 1988, Serial No. 100–P.*

EEOC Headquarters Officials Punish District Director for Exposing Headquarters Mismanagement, committee print, December 1988, Serial No. 100–Q.*

1989

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Regulations To Implement the Comprehensive Older Americans Act Amendments of 1978:*
Part 1. Washington, D.C., October 18, 1979.
Part 2. Washington, D.C., March 24, 1980.
Medicare Reimbursement for Elderly Participation in Health Maintenance Organizations and Health Benefit Plans, Philadelphia, Pa., October 29, 1979.*
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Adapting Social Security to a Changing Work Force, Washington, D.C., November 28, 1979.*
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Part 2. Washington, D.C., May 22, 1980.
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Part 2. Washington, D.C., May 13, 1980.*
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Part 2. St. Petersburg, Fla., October 28, 1980.
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Part 1. Washington, D.C., March 20, 1981.

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Part 2. Washington, D.C., March 27, 1981.
Part 3. Philadelphia, Pa., April 10, 1981.

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Part 2 (Early Retirement). Washington, D.C., June 18, 1981.
Part 3 (Cost-of-Living Adjustments). Washington, D.C., June 24, 1981.

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Part 2. Little Rock, AR, August 28, 1986.

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Reno, NV, August 17, 1987.

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Part 1—Rural Hospitals, Washington, DC, June 13, 1988.*

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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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Hearing on Adverse Drug Reactions in the Elderly, March 28, 1996, Washington, DC, Serial No. 104–11.

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Medicaid Managed Care: The Elderly and Others With Special Needs, June 24, July 8, July 15, July 22, 1997, Washington, DC, Serial No. 105–9.

2010 and Beyond: Preparing Medicare for the Baby Boomers, August 25, 1997, Sioux City, IA, Serial No. 105–10.

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