DEVELOPMENTS IN AGING: 1999 and 2000
VOLUME 1

REPORT
OF THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO
S. RES. 54, SEC. 17(c), MARCH 8, 2001
Resolution Authorizing a Study of the Problems of the Aged and Aging

JUNE 4, 2002.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512-1800; DC area (202) 512-1800
Fax: (202) 512-2250 Mail: Stop SSOP, Washington, DC 20402-0001
LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,

Hon. Dick Cheney,
President, U.S. Senate,
Washington, DC.

Dear Mr. President: Under authority of Senate Resolution 54, agreed to March 8, 2001, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 1999 and 2000, 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 1999 and 2000 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,

John Breaux, Chairman.
## CONTENTS

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Letter of Transmittal</td>
<td>III</td>
</tr>
<tr>
<td>1</td>
<td>Social Security—Old Age, Survivors and Disability:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Social Security—Old Age and Survivors Insurance</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2. Financing and Social Security's Relation to the Budget</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>3. Benefit and Tax Issues and Legislative Response</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>B. Social Security Disability Insurance</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>2. Issues and Legislative Response</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>C. The 107th Congress</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>Employee Pensions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>A. Private Pensions</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>2. Issues and Legislative Response</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>B. State and Local Public Employee Pension Plans</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>2. Issues and Legislative Response</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>C. Federal Civilian Employee Retirement</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>2. Issues and Legislative Response</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>D. Military Retirement</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>2. Issues and Legislative Response</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>3. Recent Issues and Legislative Response</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>E. Railroad Retirement System</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>2. Issues and Legislative Response</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>3. Prognosis</td>
<td>59</td>
</tr>
<tr>
<td>3</td>
<td>Taxes and Savings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>A. Taxes</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>62</td>
</tr>
<tr>
<td></td>
<td>B. Savings</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>2. Issues</td>
<td>76</td>
</tr>
<tr>
<td>4</td>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Age Discrimination</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>1. Background</td>
<td>91</td>
</tr>
<tr>
<td></td>
<td>2. The Equal Employment Opportunity Commission</td>
<td>92</td>
</tr>
<tr>
<td></td>
<td>3. The Age Discrimination in Employment Act</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>B. Federal Programs</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>1. The Adult and Dislocated Worker Program Authorized Under the Workforce Investment Act</td>
<td>103</td>
</tr>
<tr>
<td></td>
<td>2. Title V of the Older Americans Act</td>
<td>105</td>
</tr>
<tr>
<td>5</td>
<td>Supplemental Security Income</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>A. Background</td>
<td>107</td>
</tr>
<tr>
<td></td>
<td>B. Issues</td>
<td>109</td>
</tr>
<tr>
<td></td>
<td>1. Limitations of SSI Payments to Immigrants</td>
<td>109</td>
</tr>
<tr>
<td></td>
<td>2. SSA Disability Determination Process</td>
<td>110</td>
</tr>
<tr>
<td></td>
<td>3. Employment and Rehabilitation for SSI Recipients</td>
<td>111</td>
</tr>
<tr>
<td></td>
<td>4. Fraud Prevention and Overpayment Recovery</td>
<td>113</td>
</tr>
<tr>
<td>6</td>
<td>Food Assistance Programs and Food Security Among the Elderly:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overview</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>A. Background on the Programs</td>
<td>116</td>
</tr>
</tbody>
</table>
Chapter 6—Continued
A. Background on the Programs—Continued
1. Food Stamps ................................................................. 116
2. The Commodity Supplemental Food Program .................. 121
3. The Child and Adult Care Food Program ....................... 122
B. Legislative Developments .............................................. 122
C. Food Security Among the Elderly .................................. 123

Chapter 7: Health Care:
A. National Health Care Expenditures ............................... 129
1. Introduction ............................................................... 129
2. Medicare and Medicaid Expenditures .......................... 131
3. Hospitals ................................................................. 132
4. Physicians' Services ................................................. 134
5. Nursing Home and Home Health Costs ....................... 135
6. Prescription Drugs .................................................... 136
7. Health Care for an Aging U.S. Population ...................... 142

B. Issues ........................................................................... 154
1. Medicare Solvency and Cost Containment ..................... 154
2. Program Modifications ................................................ 155
3. Program Restructuring ............................................... 157
4. Prescription Drugs ...................................................... 158

Chapter 8: Medicare:
A. Background ............................................................... 145
1. Hospital Insurance Program (Part A) ......................... 146
2. Supplementary Medical Insurance (Part B) ................. 148
3. Medicare+Choice (Part C) ......................................... 151
4. Supplemental Health Coverage .................................. 153
B. Issues ........................................................................... 154
1. Medicare Solvency and Cost Containment ..................... 154
2. Program Modifications ................................................ 155
3. Program Restructuring ............................................... 157
4. Prescription Drugs ...................................................... 158

Chapter 9: Long-Term Care:
Overview ................................................................. 161
A. Background ............................................................... 162
1. What is Long-Term Care? ........................................... 162
   a. Adult Day Care ...................................................... 163
   b. Home Care .......................................................... 164
   c. Respite Care ....................................................... 165
   d. Supportive Housing .............................................. 165
   e. Continuing Care Retirement Communities .......... 166
   f. Assisted Living .................................................... 166
   g. Nursing Homes .................................................... 169
   h. Access Services .................................................. 169
   i. Nutrition Services ............................................... 169
2. Who Receives Long-Term Care? ................................. 170
3. Where is Long-Term Care Delivered? ......................... 172
4. Who Provides Long-Term Care? ................................. 172
5. Who Pays for Long-Term Care? ................................. 174
B. Federal Programs ........................................................ 178
1. Medicaid ................................................................. 178
   a. Introduction ...................................................... 178
   b. Medicaid Availability and Eligibility ...................... 180
   c. Low-Income Beneficiaries also Eligible for Medicare .. 181
   d. Spousal Impoverishment ..................................... 182
   e. Personal Needs Allowance for Medicaid Nursing Home Residents .... 184
   f. 1915(c) Waiver Programs ................................... 186
2. Medicare ................................................................. 187
   a. Introduction ...................................................... 187
   b. The Skilled Nursing Facility Benefit ...................... 187
   c. The Home Health Benefit ................................... 189
   d. The Hospice Benefit .......................................... 191
   e. Program for All-Inclusive Care for the Elderly ........ 192
3. Social Services Block Grant ....................................... 192
C. Special Issues ........................................................... 193
1. Nursing Home Quality ............................................. 193
2. System Variations and Access Issues ......................... 195
3. The Role of Case Management .................................. 195

Chapter 10: Health Benefits for Retirees of Private Sector Employers:
A. Background ............................................................... 197
1. Who Receives Retiree Health Benefits? ....................... 198
Chapter 10—Continued
A. Background—Continued
  2. Design of Benefit Plans ................................................................. 200
  3. Recognition of Employer Liability ................................................ 200
  4. Pre-Funding .................................................................................. 201
B. Benefit Protection Under Existing Federal Laws ............................. 202
  1. ERISA .......................................................................................... 202
  2. OSAQA ......................................................................................... 202
  3. HIPAA .......................................................................................... 203
C. Outlook .......................................................................................... 204

Chapter 11: Health Research and Training:
A. Background ..................................................................................... 207
B. The National Institutes of Health .................................................... 208
  1. Mission of NIH ............................................................................. 208
  2. The Institutes ................................................................................ 208
     a. National Institute on Aging .......................................................... 209
     b. National Cancer Institute ......................................................... 210
     c. National Heart, Lung, and Blood Institute ............................... 210
     d. National Institute of Dental Research ..................................... 210
     e. National Institute of Diabetes and Digestive and Kidney Diseases .................................................. 211
     f. National Institute of Neurological Disorders and Stroke ........ 211
     g. National Institute of Allergy and Infectious Diseases ............ 212
     h. National Institute of Child Health and Human Development ... 212
     i. National Eye Institute ................................................................. 212
     j. National Institute of Environmental Health Sciences ........... 212
     k. National Institute of Arthritis and Musculoskeletal and Skin Diseases .................................................. 213
     l. National Institute on Deafness and Other Communication Disorders .................................................. 213
     m. National Institute of Mental Health .......................................... 214
     n. National Institute on Drug Abuse .............................................. 214
     o. National Institute of Alcohol Abuse and Alcoholism ................ 214
     p. National Institute of Nursing Research ...................................... 215
     q. National Center for Research Resources ................................. 215
     r. National Center for Complementary and Alternative Medicine .. 215
     s. National Center on Minority Health and Health Disparities .... 215
C. Issues and Congressional Response ................................................ 216
  1. NIH Appropriations ....................................................................... 216
  2. NIH Authorizations ...................................................................... 217
  3. Alzheimer’s Disease ..................................................................... 218
  4. Arthritis and Musculoskeletal Diseases ........................................ 222
  5. Geriatric Training and Education ................................................ 223
  6. Social Science Research and the Burdens of Caregiving .............. 224
D. Conclusion ....................................................................................... 225

Chapter 12: Housing Programs:
Overview ............................................................................................ 227
A. Rental Assistance Programs ........................................................... 229
  1. Introduction .................................................................................. 229
  2. Housing and Supportive Services ................................................ 229
  3. Public Housing ............................................................................. 232
  4. Section 8 Housing Programs ....................................................... 234
  5. Project-based and Tenant-based Vouchers ................................... 234
  6. Rural Housing Services ............................................................... 235
  7. Federal Housing Administration .................................................. 239
  8. Low-Income Housing Tax Credit ................................................ 240
B. Preservation of Affordable Rental Housing ..................................... 241
  1. Introduction .................................................................................. 241
  2. Portfolio Re-Engineering Program .............................................. 242
C. Homeownership .............................................................................. 243
  1. Homeownership Rates .................................................................. 243
  2. Homeownership Tax Provisions ................................................ 244
  3. Legislative Proposals to Increase Homeownership ...................... 246
  4. Home Equity Conversion ............................................................ 247
D. Innovative Housing Arrangements .................................................. 251
  1. Shared Housing ............................................................................ 251
  2. Accessory Apartments .................................................................. 252
E. Fair Housing Act and Elderly Exemption ......................................... 253
Chapter 12—Continued
F. Homeless Assistance .............................................................. 253
G. Housing Cost Burdens of the Elderly ........................................ 257

Chapter 13: Energy Assistance and Weatherization:
Overview ...................................................................................... 259
A. Background ............................................................................... 260
   1. The Low-Income Home Energy Assistance Program ............ 260
   2. The Department of Energy Weatherization Assistance Program 263

Chapter 14: Older Americans Act:
Historical Perspective ................................................................. 266
A. Title I—Objectives and Definitions .......................................... 268
B. Title II—Administration on Aging ........................................... 268
C. Title III—Grants for States and Community Programs on Aging 268
D. Title IV—Research, Training, and Demonstration Program ..... 269
E. Title V—Senior Community Service Employment Program ..... 269
F. Title VI—Grants for Native Americans ..................................... 270
G. Title VII—Vulnerable Elder Rights Protection Activities .......... 270

Chapter 15: Social, Community, and Legal Services:
A. Block Grants ............................................................................ 291
   1. Background ........................................................................... 291
   2. Issues ...................................................................................... 294
   3. Federal Response ................................................................. 298
B. Adult Education and Literacy .................................................... 299
   1. Background ........................................................................... 299
   2. Program Description ............................................................. 300
   3. Legislation in the 106th Congress ........................................... 301
C. Domestic Volunteer Service Act ............................................... 302
   1. Background ........................................................................... 302
D. Transportation ........................................................................... 305
   1. Background ........................................................................... 305
   2. Federal Response ................................................................. 306
   3. Issues in Transportation Services for Older Persons .......... 309
E. Legal Services ........................................................................... 314
   1. Background ........................................................................... 314
   2. Issues ...................................................................................... 318
   3. Federal and Private Sector Response ..................................... 322

Chapter 16: Crime and the Elderly:
A. Elder Abuse ............................................................................ 327
   1. Background ........................................................................... 327
   2. Legislative Response ............................................................. 328
B. Consumer Frauds and Deceptions ............................................ 329
   1. Background ........................................................................... 329
   2. Legislative Response ............................................................. 330

SUPPLEMENTAL MATERIAL

List of Hearings and Forums Held in 1999 and 2000 ..................... 333
Mr. BREAUX, 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 an important topic of national debate. In May 2001, President George W. Bush established the President's Commission to Strengthen Social Security. The Commission has been directed to submit recommendations to “modernize and restore fiscal soundness to the Social Security system” in accordance with 6 guiding principles: (1) modernization must not change Social Security benefits for retirees or near-retirees; (2) the entire Social Security surplus must be dedicated to Social Security only; (3) Social Security payroll taxes must not be increased; (4) government must not invest Social Security funds in the stock market; (5) modernization must preserve Social Security's disability and survivors components; and (6) modernization must include individually controlled, voluntary personal retirement accounts, which will augment the Social Security safety net. The Commission will make specific recommendations on program changes in its final report expected in the fall of 2001.

In January 1997, the 1994–1996 Advisory Council on Social Security issued a report 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 106th Congress. Many of the financing reform bills introduced 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. None of these measures were acted upon during the 106th Congress.

Lawmakers, however, took up a number of other Social Security measures during the 106th Congress. In December 1999, the Ticket to Work and Work Incentives Improvement Act of 1999 was signed into law (H.R. 1180, P.L. 106–170). Under the legislation, a disabled recipient is provided with a "ticket to work" that can be used to obtain employment, vocational rehabilitation, or other support services from approved providers. In turn, the service provider is entitled to a share of the cash benefit savings that result from the recipient's return to work.

In April 2000, Congress enacted the Senior Citizens' Freedom to Work Act (P.L. 106–182) eliminating the earnings test for persons at the full retirement age through age 69 (the earnings test did not apply to persons age 70 and older). Under the new law, beneficiaries who have earnings from work above a certain amount are no longer subject to a reduction in Social Security benefits once they reach the full retirement age. P.L. 106–182 does not affect persons below the full retirement age (currently ages 62 to 64).

In July 2000, the House of Representatives passed H.R. 4865 which would repeal the second (or 85 percent) tier of benefit taxation effective in 2001. To compensate for the loss of revenue to the Medicare HI trust fund, an amount equal to the revenue that would have been generated had the tax not been repealed would be credited to the HI trust fund through a permanent appropriation from the general fund. The Senate did not act on the measure prior to adjournment of the 106th Congress.

Congress considered a number of Social Security "lock box" measures that would create additional procedural obstacles for bills that cause the budget surpluses to fall below a level equal to the Social Security (and, in some cases, Medicare) surpluses if not used for Social Security or Medicare reform. Among them were measures to create new points of order that could be lodged against bills that would cause budget surpluses to be less than Social Security and Medicare HI surpluses, to require new limits on Federal debt that would decline by the amount of annual Social Security surpluses,
would decline by the amount of annual Social Security surpluses, and to amend the Constitution to require a balanced Federal budget without counting Social Security. While the House approved three specific "lock box" bills consisting primarily of procedural points of order (H.R. 3859, H.R. 5173 and H.R. 5203), the Senate could not reach a consensus on them and none were ultimately passed.

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 generally as Social Security, monthly benefits are based on a worker's earnings. In December 1999, $385.8 billion in monthly benefits were paid to Social Security recipients, with payments to retired workers averaging $804 and those to disabled workers averaging $754. In 1999, administrative expenses were $3.0 billion, representing less than 1 percent of total revenues.

The Social Security program touches the lives of nearly every American. In December 1999, there were 44.6 million Social Security recipients: 27.8 million retired workers (62.3 percent of total recipients); 4.9 million disabled workers (10.9 percent); 4.9 million dependent family members of retired and disabled workers (11.0 percent); and 7.0 million surviving family members of deceased workers (15.8 percent). In 1999, there were an estimated 158.5 million workers in Social Security-covered employment, representing over 95 percent of the total American work force.

In 2001, Social Security contributions are paid on earnings up to $80,400, 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 2000, the Social Security trust funds held assets totaling $1.1 trillion.

(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 im-
plemented 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 Euro-
pean 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 es-

tablished an unemployment program based on a similar principle.
In 1911, England followed by adopting both old age and unemploy-
ment insurance plans. Borrowing from these programs, the Roo-
sevelt Administration developed a social insurance program to pro-
tect workers and their dependents from the loss of income due to
old age or death. Roosevelt followed the European model: govern-
ment-sponsored, compulsory, and independently financed.

While Social Security is generally regarded as a program to bene-
fit the elderly, the program was designed within a larger
generational context. According to the program's founders, by meet-
ing the financial concerns of the elderly, some of the needs of the
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 establish-
ment, Social Security has been expanded and changed substan-
tially. Disability insurance was pioneered in the 1950's. Neverthe-
less, the underlying principle of the program as a mutually benefi-
cial compact between younger and older generations remains
unaltered and accounts for the program's lasting popularity.

Social Security benefits, like those provided separately by em-

ployers, are related to each worker's average career earnings.
Workers with higher career earnings receive greater benefits than
do workers with lower earnings. Each individual's 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 work-
ers 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 pre-
serve the recipient'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 recipients' self-respect.

The Social Security program came of age in the 1980's as the first generation of lifelong contributors retired and drew benefits. During the 1990's, payroll tax rates stabilized and, at the start of the 21st century, there are large accumulated reserves in the Social Security trust funds.

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 program 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 ex-
penditures, 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 of restoring solvency to Social Security equitably between workers, Social Security recipients, 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 recipients, 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 recipients.

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 from 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 (alternative II) and finally the more pessimistic alternative III. The intermediate assumptions are 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 14 percent in 1983, but increased to approximately 216 percent by 2000. Under the Social Security trustees’ intermediate assumptions, the contingency fund ratio in 2001 is an estimated 239 percent.

(D) OASDI NEAR-TERM FINANCING

Combined Social Security trust fund assets are expected to increase over the next 5 years. According to the 2001 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 24 years peaking at $6.5 trillion in 2024.

(E) OASDI LONG-TERM FINANCING

In the long run, the Social Security trust funds will experience just over two decades of rapid growth, followed by declining fund balances thereafter. Beginning in 2016, Social Security's expenditures are projected to exceed tax income (i.e., income excluding interest). Beginning in 2025, program expenditures are projected to exceed total income (i.e., tax income plus interest income). Under the intermediate assumptions, the program's cost is projected to exceed its income by 14 percent on average over the next 75 years.

It should be noted that the OASDI trust fund experience in each of the three 25-year periods between 2001 and 2075 varies considerably. In the first 25-year period (2001 to 2025) income is expected to exceed costs on average by 3 percent. Annual balances are projected to remain positive through 2024, with negative balances occurring thereafter. The contingency fund ratio is projected to peak at 436 percent at the beginning of 2014. In the second 25-year period (2026 to 2050) the financial condition of OASDI deteriorates and the trust funds are projected to become insolvent early in the period (2038) under intermediate projections. On average, program costs are expected to exceed income by 33 percent. The third 25-year period (2051 to 2075) is expected to be one of continuous deficits. As annual deficits persist, program costs are expected to exceed income on average by 40 percent.

(1) Midterm Reserves

It is projected that, from 2001 to 2024, 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 tax revenues (beginning in 2016). 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 during periods of on-budget deficits, and Social Security taxes raised and income taxes lowered when Social Security's outgo begins to exceed its income, the two tax methods have vastly different distributional consequences. The significance lies with the fact that there is incentive to spend reserve revenues at present 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 life 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 recipients 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 will, as a whole, rise somewhat over levels in the 1970’s. Currently, Social Security expenditures represent approximately 4.2 percent of GDP. Under intermediate assumptions, Social Security expenditures are expected to rise to 6.7 percent of GDP by 2075, still substantially less than the ratios of other developed nations.

(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 from 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 continued to employ the same interpretation of the 1990 law.

(G) CURRENT 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 75-year period. These firewall provisions make it more difficult to enact changes in the payroll tax rates or other aspects of the Social Security program 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, most 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 recipients 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.

Pressure to repeal or mitigate the effects of the taxation of Social Security benefits has continued. In the 106th Congress, 15 bills were introduced to liberalize the taxation provision. Ten bills (H.R. 48, H.R. 107, H.R. 688, H.R. 3438, H.R. 4865, S. 137, S. 286, S. 482, S. 488, S. 2180) would repeal the provision enacted in 1993 subjecting up to 85 percent of Social Security benefits to income taxes, returning the maximum amount that can be subject to taxation to 50 percent of benefits. Two bills (H.R. 761, S. 2304) would also repeal the 1983 provision, and thus restore the original tax-free status of Social Security benefits. Two bills would remove certain income from the computation of how much of the benefit is taxable. H.R. 291 would exclude income from municipal bonds, and H.R. 3857 would exclude income from workers’ compensation. One bill, H.R. 3437, would index the $25,000, $32,000, $34,000 and $44,000 thresholds so that they would rise each year in proportion to the rate of inflation.

On July 13, 2000, during consideration of H.R. 8, the Death Tax Elimination Act, the Senate adopted by a vote of 58–41 an amendment by Senator Grams that would have repealed the 1993 provision effective in 2001. However, this amendment was later dropped in order to make the Senate version of the bill identical to the House-passed version.

On July 19, 2000, the House Committee on Ways and Means approved H.R. 4865, a bill that, effective in 2001, would have repealed the 1993 provision, thus restoring the maximum amount of benefits subject to taxation to 50 percent, by a vote of 22–15. For
nonresident aliens, the percentage of benefits subject to income tax withholding likewise would have dropped gradually to 50 percent. According to preliminary estimates, about 20 percent of Social Security recipients (about 9 million recipients) would have been affected by the measure. The resulting loss of revenue to the Medicare trust funds was estimated to be $44.6 billion over 5 years. To compensate, an amount equal to what the 1993 provision would have generated would have been calculated by the Treasury Department and such amount would have been credited to the HI trust fund through a permanent appropriation from the general fund. The Committee also approved an amendment that would have required the Treasury Department to report to Congress annually the amount and timing of such transfers. On July 27, 2000, the House of Representatives approved H.R. 4865 by a vote of 265 to 159. A Democratic alternative, which would have raised the thresholds at which the 85 percent taxation applies to $80,000 (single) and $100,000 (couple), with the general fund reimbursing the HI trust fund for the resulting foregone revenue, was rejected by a vote of 169-256. Under the Democratic proposal, the tax reductions would have applied only in years when the portion of the budget surplus excluding Social Security and Medicare was adequate to cover the general fund reimbursement of the HI trust fund. The Senate did not take up H.R. 4865 before adjournment of the 106th Congress.

(B) SOCIAL SECURITY EARNINGS TEST

The earnings test is a provision in the law that reduces the Social Security benefits of recipients who earn income from work above specified amounts (these “exempt” amounts are adjusted each year to rise in proportion to average wages in the economy). 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 who wish to remain in the work force. Opponents 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. Fur-
thermore, 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: $12,500 in 1996; $13,500 in 1997; $14,500 in 1998; $15,500 in 1999; $17,000 in 2000; $25,000 in 2001; and $30,000 in 2002.

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 ages 65–69 were affected by the new earnings test.

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: $14,500 in 1998; $17,000 in 1999; $18,500 in 2000; $26,000 in 2001; $30,000 in 2002; $31,300 in 2003; $34,000 in 2004; $35,400 in 2005; $36,800 in 2006; $38,350 in 2007; and $39,750 in 2008. After 2008, the exempt amount once again would be indexed to average wage growth. The Senate did not take up the bill, and the measure was not included in any legislation passed by the 105th Congress.

During the 106th Congress, the Senior Citizens’ Freedom to Work Act (P.L. 106–182, signed April 7, 2000) was enacted eliminating the earnings test for persons at the full retirement age through age 69 (the earnings test did not apply to persons age 70 and older). Under the new law, recipients are no longer subject to a Social Security benefit reduction due to post-retirement earnings beginning with the month in which they reach the full retirement age. (Under the old law, Social Security benefits for recipients ages 65–69 would have been reduced $1 for every $3 of earnings above $25,000 in 2001.) During the year in which a person attains the full retirement age, the earnings test applicable to persons ages 65–69 under the old law ($25,000 in 2001) still applies for months preceding the attainment of the full retirement age.

P.L. 106–182 does not affect persons below the full retirement age (currently ages 62 to 64). In 2001, recipients below the full retirement age may earn up to $10,680 with no reduction in benefits. If they earn more than $10,680, their benefits are reduced $1 for every $2 of earnings above that amount.

(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 bene-
fits 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 earnings of recipients.

Prior to the effective date of the 1972 amendments, Social Security replaced 38 percent of pre-retirement earnings 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 earnings. 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 earnings.

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 recipients 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 and 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."
Despite the Commission's findings, a number of notch bills have been introduced in Congress over the years. Thus far in the 107th Congress, six bills have been introduced that would provide additional cash benefits to workers born in the notch years (and their dependents and survivors). There has been no legislative action on these measures.

(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, concern persists over the 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 last four Congresses would, among other things, accelerate the phase-in of the increase in the full retirement age to 67, raise the early retirement age to 65 or 67, and raise the full retirement age to 69 or 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 beginning in 2000 until it reaches age 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 under 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 reaches age 65, where it would remain, but with increased actuarial reductions as the full retirement age continues to increase.

During the 106th Congress, a number of proposals to raise the retirement age were introduced. Representative Sanford introduced a bill (H.R. 251) that would raise the full retirement age (FRA) by 2 months per year that a person was born after 1937, reaching age 70 for those born in 1967, and thereafter by 1 month every 2 years. The early retirement age would likewise rise, reaching age 65 for
those born in 1954, and rising again beginning with those born in 1968 by 1 month every 2 years. Representative Porter, et al., introduced a bill (H.R. 874) that would raise the FRA by 2 months for each year that a person was born after 1937, until it reaches age 70 for those born in 1967 or later. It would gradually increase the reduction for early retirement, reaching 53 percent for persons born after 1966. Representatives Kolbe and Stenholm introduced a bill (H.R. 1793) that would raise the FRA by 2 months per year for persons born from 1938 to 1949, and increase the early and full retirement ages by one-half month per year thereafter. From 2001 to 2005, it would gradually increase the actuarial reduction for persons retiring at the early retirement age, reaching 37 percent for persons born in 1943 and later. Representative Nick Smith introduced a bill (H.R. 3206) that would raise the FRA by 2 months per year for persons born from 1938 to 1949, and increase it by one-half month per year thereafter. Senator Moynihan introduced a bill (S. 21) that would restore the FRA to 65. Senator Gregg, et al., introduced a bill (S. 1383) that is similar to H.R. 1793, but would not change the early retirement age and would increase the reduction for early retirement beginning in 2000. None of these bills were enacted in the 106th 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 recipients should receive a full benefit surfaced. As a result, the 1983 reforms included a tax of 50 percent on benefits for higher income recipients (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. Recipients 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). Those who support
a means test contend that 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 perspective, 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

While Social Security is by law considered "off budget" for many key aspects of developing and enforcing budget goals, it is still a Federal program and its income and outgo help to shape the year-to-year financial condition of the government. As a result, fiscal policymakers often focus on "unified" or overall budget figures that include Social Security. With former President Clinton's urging that future budget surpluses be reserved until Social Security's problems were resolved, and his various proposals to use a portion of the projected surpluses (or the interest thereon) to shore up the system, Social Security's treatment in the budget became a major policy issue in the past two Congresses. In his State of the Union message in 1998 he had urged setting the entire amount of future budget surpluses aside for debt reduction. Later in the year, the House Republican leadership attempted to set alternative parameters with passage of a tax cut bill, H.R. 4579, and a companion measure, H.R. 4578, that would have created a new Treasury account to which 90 percent of the next 11 years' surpluses would have been credited. The underlying principle was that 10 percent of the surpluses be used for tax cuts and the remainder used for debt reduction until Social Security reform was enacted. Both bills, however, were opposed by Democratic Members, who argued for
setting all of the budget surpluses aside. The Senate did not take up either measure before the 105th Congress adjourned.

The idea re-emerged, however, in the 106th Congress with substantial support shown by both parties for setting aside a portion of the budget surpluses equal to the Social Security and, in some instances, Medicare Hospital Insurance (HI) trust fund surpluses. Budget resolutions for both FY2000 and FY2001 incorporated budget totals setting aside an amount equal to the Social Security surpluses for those years, as well as reserving funds for Medicare reform. By setting them aside, they in effect dedicated these amounts to debt reduction. The 106th Congress went on to consider other so-called “lock box” measures, intended to create additional procedural obstacles for bills that would have caused the budget surpluses to fall below a level equal to the Social Security (and in some cases Medicare) surpluses if not used for Social Security or Medicare reform. Among them were measures to create new points of order that could be lodged against bills that would cause budget surpluses to be less than Social Security and Medicare HI surpluses, to require new limits on Federal debt that would decline by the amount of annual Social Security surpluses, and to amend the Constitution to require a balanced Federal budget without counting Social Security. While the House approved three specific “lock box” bills consisting primarily of procedural points of order (H.R. 3859, H.R. 5173, and H.R. 5203), the Senate could not reach a consensus on them and none were ultimately passed.

The 107th Congress has considered similar legislation with House passage of H.R. 2 on February 13, 2001. H.R. 2 again attempts to create points or order against measures that would cause the budget surpluses to be less than Social Security and Medicare HI surpluses. In the Senate, similar Democratic and Republican provisions were offered as amendments to S. 420, the Bankruptcy Reform Act of 2001. One offered by Senator Conrad would have taken Medicare HI off-budget and enhanced procedural points of order for Social Security. Another offered by Senator Sessions contained provisions similar to H.R. 2. Neither amendment was adopted having been set aside due to procedural points of order raised during Senate debate on March 13, 2001.

(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 ac-
count” 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 during the past two Congresses. A number of 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 have been acted upon, Congress will likely consider similar measures in the future.

On May 2, 2001, President George W. Bush signed Executive Order 13210 establishing the President’s Commission to Strengthen Social Security. Under the Executive Order, the Commission is directed to submit recommendations to “modernize and restore fiscal soundness to the Social Security system” in accordance with 6 guiding principles: (1) modernization must not change Social Security benefits for retirees or near-retirees; (2) the entire Social Security surplus must be dedicated to Social Security only; (3) Social Security payroll taxes must not be increased; (4) government must not invest Social Security funds in the stock market; (5) modernization must preserve Social Security’s disability and survivors components; and (6) modernization must include individually controlled, voluntary personal retirement accounts, which will augment the Social Security safety net. On July 24, 2001, the Commission appointed by President Bush held its second public meeting. At that time, the Commission unanimously approved an interim report describing its views on the nature of Social Security’s long-range financing problems and, in general terms, a range of options for restoring long-range solvency to the system and improving Social Security benefits, especially for low-income individuals, women, minorities, and younger workers. The Commission will make specific recommendations on program changes in its final report due in the fall of 2001.

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 recipients 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 2026.

More recently, Congress has addressed concerns about the small number of disability recipients who leave the benefit rolls because they return to work. During the 106th Congress, legislation was enacted designed to improve work incentives for disabled recipients. The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106–170, signed December 17, 1999) created the Ticket to Work and Self-Sufficiency Program which provides a disabled recipient with a “ticket to work” that can be used to obtain employment, vocational rehabilitation, or other support services from approved providers. The service provider, in turn, is entitled to a share of the cash benefit savings that result from the recipient’s return to work.

(A) RECENT HISTORY

Since the inception of SSDI, SSA has determined the eligibility of recipients. 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 recipients 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 projected that the trust fund would be depleted 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 each 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 2001 trustees' report, the DI trust fund is projected to remain solvent until 2026 and the OASI fund is projected to remain solvent until 2040 (on a combined basis, the trust funds are projected to remain solvent until 2038).

**(B) 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 (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 finances. Federal law did not require the use of representative payees for drug addicts and alcoholics enrolled in the DI program.

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

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

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

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 disabiliing 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 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. As proposed, the new process would offer claimants a range of options for filing a claim, and claimants who are able to do so would play a more active role in developing their claims. In addition, claimants would have the opportunity to have a personal interview with decisionmakers at each level of the process. The redesigned process would include two basic steps, instead of a four-level process. The success of the new process would depend on SSA's ability to implement the simplified decision method and provide consistent direction and training to all adjudicators. Also, its success would depend on better collection of medical evidence, and the development of an automated claims processing system.

Between 1994 and 1997, SSA tested many of the 83 initiatives included in the original redesign plan. In February 1997, the Agency reassessed its plan and decided to focus on a smaller number of initiatives. On October 1, 1999, SSA began testing a prototype plan, which combines several initiatives tested by the Agency over the last few years, in 10 States: Alabama, Alaska, Colorado, Louisiana, Michigan, Missouri, New Hampshire, Pennsylvania, and parts of California and New York. An evaluation of the redesigned disability determination process in these States will allow SSA to “further analyze and refine its improvements to the disability process” prior to national implementation (SSA Performance and Accountability Report for Fiscal Year 2000).

In addition, SSA is currently implementing a Hearings Process Improvement Plan nationwide with the goal of reducing the time it takes to process a typical case from request for hearing through final hearing disposition to 180 days or less. SSA expects to reach its goal by 2004.

(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 the 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 the DI program are still eligible for benefits. By law, SSA is required to conduct CDRs to determine whether recipients 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 recipients 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 Performance and Accountability Report for Fiscal Year 2000, SSA reports that it has exceeded its CDR completion goals for each fiscal year 1998 through 2000.

(E) RETURN TO WORK AND REHABILITATION

In fiscal year 1998, 10.3 million individuals received either Social Security or SSI disability benefits. Together they represent the two largest disability programs in the nation, with estimated expenditures of $66 billion in fiscal year 1998. While both Social Security and SSI currently include a number of work incentives and offer rehabilitation services to the working disabled, the number of people who leave the rolls to return to work is very small. Currently, less than one-half of 1 percent of Social Security recipients and about 1 percent of SSI recipients leave the SSA disability rolls each year by returning to work.

The small incidence of return to work on the part of disabled recipients may be due in part to the Social Security and SSI requirements that a worker’s impairment make him or her unable to engage in any substantial work activity. Since eligibility depends upon proving inability to work, recipients risk losing both cash benefits and health insurance coverage if they attempt to work. While existing incentives in the Social Security disability and SSI programs attempt to lessen this risk, proponents of greater work opportunity argued that more focused efforts were needed to resolve the conflict between choosing work or continued health insurance coverage for disabled recipients.

During the 106th Congress, the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170, signed December 17, 1999) was enacted creating the Ticket to Work and Self-Sufficiency Program. The purpose of this new program is to help persons leave the Social Security disability and SSI rolls through greater accessibility to a broader pool of vocational rehabilitation (VR) providers. Under the new law, the Commissioner of Social Security will provide “tickets to work” to disabled Social Security and SSI recipients that can be used as vouchers to obtain employment services, case management, vocational rehabilitation, and support services from providers of their choice, including state VR agencies. The legislation also provides for up to 54 additional months of Medicare coverage for Social Security disability recipients who return to work and prevents work activity from triggering an unscheduled CDR.
As revenue raising measures, P.L. 106–170 expanded the restriction on Social Security benefits for prisoners to include certain sex offenders and prisoners jailed for under 1 year and required the Commissioner of Social Security to impose an assessment on direct fee payments to attorneys representing Social Security disability claimants to recover related administrative costs.

C. THE 107th CONGRESS

The Social Security reform debate continues as policymakers address ways to resolve Social Security's long-range financing problems. The options being considered range from relatively minor adjustments to the current program to major changes in the structure of the program such as the creation of personal savings accounts. The President's Commission to Strengthen Social Security will make specific recommendations on program changes in its final report scheduled to be released in the fall of 2001.
CHAPTER 2

EMPLOYEE PENSIONS

BACKGROUND

Many employees receive retirement income from sources other than Social Security. About half of all workers in the United States participate in pension plans sponsored by employers or unions.

In June of 2001, the President signed H.R. 1836, the Economic Growth and Tax Relief Reconciliation Act of 2001 (P.L. 107–16). Title VI of the bill deals with pension plans and retirement savings accounts. P.L. 107–16 will increase the maximum allowable annual contributions to individual retirement accounts (IRAs), § 401(k) plans, § 403(b) annuities, and § 457 deferred compensation plans for employees of state and local governments. Other measures are intended to encourage employers to offer pensions, increase participation by eligible employees, raise limits on benefits, improve asset portability, strengthen legal protections for plan participants, and reduce regulatory burdens on plan sponsors.

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 that provide members of a union with continued benefit accrual while working for any number of employers within the same industry and/or region. In 1999, approximately 57 percent of private-sector workers between the ages of 21 and 64, who worked 35 hours or more per week for the full year participated in an employer-sponsored pension or retirement savings plan. In firms with more than 500 employees, 78 percent of workers participated in a retirement plan, while just 45 percent of workers in firms of less than 500 employees participated in such plans.

Assets of retirement plans of all types totaled $3.5 trillion in 1997. Defined benefit plans had total assets of $1.7 trillion, while defined contribution plans had assets totaling $1.8 trillion. In 1997, nearly half of private plan participants (an estimated 46 percent) were 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 pay and length of service. In the private sector, 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 accrued 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, only about 3 percent of defined-benefit plans in the private sector require contributions from employees. Since the 1920's, Congress has granted special tax treatment to pension plans to encourage pension coverage. Private pensions are provided voluntarily by employers; however, the Internal Revenue Code requires that pension trusts receiving favorable tax treatment must 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.

In the Employee Retirement Income Security Act (ERISA) of 1974, Congress established minimum standards for pension plans to ensure a broad distribution of benefits and to limit the tax benefits of pensions provided to highly compensated company officers and employees. ERISA also established standards for funding and administering pension trusts and created the Pension Benefit Guaranty Corporation, an employer-financed insurance program 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 bene-
fits. 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. ERISA permits employers to exclude part-time employees, newly hired employees, and workers under age 21 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. The Tax Reform Act of 1986 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.

Since 1999, salary deferral plans have been exempted 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 defined-benefit 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).

Being covered by a pension plan does not insure that a worker will receive retirement benefits. To receive retirement benefits, a worker must vest under the plan. Vesting requires an employee to
remain 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. Under the Economic Growth and Tax relief Reconciliation Act of 2001, the maximum vesting schedule for defined contribution plans was further reduced. DC plans that use cliff vesting must now vest participants after no more than 3 years, and those that use graded vesting will have to vest participants in no more than 6 years.

(1) Access

Most non-covered 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. Beginning in 2002, this limit will rise incrementally until it reaches $10,000. 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.

According to data collected by the Bureau of the Census, of those who had received at least one lump-sum distribution between 1975 and 1995, 33 percent reported that they had rolled over the entire amount of the most recent distribution, accounting for 48 percent of the total dollar value of these distributions. Another 35 percent of recipients reported that they saved at least part of the distribution, and the remainder spent the entire amount. Thus, distributions appear to reduce retirement income rather than increase it. 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 preferential tax treatment. The revenue lost from the exemptions for pension plans is the largest tax expenditure in the Federal budget, greater than either the mortgage interest deduction or the deduction for employer-sponsored health insurance. 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.

P.L. 107-16 will incrementally raise the annual limit on IRA contributions. From 2002 to 2004, the limit will be $3,000. In 2005, 2006, and 2007, the limit will be $4,000, and in 2008 the limit will be $5,000. In years after 2008, the limit will be indexed to the CPI.

(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 unable to collect much from the financially troubled companies because they were likely to have little or no net worth.

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

The percentage of workers participating in employer-sponsored retirement plans has remained level at about 50 percent of the work force since the late 1970's. Since then, there has been a 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.

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 pension funds may be placed at risk by those who advocate that pension managers engage in “economically targeted investing” (ETI).

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 countered 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 addition, pre-retirement withdrawals were restricted unless due to hardship. The maximum contribution to a 457 plan (unfunded deferred compensation plan for a State or local government) remained at $7,500, but is coordinated with contributions to a 401(k) or 403(b) plan. (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 non-contributory 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 pen-
sion 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 em-
ployees. Like other employer-provided defined benefit plans, the Federal civil service plans are financed mostly by the employer. 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. The trust fund provides automatic budget authority for the payment of benefits to retirees and survivors without the Congress having to enact annual appropriations.

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.

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.

(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 serv-
ice. 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 calendar 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 calendar year (July, August, and September) and comparing it with that of the previous year.

(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 supplement 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 ($80,400 in 2001). The wage base is indexed to the annual growth of wages in the national economy. Executive branch employees enrolled in FERS contribute the difference between 7 percent of gross pay and the Social Security tax rate. Thus, in 2001, FERS participants contribute 0.8 percent of wages to the Civil Service Retirement and Disability Fund. This contribution rate applies to all wages, including wages about the Social Security taxable wage base.

(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 $10,500 in 2001. 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 auto-
matic 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 became available to TSP participants in May 2001.

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) 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.
(D) 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:

<table>
<thead>
<tr>
<th>Years of Social Security coverage:</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 or fewer</td>
<td>40</td>
</tr>
<tr>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>22</td>
<td>50</td>
</tr>
<tr>
<td>23</td>
<td>55</td>
</tr>
<tr>
<td>24</td>
<td>60</td>
</tr>
<tr>
<td>25</td>
<td>65</td>
</tr>
<tr>
<td>26</td>
<td>70</td>
</tr>
<tr>
<td>27</td>
<td>75</td>
</tr>
<tr>
<td>28</td>
<td>80</td>
</tr>
<tr>
<td>29</td>
<td>85</td>
</tr>
<tr>
<td>30 or more</td>
<td>90</td>
</tr>
</tbody>
</table>

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 30 years, the military retirement system has been the object of intense criticism and equally intense support among military personnel, politicians, and defense manpower analysts. Critics of the military retirement system have periodically alleged,
since its basic tenets were established by legislation enacted in the late 1940's, that it costs too much, has lavish benefits, and contributes to inefficient military personnel management. Others have strongly defended the existing system in particular, its central feature of allowing career personnel to retire at any age with immediate retired pay upon completing 20 years of service, and providing no vesting in the system before the 20-year point as essential to recruiting and retaining sufficient high-quality career military personnel who can withstand the rigors of wartime service when necessary. Major cuts in retired pay for future retirees were enacted in the Military Retirement Reform Act of 1986 (P.L. 99-348, July 1, 1986; 100 Stat. 682; the "1986 Act," now referred to frequently as the "Redux" military retirement computation system). Although enactment of Redux in 1986 represented a success for those who argued that the pre-1986 system was too generous, the repeal of compulsory Redux in late 1999 in the FY2000 National Defense Authorization Act (Secs 641.a.-644, P.L. 106--65, October 5, 1999; 113 Stat. 512 at 662) just as clearly repudiated congressional endorsement of this point of view 13 years later.

The Congress began taking notice publicly of potential problems related to Redux in 1997, well before the executive branch addressed the issue. During the fall of 1998, the Clinton Administration announced that it supported repeal of Redux. Eventually, the FY2000 National Defense Authorization Act repealed compulsory Redux; it allows post-August 1, 1986 entrants to the armed forces to retire under the pre-Redux system or opt for Redux plus an immediate $30,000 cash payment.

In fiscal year 2000, 2.0 million retirees and survivors received military retirement benefits, with total Federal military retirement outlays of an estimated $32.9 billion. Three broad 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 military Survivor Benefit Plan (SBP). With the exception of the SBP, all benefits are paid by contributions from the military services, without contributions from participants.

A servicemember becomes entitled to retired pay upon completion of 20 years of service, regardless of age. (The average non-disabled enlisted member retiring from an active duty military career in FY2000 was 42 years old and had 22 years of service; the average officer was 47 and had 24 years of service.) 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 retired pay computation base is the final monthly basic 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 (36 months) of basic pay. Basic pay is the one element of military compensation that all military personnel in the same pay grade and with the same number of years of military service receive. Basic pay; basic allowance for housing, or BAH (received by military personnel not living in military housing); basic allowance for subsistence, or BAS (cost of meals; all officers receive the same BAS; enlisted BAS varies con-
siderably based on the nature and place of duty); and the Federal income tax advantage that accrues because the BAH and BAS are not subject to Federal income tax all comprise what is known as Regular Military Compensation, or RMC. RMC is that index of military pay which tends to be used most often in comparing military with civilian compensation; analyzing the standards of living of military personnel; and studying military compensation trends over time, by service, by geographical area, or by occupational skill. RMC excludes all special pays and bonuses, reimbursements, educational assistance, deferred compensation (i.e., an economic valuation of the present value of future military retired pay), or any kind of attempt to estimate the cash value of non-monetary benefits such as health care or military retail stores. Basic pay generally comprises about 70 percent of the total military compensation, RMC and other components, being received by active duty personnel at the time they retire.

Retirement benefits are computed using a percentage of the retired pay computation base. Because the FY2000 National Defense Authorization Act gives each military member the option of choosing the pre-Redux or the Redux formulae to compute his or her retired pay, an accurate description of the retired pay computation formula is lengthy and complex. All military personnel who first entered military service before August 1, 1986 have their retired pay computed at the rate of 2.5 percent of the retired pay computation base for each year of service. The minimum amount of retired pay to which a member entitled to compute his or her retired pay under this formula is therefore 50 percent of the computation base. A 25-year retiree receives 62.5 percent. The maximum, reached at the 30-year mark, is 75 percent.

Military personnel who first enter service on or after August 1, 1986 are required to select one of two options in calculating their future retired pay, within 180 days of reaching 15 years of service:

**Option 1: Pre-Redux.**—They can opt to have their retired pay computed in accordance with the pre-Redux formula, described above, but with a slightly modified COLA formula which is less generous than that of the pre-Redux formula.

**Option 2: Redux.**—They can opt to have their retired pay computed in accordance with the Redux formula and receive an immediate (pre-tax) $30,000 cash bonus.

The Redux formula has different features for retirees who are under age 62 and those who are 62 and older:

**The Redux formula: under-62 retirees.**—For under-62 retirees, retired pay is computed at the rate of 2.0 percent of the computation base for each year of service through 20, and 3.5 percent for each year of service from 21 through 30. Under this new formula, therefore, a 20-year retiree will receive 40 percent of his or her retired pay computation base upon retirement, and a 25-year retiree will receive 57.5 percent. A 30-year retiree will continue to receive the maximum of 75 percent of the computation base. This Redux formula, therefore, is “skewed” sharply in favor of the longer-serving individual.

**The Redux formula: retirees 62 and over.**—When a Redux retiree reaches age 62, his or her retired pay will be recomputed based on the pre-Redux “old” formula: a straight 2.5 percent of the retired
pay computation base for each year of service. Thus, beginning at age 62, the 20-year Redux retiree who began receiving 40 percent of his or her computation base upon retirement will begin receiving 50 percent of the original computation base; the 25-year retiree's benefit will jump from 57.5 percent to 62.5 percent; and the 30-year retiree's benefit, already at 75 percent, will not change.

Benefits are payable immediately upon retirement from military service (except for reserve retirees, who cannot begin receiving their retired pay until age 60), regardless of age, and without taking into account any other sources of income, including Social Security. By statute, all pre-Redux benefits receive cost-of-living-adjustments (COLASs) which are fully indexed for changes in the CPI; however, retirees who elect to retire under Redux will have their COLAs held to one percentage point below that mandated by the CPI.

2. ISSUES AND LEGISLATIVE RESPONSE

(A) CONCURRENT RECEIPT OF MILITARY RETIRED PAY AND VA DISABILITY COMPENSATION

Many would argue that the military retirement issue currently receiving the greatest amount of congressional interest is that involving the interaction of military retired pay and Department of Veterans' Affairs (VA) disability compensation. Current law requires that military retired pay be reduced by the amount of any VA disability compensation received. For several years, some military retirees have sought a change in law to permit receipt of all or some of both, and legislation to allow this has been introduced in the past several Congresses. The issue is usually referred to as "concurrent receipt," because it involves the simultaneous receipt of two different benefits.

Concurrent receipt's proponents have generally argued that because military retired pay is earned for length of military service entitling one to retirement, and the VA compensation is for disability, they are provided for two completely different reasons and thus need not be offset on grounds of duplication. They also allege that people receiving VA disability compensation who are eligible for a wide range of other benefits do not have the compensation offset against their other Federal payments, and therefore military retirees should not be so targeted. Those who argue against concurrent receipt usually cite its cost estimated by the Congressional Budget Office as, for full concurrent receipt, as almost $3 billion in FY2002 and, if implemented, almost $40 billion for the FY2002–FY2011 timeframe. They also are concerned that eliminating this offset could be the "camel's nose in the tent," leading to pressure to eliminate other offsets which could cost the Federal Government tens of billions of dollars yearly. Interestingly, some analysts also assert that the reason there is no analogous offset for VA disability compensation and civilian benefits is that, in fact, the military retiree situation is unique. They note that the combinations of benefits other than the simultaneous receipt of military retirement and VA disability compensation involve receiving two separate benefits from the same Federal agency, unlike the military retirement-VA
compensation situation, where benefits from two separate Federal agencies are involved.

Congress acted in 1999 and 2000, in the FY2000 National Defense Authorization Act (Sec. 658, P.L. 106–65, October 5, 1999; 113 Stat. 512 at 668) and FY2001 National Defense Authorization Act (Sec. 657, P.L. 106–398; 114 Stat. 1654 at 1654A–166) respectively, to award a special payment to severely disabled military retirees who are also receiving VA compensation. This left both the existing prohibition on concurrent receipt and the offset requirement intact. However, it had the effect of providing a de facto partial concurrent receipt for the affected retirees (persons receiving military nondisability or disability retirement and at least 70 percent disabled; a total of about 20,000 retirees).

Numerous bills have been introduced throughout the 1990's and into the current decade to allow either partial or full concurrent receipt. None have been enacted. In the 1st session, 107th Congress, the House version of the FY2002 budget resolution directed DOD to prepare a study of concurrent receipt and report its recommendations. The Senate version, however, would have authorized $2.9 billion in new budget authority in FY2002 to "fund the payment of retired pay and compensation to disabled military retirees," which implies full concurrent receipt and is consonant with full concurrent receipt's costs as computed by CBO. However, the House provision calling for a study only prevailed in conference. Any further action in 2001 will almost certainly come in as provisions in the FY2002 National Defense Authorization Act, which has not yet been reported out of either of the Armed Services Committees as of this writing.

(B) CHANGING THE 20-YEAR RETIREMENT NORM

As noted above, the defining paradigm of the military retirement system since the late 1940's has been allowing career personnel to retire at any age with immediate retired pay upon completing 20 years of service, and providing no vesting in the system before the 20-year point. This was originally enacted, and has been defended, as essential to recruiting and retaining sufficient high-quality career military personnel who can withstand the rigors of wartime service when necessary. The lack of vesting before the 20-year mark, it is asserted, keeps people in who might otherwise leave the military much earlier. Once the career member reaches the point roughly of 8–12 years of service, the "pull" of 20-year retirement termed by some the "pot of gold at the end of the rainbow" is enough to keep people in to the 20-year point. When the 20-year mark is reached, the opportunity for immediate retirement prevents the services from being saddled with too many people in their 40's and 50's who cannot stand the stress of military life, including, but not limited to, field training, overseas deployments, and combat. These supporting comments have been matched by those highly critical of existing 20-year retirement, who say that it fails to assist personnel managers at all in retaining servicemembers in the junior part of the career force, because the 20-year retirement point is too far away to have any influence on their decisions; that it leads too many people with between 10 and 20 years of service to stay in to reach the 20-year point; and that it leads to a wholesale
hemorrhage of personnel once they reach 20 years. It has also been criticized on cost grounds; allowing large numbers of people to begin drawing retired pay beginning in their early 40's generates very substantial retired pay outlays for the Federal Government.

These sets of pros and cons have dueled for the allegiance of policymakers in both the executive and legislative branches since the 1960's, with little change until quite recently. However, two factors are leading to interest in changing the way 20-year retirement has worked. First, most analysts have come to feel that a variety of developments in officer personnel management, some resulting from statutes in the Goldwater-Nichols DOD Reorganization Act of 1986 dealing with joint duty requirements, have combined to make it virtually impossible for officers to receive a reasonable range of assignments, giving them the right kinds of experience, within the timeframe of a roughly 20-year career. This results in officers separating or retiring before they can get the requisite experience or requires the promotion of officers into senior positions without having had the breadth and depth of experience needed to best do their jobs. Eliminating near-automatic entitlement to 20-year retirement, it is felt, would do much to deal with these problems. Second, the difficulties the services are experiencing in retaining trained specialists and matching civilian salaries in high-demand occupational skills has led many to urge that military personnel should be vested in their retirement after, say, 5 to 7 years of service, perhaps with a deferred retirement benefit, so that the services can compete with the lucrative benefits offered by the private sector.

(C) 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 widespread; 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 ex-
tensive 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 plant 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.

(D) THE MILITARY SURVIVOR BENEFIT PLAN

The Military Survivor Benefit Plan (SBP) was created in 1972 by Public Law 92-425. Under the plan, a military retiree can have a portion of his or her retired pay withheld to provide a survivor benefit to a spouse, spouse and child(ren), child(ren) only, a former spouse, or a former spouse and child(ren). Under the SBP, a military retiree can provide a benefit of up to 55 percent of his or her own military retired pay at the time of death to a designated beneficiary. A retiree is automatically enrolled in the SBP at the maximum rate unless he or she (with spousal or former spousal written consent) opts not 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 perspective 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 chooses 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 retired pay on October 1, 1985 (i.e., those who had not been an 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: Supplemental Coverage

Beneficiary dissatisfaction with both the Social Security offset and the two-tier method prompted Congress to modify the military
SBP. In so doing, Congress created a supplement coverage option. 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 in order to provide the Supplemental coverage.) The costs of these additional benefits are actuarially neutral participants will pay the full cost of this option. Thus, under the Supplemental coverage option, eligible participants 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 received a 2.1 percent COLA effective January 1, 1998, a 1.3 percent COLA effective January 1, 1999, a 2.4 percent COLA effective January 1, 2000, and a 3.5 percent COLA effective January 1, 2001.

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 had 1 year to make this decision. In addition, those who have retired since May 17, 1996, including future retirees, were 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.

In 2000, a conference committee rejected Senate language that would increase the SBP benefit by “reducing the amount of the offset from a survivor benefit annuity when the surviving spouse becomes eligible for social security benefits based on the contributions of the deceased service member.” However, an amendment was included that expressed the sense of the Congress that legislation should be enacted that increases the minimum basic annuities for surviving spouses who are 62 years of age or older.
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 FY2001, $8.3 billion in retirement, disability, and survivor benefits were paid to 673,000 beneficiaries of the rail industry program. As of January 2001, the Railroad Retirement equivalent of Social Security (Tier I) is increased by 3.5 percent as a result of the Cost-of-Living Adjustment (COLA) applied to those benefits. The industry pension component (Tier II) is increased by 1.1 percent because of an automatic adjustment (32.5 percent of the Tier I COLA) to that benefit. As of September 2001, the regular Railroad Retirement annuities average $1,381 per month, and combined benefits for an employee and spouse average $1,911. Aged survivors average $826 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 2001, the tax is 6.2 percent of pay for both employers and employees up to a maximum taxable wage of $80,400.

Tier II benefits are also financed by a payroll tax. In 2001, the payroll tax is 16.10 percent for employers and 4.90 percent for employees on the first $59,700 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 determined 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 FY2001, Congress has appropriated $156 million (down from $430 million in FY 1983). 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 (most 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.
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 strengthen 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. 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.

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 most recent actuarial valuation also concluded that the system’s financing is sound for the intermediate term and probably sound for the 75 years of the actuarial valuation. Only the most pessimistic assumption resulted in cash flow problems arising between 2035 and 2068. No cash flow problems exist after 2068.

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 pro-
gram 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 105th Congress passed concurrent resolutions that urged rail labor, management, and retirees to negotiate an improvement to Railroad Retirement widow(er)ss benefits. Legislation (H.R. 4844) based on this agreement was introduced in the 106th Congress. H.R. 4844 was much broader than modification to widow(er)s' benefits. Though it was passed by the House of Representative, it was not considered by the Senate as a whole. Legislation containing the same provisions as those in the House-passed version of H.R. 4844 was introduced in the 107th Congress. The Railroad Retirement and Survivors' Improvement Act of 2001 (H.R. 1140, S. 697) would expand benefits for the widow(er)s of rail employees, lower the minimum retirement age at which employees with 30 years of experience are eligible for full retirement benefits, reduce the number of years required to be fully vested for tier II benefits, repeal a maximum limitation on benefits, expand the system's investment authority, and phase in changes to the tier II tax structure. H.R. 1140 has been passed by the House of Representative and referred to the Senate Committee on Finance. S. 697 has also been referred to the Senate Committee on Finance.
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 care.

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 taxpayers with higher incomes 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 when a single taxpayer's provisional income exceeds $34,000 or in the case of married taxpayers with provisional income in excess of $44,000. Those Federal taxes collected on Social Security income 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 with both indexed for inflation. The effect was 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 population at large but did not include provisions specifically targeting the elderly. However, this Act did provide a tax credit to small businesses for expenditures they make for removal of architectural, communication, physical, or transportation barriers that prevent 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 consisted of a variety of measures applying to particular types of taxpayers, income, and activities. Included among its most promi-
nent features and of interest to many older Americans were a cut in the tax rates that apply to capital gains, a reduction of estate taxes, and the expansion of Individual Retirement Accounts.

The Economic Growth and Tax Relief Reconciliation Act of 2001 (P.L. 107-16) included broad-based tax cuts and some targeted provisions. The new law reduces tax rates and expands exemptions for the estate and gift tax over time, and eventually repeals the estate tax (retaining a gift tax and providing for carry-over basis for assets, both with large exemptions). Pension provisions have been liberalized, limits on IRAs are increased, and special catch-up contributions to IRAs are allowed for those age fifty and over.

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 in the case of 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 and the standard deduction, the additional standard deduction for the elderly is 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 completely 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 included in 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 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 in the case of higher income beneficiaries. Thus, 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). Social Security 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 only on up to one-half of their benefits. Taxes collected on Social Security benefits are returned to the Social Security trust funds.

Revenues from the taxation of Social Security benefits have risen in every year since the tax was first imposed. Thus, these revenues are a continuing source of funding for Social Security. In 1997, $7.9 billion was contributed to the trust fund. That contribution in funding rose to $9.7 billion in 1998, $11.6 billion in 1999, and $12.3 billion for calendar year 2000.

(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, but Social Security and Railroad Retirement (Tier I) benefits were tax-free. The congressional rationale for this credit was 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 income 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 lend 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 a qualified facility must own or operate substantially all of the facilities used to provide care by the continuing care facility and that substantially all of the residents must have entered into continuing care contracts. Thus, qualified facilities hold the proceeds of the loans and in turn provide 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 lent to a continuing care facility is inflation adjusted. In 2001 a taxpayer may lend up to $144,100 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 the 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 as provided by the Act, the provision of future inflation adjustments, and the addition to the Internal Revenue Code of an extra standard deduction amount for those elderly (or blind) taxpayers who do not itemize deductions.

(2) Deduction of Medical and Dental Expenses

The Medicare program has grown from 19 million to 40 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 percent Medicare versus 11.3 percent 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 13 percent. In 1999 it was found that elderly households with less than $10,000 in after-tax income spent 27 percent for health expenditures. Shares continue to fall with incomes: 21 percent for the $10,000 to $20,000 class, 14 percent for the $20,000 to $30,000 class, 12 percent for the $30,000 to $40,000 class, 9 percent for the $40,000 to $50,000 class, 8 percent for the $50,000 to $70,000 class. Elderly households with after-tax incomes greater than $70,000 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, installation 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 3 year period, 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 2001 is $2,900. The standard deduction is $4,550 for a single person, $6,650 for a head of household, $7,600 for a married couple filing jointly, and $3,800 for a married person filing separately. The additional standard deduction amount for an elderly single taxpayer is $1,100 while married individuals (whether filing jointly or separately) may each receive an additional standard deduction amount of $900.

(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 2001, single persons age 65 or older do not have to file a return if their income is below $8,550. For married couples filing jointly, the limit is $14,300 if one spouse is age 65 or older and $15,200 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 $1,850 ($2,950 if 65 or older and blind), or their gross income exceeds the larger of $750 or the filer's earned income (up to $4,300) plus $250, plus $1,100 ($2,200 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 $4,700 ($5,600 if 65 or older and blind), their unearned income exceeds $1,650 ($2,550 if 65 or older and blind), or their gross income was more than the larger of $750 or their earned income (up to $3,550) plus $250, plus $900 ($1,800 if 65 or older and blind). All these amounts may rise for tax year 2002 since they are subject to an inflation adjustment.

(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 2001, the 31 percent rate applies to single individuals with taxable income (not gross income) between $65,550 and $136,750. It applies to joint filers with taxable income between $109,250 and $166,550, and to heads of households with taxable income between $93,650 and $151,650. 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 2001 begins at $132,500 for single filers, $199,450 for joint filers, and $166,200 for heads of households. OBRA90 also provided a limitation on itemized deductions. Allowable deductions for 2001 were reduced by 3 percent of the amount by which a taxpayer's adjusted gross income exceeds $132,950. Deductions for medical expenses, casualty and theft losses, and investment interest are not subject to this limitation. (These phase-outs are scheduled to be repealed over a number of years by the 2001 tax legislation).

Additionally, the Act raised excise taxes on alcoholic beverages, tobacco products, and 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 luxury tax on cars is being phased out.

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 pro-
vide 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 em-
ployees are those who 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. How-
ever, as might be expected, some high-income elderly will pay high-
er Federal taxes. Some of the excise taxes were found to have a
negative effect on the elderly, in particular the 5 cents a gallon in-
crease 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 in-
cluded 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. In 2001, this rate applies to single individuals
with taxable incomes between $136,750 and $297,350 ($166,500/
$297,350 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 $297,350. It also made perma-
nent 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 men-
tioned earlier in this print, an increase was provided in the tax-
atation 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 ex-
tension 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 Secu-
rity 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

This Act (P.L. 105-34) provided 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 narrowly focused 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 that 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 tax 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 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. Additional detail on the IRA provisions is provided later in this chapter.

(3) Estate and Gift

The Act reduced the estate and gift tax in a number of ways, but by far the largest reduction was a phased-in increase of the unified credit, which provided an effective tax exemption for transfers below a certain level. The 1997 Act gradually increased the exemption to $1,000,000, as follows: $625,000 in 1998; $650,000 in 1999; $675,000 in 2000 and 2001. Further scheduled increases have been superseded by the Economic Growth and Tax Relief Reconciliation Act of 2001 (P.L. 107–16). That Act provided 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 account provisions.

(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 1980's the Economic Recovery Tax Act of 1981 (ERTA) and the Tax Reform Act of 1986 (TRA86). 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 we will not attempt a full assessment of the Taxpayer Relief Act, 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.

**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 includable 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.

**THE ECONOMIC GROWTH AND TAX RELIEF**

Reconciliation Act of 2001 (P.L. 107–16) was a major tax revision, although provisions are phased in over a 9-year period. It lowers marginal tax rates, create a new bottom 10 percent tax bracket, increases the standard deduction and width of the 15 percent rate bracket to twice that of single returns for married taxpayers who
file jointly, eliminates phase-outs of itemized deductions and personal exemptions, expands the child credit and makes it partially refundable, reduces rates and expands exemptions for the estate and gift tax (eventually repealing the estate tax while retaining the gift tax and providing for a carry-over basis for assets, liberalizes and expands on IRA, pension, education, and child care benefits and pensions. Because the bill passed as part of the budget resolution, it sunsets at the end of 2010, but the following discussion assumes the provisions will be made permanent. The discussion focuses on two provisions that may be of special interest to older taxpayers: the phaseout of the estate and gift tax and the increase in the individual retirement account limits.

(1) Estate and Gift Tax

The estate and gift tax revisions gradually reduce the rates and increase the exemptions for the estate and gift tax (with rates falling to 45 percent and exclusions rising to $3.5 million by 2009). In 2010 the estate gift tax is repealed. A gift tax would be retained with the continued annual exclusion of $10,000 per donee plus a $1 million lifetime exemption. A rationale for retaining the gift tax is to prevent the splitting of assets among wealthy families to take advantage of lower tax rates under a progressive rate structure. In addition, appreciated assets will be subject to "carryover basis" rules when the estate tax is repealed: thus, when heirs sell assets they will have to include in gains the appreciation that occurred during the lifetime of the donor.

(2) Individual Retirement Accounts

The tax cut will gradually increase the limits on IRAs: to $3,000 in 2002-4, $4,000 in 2005-7, and $5,000 in 2009, with amounts subsequently indexed in $500 increments. Individuals over age 50 will be allowed an additional $500 in 2002-5, and an additional $1,000 in 2006 and thereafter.

(3) Pensions

For pensions, the bill contains provisions designed to expand coverage by increasing contribution and benefit limits for qualified plans and by increasing elective deferral limits. The bill also contains provisions designed to enhance pension benefits for women, to increase plan portability, to strengthen pension security and enforcement, and to reduce regulatory burdens.

(4) The Impact of the Economic Growth and Tax Relief Reconciliation Act of 2001

This tax bill had general tax cuts that tend to favor higher income individuals (rate reductions, estate and gift tax), with more targeted tax cuts for the middle class that particularly favored married couples and families with children. Overall, the tax changes increased the disposable income more for higher income individuals.
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 tradeoff 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. According to the Census Bureau’s Current Population Reports on Money Income in the United States, in 1999, 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 20 percent of the total income of white households, but for less than 10 percent of black and Hispanic household income.

The median net worth of all families in 1998 was $56,400, according to the Federal Reserve Board’s Survey of Consumer Finances. The median net worth for white families was $94,900, while the median net worth for other families was $16,400. The wealthiest age group included those families headed by someone between the age of 55 and 64, whose median net worth was $146,500.

The effort to increase national investment springs, in part, 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 1990’s ranged between 4 percent and 9.5 percent of disposable income but, recently it has fallen considerably 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. Most recently, the rise in the stock market was argued to increase wealth and, because of higher wealth, consumption. (Indeed, this possible reason illustrates one of the uncertainties regarding the effects of rates of return on savings: higher returns can actually discourage savings through an “income” or “wealth” effect. When individuals have higher wealth and income they consume more at every point in time. Higher returns also provide a substitution of consumption into the future which increases savings, and the final effect on savings depends on the magnitude of these income and substitution effects.) 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 2000, Commerce Department figures indicate that the personal savings rate was 0.2 percent, compared to 2.2 percent for 1999. 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 (and empirical evidence on this issue is mixed), critics suggest this outcome 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. IRA availability was limited in the Tax Reform Act of 1986 (TRA) to those with no employer pensions plans and lower and moderate income individuals with employer plans. However, the availability of IRAs was greatly expanded in 1997 and contribution limits were increased in The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA). The 2001 Act also liberalized pension tax rules in a variety of ways.

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 existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy.

2. ISSUES

(A) INDIVIDUAL RETIREMENT ACCOUNTS (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 ex-
isting 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 10 percent penalty on early 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.
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 (MSAS) 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 non-deductible 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 FIRE (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 H.R. 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, non-working 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 expenses 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 1 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).

(d) Additional Proposals and The Economic Growth and Taxpayer Relief and Reconciliation Act of 2001 (EGTRRA)

Proposals to expand IRAs continued following the 1997 tax cut. The Senate version of the Taxpayer Refund and Relief Act of 1999, would have increased contribution limits to $5,000, increased income limits for deductible IRAs and eliminated income limits for Roth IRAs. The House bill's provisions were much more limited: Roth IRA limits would have been increased. The final bill more closely followed the Senate version, although the income limits for Roth IRAs were to be increased with no change for deductible IRAs. The President vetoed the tax cut because of its large revenue cost. Several bills including IRA provisions saw some legislative action in 2000, but none were enacted.

EGTRRA expanded both IRAS and benefits for pensions in general. Under EGTRRA, IRA limits will be increased to $3,000 in 2002–4, $4,000 in 2005–7 and $5,000 in 2008. Thereafter the limits will be indexed for inflation. EGTRRA increased the maximum contributions for those 50 and over by an additional $500 in 2002–5 and $1,000 in 2006 and subsequent years. Some, but not all, proposals during the 1998–2000 period proposed increasing the income limits as well, but these increases were not included in EGTRRA.

EGTRRA also enacted a temporary tax credit for elective deferrals and IRA contributions for lower income individuals in 2002, beginning at 50 percent and falling to 10 percent, but this provision is to sunset after 2006.

(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 principle 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 1 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

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 an-
other 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 savings. 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. Second, 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 Pro-
grams 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 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 buildup 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 deny 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. Because 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. 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 that 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, the number of complaints has declined to 16,008 in fiscal year 2000.

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, 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 2000, the EEOC received 16,008 ADEA complaints and filed suit in just 27 cases.

3. The Age Discrimination in Employment Act

(A) BACKGROUND

Over three decades ago, 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 should 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 its enactment in 1967, the ADEA has been amended numerous 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 covered workers was also 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
shift 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 included 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. In addition, 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 Act Amendments of 1996 (P.L. 104–208) amended the 1986 amendments to restore the public safety exemption. These amendments allowed 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 (P.L. 105–244) (HEA of 1998). The HEA of 1998 created 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 high-
er education. 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, the exemption expired.

The Committee reached two key conclusions:

1. 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.

2. 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 suggested 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 that Congress, the Internal Revenue Service, and the EEOC "permit colleges and universities to offer faculty voluntary retirement incentive programs that are not classified as an employee benefit,
include an upper age limit for participants, and limit participation on the basis of institutional needs.” The Committee also recommended policies that would allow universities to change their pension, health, and other benefit programs in response to changing faculty behavior and needs.

The 1998 ADEA amendments contained in the Higher Education Amendments of 1998 incorporated the suggestions of the Committee. The HEA of 1998 allowed 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 prohibited 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 1985, the Court outlined the standards for proving a “bona fide occupational qualification” (BFOQ) defense for public safety jobs in two cases, *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 indicated 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 either because (a) it has reasonable cause to believe that all or substantially all persons over that age would be unable to safely do the job or (b) it is highly impractical to deal with older persons individually.

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

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

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. In addition, they contend that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under the ADEA. Because of the conflicting case law on BFOQs, costly and time-consuming litigation would be likely. They note that jurisdictions wishing to retain the hiring and retirement standards 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 these governments 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 maintain 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.

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

The 1986 amendments to the ADEA 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, albeit 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. The EEOC did not promulgate guidelines to assist State and local governments in administering the use of such tests.

In the early 1990's, the issue of mandatory retirement for public safety officers was addressed in two bills introduced in the House of Representatives. On July 23, 1993, Representative Major R. Owens, together with Representative Austin J. Murphy and 15 other cosponsors, introduced H.R. 2722, "Age Discrimination in Employment Amendments of 1993." It is similar but not identical to H.R. 2554, "Firefighters and Police Retirement Security Act of 1993," that Representative Murphy introduced on June 29, 1993.

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

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

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

On November 8, 1993, H.R. 2722, as amended, passed in the House by voice vote, under suspension of the rules (two-thirds vote required). On November 9, 1993, H.R. 2722 was referred to the Senate Committee on Labor and Human Resources. There was no further action on H.R. 2722 in the 103d 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 established by showing simply that an employee was replaced by someone outside of the class. The plaintiff must show that he was replaced because of his age. The Court evaluated whether the prima facie elements evinced by the U.S. Court of Appeals for the Fourth Circuit 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." The Court found 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. 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.

In 1993, the Court ruled on two cases affecting the aged 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 held unanimously that there can be no violation of the ADEA when the employer's allegedly unlawful conduct is motivated by some factor other than the employee's age. The fact that an employee's discharge occurred a

---

2 *O'Connor*, 517 U.S. at 310.
3 See *O'Connor*, 517 U.S. at 312. Justice Scalia, writing for the majority, stated: "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'" (voting *Texas Dept. of Community Affairs v. Burdine*, 450 U.S. 248, 254 n. 7 (1981).
few weeks before his pension was due to vest did not establish a per se violation of the statute.

In Biggins, 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 affirmed the judgment on both the ADEA and ERISA counts, but reversed on the issue of willfulness.

On appeal, the 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 on productivity and competence directly instead of relying on age as a proxy for them. However, 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 is usually the case with pension status. O’Connor 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 recently hired. 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 that its holding did 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 Biggins Court also held that the “knowledge or reckless disregard” standard for liquidated damages established in TransWorld Airlines, Inc. v. Thurston, 469 U.S. 111 (1985), 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 Court altered the burden shifting analysis for resolving Title VII intentional discrimination cases set forth in Texas Department of
tiffs 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 Reeves v. Sanderson Plumbing Products, 530 U.S. 133 (2000), the Court ruled that a plaintiff’s prima facie case, combined with sufficient evidence to find that the employer’s asserted justification is false, may permit the trier of fact to conclude that the employer engaged in unlawful discrimination. Reeves, a then 57 year-old supervisor at Sanderson Plumbing, was discharged for allegedly making numerous timekeeping errors and misrepresentations. At trial, Reeves established a prima facie case for violation of the ADEA and offered evidence to demonstrate that Sanderson Plumbing’s explanation for his termination was a pretext for age discrimination. Reeves introduced evidence of his accurately recording the attendance and hours of the employees under his supervision. Reeves also showed that an executive at Sanderson Plumbing demonstrated age-based animus in his dealings with him. A jury awarded Reeves $35,000 in compensatory damages. The district court awarded $35,000 in liquidated damages, based on the jury’s finding that the age discrimination was willful, and an additional $28,491 in front pay. The Fifth Circuit reversed, finding that Reeves had not introduced sufficient evidence to sustain the jury’s finding of unlawful discrimination.

The Supreme Court reversed the Fifth Circuit’s decision. Justice O’Connor, writing for a unanimous Court, maintained that the Fifth Circuit disregarded impermissibly critical evidence favorable to Reeves. To determine whether a party is entitled to judgment as a matter of law, a reviewing court must consider the evidentiary record as a whole and disregard evidence favorable to the moving party. The Fifth Circuit ruled that Sanderson Plumbing was entitled to judgment as a matter of law. However, in disregarding evidence favorable to Reeves and failing to draw all reasonable inferences in his favor, the Fifth Circuit impermissibly substituted its judgment concerning the weight of the evidence for the judgment of the jury.

Since 1990, the Court has decided several other cases involving the ADEA. In Gilmer v. Interstate/Johnson Lane Corp., 500 U.S. 20 (1990), the Court found 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
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 Appfels Coffee Co., 792 F.2d 1492 (9th Cir. (1992)). As a result of the holding in Hicks, an employee who dis credits all of an employer's articulated legitimate non-discriminatory reasons for an employment decision is not automatically entitled to judgment in an action under the ADEA.

Prior to Hicks, in McDonnell-Douglas Corp. v. Green, 411 U.S. 792 (1973), the Court established a three-step framework for resolving Title VII cases involving intentional discrimination. This framework was reaffirmed by the Court in Burdine: 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 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 majority in Hicks held that an employee who dis credits all of an employer's stated reasons for his demotion and subsequent discharge is not automatically entitled to judgment in his case under Title VII. Accordingly, the trial court in Hicks was justified in granting 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 viewed him differently. At trial, the plaintiff alleged that the employment decisions were racially motivated. However, the employer claimed that the plaintiff had violated work rules. The district court found this reason to be pretextual. Nevertheless, it ruled for the halfway house. The district court felt that the plaintiff had not shown that the effort to terminate him was motivated by race rather than some other factor. The U.S. Circuit Court of Appeals for the Eighth Circuit reversed. The Eighth Circuit maintained 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 held that the plaintiff was not entitled to judgment even though he had established a prima facie case of discrimination and disproved the employer's only proffered reason for its conduct. Instead, the majority said that plain-
ADEA claim with the EEOC upon being fired at age 62. The Court maintained that Congress would have explicitly precluded arbitration in the ADEA had it not wanted arbitration to be an appropriate method of attaining relief. The compulsory arbitration clause required simply that the plaintiff's claim be brought in an arbitral rather than a judicial forum.

In *Oubre v. Entergy Operations, Inc.*, 522 U.S. 422 (1998), the 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.

Finally, in *Kimel v. Florida Board of Regents*, 528 U.S. 62 (2000), the Court determined that states are immune from suit by public employees under the ADEA. In a divided opinion, the Court found that the ADEA is not appropriate legislation under section 5 of the Fourteenth Amendment. As legislation enacted solely under Congress' Commerce Clause authority, the ADEA did not abrogate the states' sovereign immunity. Because the ADEA prohibits substantially more state employment decisions than would likely be found unconstitutional under the applicable equal protection rational basis standard, the Court maintained that it lacked a "congruence and proportionality" between the injury to be prevented or remedied and the means adopted to achieve that end. Further, the Court found no evidence in the legislative history of the ADEA to suggest that state and local governments were unconstitutionally discriminating against their employees. Thus, the enactment of the ADEA did not appear to be appropriate legislation under section 5 of the Fourteenth Amendment.

**B. FEDERAL PROGRAMS**

There are two primary sources of Federal employment and training assistance available to older workers. The first, and larger of the two, is "Adult and Dislocated Worker Employment and Training Activities" 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 was to consolidate, coordinate, and improve employment, training, literacy, and vocational rehabilitation programs. Among other things, WIA repealed the Job Training Partnership Act (JTPA) on July 1, 2000, and replaced it with new training provisions under Title I of WIA. States were required to implement WIA no later than July 1, 2000. The first full year of WIA implementation ended June 30, 2001. Data is
not yet available on the total number of individuals served or the percent who were 55 years of age and older.

Under WIA, for the most part, one set of services and one delivery system are authorized both for “adults” and for “dislocated workers,” but funds continue to be appropriated separately for the two groups. Funds for these programs are contained in the Labor-HHS-ED appropriations act. The FY2001 appropriation for adult activities is $950 million, and for dislocated workers is approximately $1.4 billion.

Funds from the adult funding stream 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. At least 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 used to allocate funds to States. 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.

Funds from the dislocated worker funding stream 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. 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. Local areas, with the approval of the Governor, may transfer 20 percent of funds between the adult program and the dislocated worker program.

Funds appropriated for adult and dislocated worker activities are used to provide services to adults age 18 and older and to individuals who meet the definition of being a dislocated worker (i.e., a person who has lost a job or received notice, and is unlikely to return to the current job or industry; was self-employed, but is now unemployed due to economic conditions or natural disaster; or is a displaced homemaker.) Three levels of service are provided: “core services,” “intensive services,” and “training services.” Any individual who meets the definition of an adult or a dislocated worker 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 or retain employment through those services. There is no income eligibility requirement for receiving services, although for intensive and training services provided from appropriations for adult activities, local areas are required to give priority 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 (ITA’s), which are used by participants to purchase training services from eligible providers in consultation with a case manager. (Eligible providers are entities that meet minimum requirements established by the Governor.) Payments from ITA’s may be made in a variety of ways, including the electronic transfer of funds through financial institutions and vouchers. In addition to core, intensive, and training service, local areas can decide whether or not to provide supportive services, such as transportation and child care to individuals receiving any of the three levels of service who are unable to obtain them through other programs.

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 years 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 1960’s 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.

Persons eligible under the program must be 55 years of age and older (with priority given to persons 60 years and older), unemployed, and have income levels of not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services (DHHS).

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 1999–2000 (July 1, 1999-June 30, 2000), 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. About 74 percent of participants were women. About half completed high school education. About 84 percent of participants were age 60 and older and over one-third were 70 years or older. Members of minority racial or ethnic groups made up 42 percent of total participants.

For further information, see section on the Older Americans Act.
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 January 2001, 6.4 million individuals received assistance under the program.

To those who meet SSI's nationwide eligibility standards, the program provides monthly cash payments. In most States, SSI eligibility automatically qualifies recipients for Medicaid coverage and food stamp benefits. 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 1999, the elderly poverty rate was 9.8 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.

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 systematic 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, or who are blind or disabled and were lawfully residing in the United States on August 22, 1996 to maintain their SSI eligibility.

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 expected to result in death or that can be expected to last, or has lasted, for a continuous period of 12 months. Disabled children are those with marked and severe functional limitations.

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, $531 for an individual and $796 for a couple in 2001. 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 medi-
cal 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 2001, that totaled $354 for a single person and $531 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 December 1999, 4.1 percent, or 268,800 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 DETERMINATION PROCESS

In 2000, it was estimated that 8.7 million DI and disabled adult SSI beneficiaries received benefits from SSA. The workload for initial disability claims was 2.0 million in fiscal year 2000. In 1994, SSA began to examine the disability process used for the SSI and Social Security Disability Insurance (SSDI) programs. This represented 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. In 1996, SSA developed a 7 year plan to process the backlog of continuing disability reviews (CDRs) and to address the new SSI CDR workload. SSA became current in the SSDI program in 2000 and expects to be current in the SSI program by the end of fiscal year 2002. SSA has taken steps to reduce hearing processing times from the peak of 397 days in fiscal year 1997 to about 300 days as of June 2001. Processing times for cases at the Appeals level have been reduced by 140 days since April 2000 and pending cases have been reduced by 45,000. Over the 7 years of its plan, SSA estimates an average savings of $10 in benefits for every administrative dollar spent.

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.

SSA is developing a plan to identify the near-term and longer-term operational policy changes and disability process improvements to improve the administration of the SSI and SSDI programs. SSA is currently testing a new decision process in 10 states. This process involves an enhanced role for the disability examiner at the State DDS, the elimination of the reconsideration step for initial disability claims, and the implementation of informal conferences between the decisionmaker and the claimant if the evidence does not support a fully favorable determination. Early indications suggest that the new process has improved the accuracy of disability determinations. Once sufficient data has been gathered on these test sites, SSA will decide whether to extend the process to other states.

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 352,940 in March 2001; 12,450 of the individuals with earnings were age 65 and older.

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 $740) 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 March 2001, only 5.3 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 activ-
ity 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 106th Congress, the Ticket to Work and Work Incentive Improvement Act (P.L. 106-170) was signed into law. The law contained a number of provisions designed to eliminate work disincentives that existed in the SSI program. Under this law, an individual whose eligibility for SSI benefits (including eligibility under section 1619(b)) has been terminated due to 12 consecutive months of suspension for excess income from work activity, may request reinstatement of SSI benefits without filing a new application. To be eligible for this expedited reinstatement of benefits, an individual must have become unable to continue working due to a medical condition and must file the application for reinstatement within 60 months of the termination of benefits.

The ticket to work law also requires SSA to establish a community-based Work Incentive Planning and Assistance Program to provide individuals with information on SSI work incentives. Specifically, SSA must establish a corps of work incentive specialists within the agency and a program of grants, cooperative agreements, and contracts to provide benefit planning and assistance to individuals with disabilities and outreach to individuals who may be eligible for the Work Incentive Program. SSA is authorized to make grants directly to qualified protection and advocacy programs to provide services and advice about vocational rehabilitation, employment services, and obtaining employment to SSI beneficiaries.

P.L. 106-170 allows States to have the option of covering additional groups of working individuals under Medicaid. States may provide Medicaid coverage to working individuals with disabilities who, except for their earnings, would be eligible for SSI and to working individuals with disabilities whose medical conditions have improved. Individuals covered under this new option could buy into Medicaid coverage by paying premiums or other cost-sharing charges on a sliding fee scale based on income established by the State. States are permitted to allow working individuals with incomes above 250 percent of the Federal poverty level to buy into the Medicaid Program.

4. FRAUD PREVENTION AND OVERPAYMENT RECOVERY

During the 106th Congress, legislation related to SSI fraud reduction and overpayment recovery was signed into law. The Foster Care Independence Act of 1999 (P.L. 106-169) contained provisions to make representative payees liable for the repayment of Social Security benefit checks distributed after the recipient's death and authorized SSA to intercept Federal and State payments owed to individuals and to use debt collection agencies to collect overpayments. Under the law, individuals or their spouses who dispose of resources at less than fair market value will be ineligible for SSI benefits from the date the individual applied for benefits or, if later, the date the individual disposed of resources at less than fair market value, for a length of time calculated by SSA. The ineligibil-
ity period may not exceed 36 months. Certain resources are exempt from the provision and the Commissioner of SSA has some discretion in making determinations regarding ineligibility. P.L. 106–169 authorized SSA to establish new penalties for individuals who have fraudulently claimed benefits in cases considered too small to prosecute in court. Health care providers and attorneys convicted of fraud or administratively fined for fraud involving SSI eligibility determinations are barred from participating in the SSI program for at least 5 years under P.L. 106–169. Under the law, assets and income in irrevocable trusts, previously exempt from SSI resource limit calculations, will be counted toward the resource limits for program eligibility and for determining benefit amounts.
Chapter 6

FOOD ASSISTANCE PROGRAMS AND FOOD SECURITY AMONG THE ELDERLY

OVERVIEW: 1999–2000

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 programs), the Federal Government supports three non-emergency food assistance programs affecting significant numbers of older persons: the Food Stamp program, the Commodity Supplemental Food program, and the Child and Adult Care Food program.1

Significant legislative revisions to the Food Stamp program were included in FY2001 Agriculture Department appropriations measure, and the Agriculture Risk Protection Act contained amendments affecting administration of the Child and Adult Care Food program. The FY2001 appropriations law changed rules governing the treatment of vehicles as assets in judging food stamp eligibility, liberalized the treatment of excessively high shelter expenses when determining food stamp benefits, and revised the terms of Puerto Rico’s nutrition assistance block grant (operated in lieu of food stamps in the Commonwealth). The Agriculture Risk Protection Act incorporated amendments to improve the integrity and management of the Child and Adult Care Food program. No legislation affecting the Commodity Supplemental Food program was considered in the 106th Congress.

In 1999 and 2000, food stamp enrollment and spending continued to drop significantly. Participation went from a monthly average of 19.8 million persons during FY1998, to 18.2 million people in FY1999 and 17.2 million in FY2000. An improved economy, program changes wrought by Federal and State welfare reform initiatives, and restrictions on eligibility placed into law in 1996 (e.g., loss of eligibility for many noncitizen and able-bodied adults without dependents) contributed to this decline. Participation by elderly persons, (age 60+), on the other hand, increased slightly from 1.6 million people in FY 1998 to 1.7 million in FY2000; overall, the proportion of elderly recipients in the food stamp caseload rose

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 state agencies)—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 like food banks, food pantries, and emergency shelters/soup kitchens. The Emergency Food and Shelter program, operated under the Federal Emergency Management Administration, makes grants to local public and private nonprofit entities (through local boards) to provide services to the homeless. No significant legislative changes were made to these programs in the 106th Congress.
from 8.2 percent in FY1998 to 10 percent in FY2000. However, the rate at which eligible elderly persons actually enroll in the Food Stamp program (a 29 percent participation rate) remains the lowest of any major demographic group other than able-bodied adults without dependents. Spending for the regular Food Stamp program tracked the decline in participation and decreased from $19.2 billion in FY1998, to $18.1 billion in FY1999 and $17.3 billion in FY2000.

Participation by elderly persons in the Commodity Supplemental Food program and the Child and Adult Care Food program grew noticeably in 1999 and 2000. Elderly enrollees in the Commodity Supplemental Food Program increased from 249,000 persons in FY1998, to 279,000 people in FY1999 and 294,000 in FY 2000, while spending for all recipients (including women, infants, and children) grew from $89 million in FY1998, to $90 million in FY1999 and $92 million in FY2000. Participation in and spending for the adult-care component of the Child and Adult Care Food program also rose—from 58,000 persons in ($32 million) in FY1998, to 63,000 people ($37 million) in FY 1999 and 68,000 ($43 million) in FY2000.

A. BACKGROUND ON THE PROGRAMS

1. FOOD STAMPS

The Food Stamp program provides monthly benefits—averaging $73 a person in FY2000—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 counties 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 par-
ticipation. 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 (particularly the elderly who were resident in the United States at enactment of the welfare reform law in August 1996). Two other 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).2

Eligibility. Applicants for food stamps must have their eligibility determined, and if eligible, their benefits issued, within 30 days of application—or 7 days if they are very poor. In most cases, benefits are issued within 2 weeks of initial application; however, applicants can be refused benefits if they fail to cooperate with the State administering agency in obtaining the information necessary for a determination. Initial determination of eligibility usually involve face-to-face interviews and presentation of requested documentation about income, assets, living expenses (such as rent and utility payments), and other items (or contacts that can provide corroboration of household circumstances).

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; ineligible individuals (e.g. some noncitizens) living with others may be treated as non-household members (although their financial resources can be counted as available to their co-residents). Households are certified eligible for “certification periods” that differ according to the variability of their circumstances: from 1-3 months to as long as 2 years. They often must have to face-to-face interviews for recertification, and during their certification period, they must report significant changes in their circumstances. States, in turn, must act on those reports of changed circumstances (e.g., income, household size) by adjusting benefits or eligibility status.

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 eligi-

---

2See the discussion of Legislative Developments in the next section of this chapter for the most recent legislative changes.
ability to households with monthly total cash income at or below 130 percent of the Federal income poverty guidelines, annually adjusted 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 FY2001, 130 percent of the poverty guidelines equals $905 a month for one person, $1,219 for two-person households, $1,533 for three-person households, and higher amounts for larger households. However, a slightly more liberal income 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, either all or a portion of the value of any car, certain 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 generally is limited to legal residents (1) with substantial U.S. work histories, (2) who are veterans or active duty military personnel (and their families), (3) who are refugees, asylees, Cuban/Haitian entrants, or have been admitted for certain humanitarian reasons (for seven years after entry), (4) who are children and entered the country by August 22, 1996, (5) who were elderly (age 65+) and here as of August 22, 1996, (6) who receive disability benefits and entered before August 22, 1996 (including persons who become disabled after that date), and (7) who are 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.

---

3 Income eligibility limits are 25 percent higher in Alaska and 15 percent higher in Hawaii.
Benefits. Food stamp benefits are aimed at increasing recipients’ food purchasing power. In FY2000, monthly benefits averaged $73 a person (about $180 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 (see the discussion of “deductions” below). 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—i.e., 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). This is done 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. Deductions for dependent care costs and for the shelter expenses of households without elderly or disabled person are subject to monthly dollar limits. As a result of these deductions, an average of about 50 percent-60 percent of gross monthly household income is actually counted as net income for benefit determinations.

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 FY2001, maximum monthly benefits in the 48 States and the District of Columbia are $130 for one person, $238 for two-person households, $341 for three-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 all States and the District of Columbia (representing over three-quarters of recipients) now receive their benefits through electronic benefit transfer (EBT) systems. These EBT systems deliver benefits by using special ATM-like debit cards rather than coupons, and all States are expected to use EBT systems by the end of 2002. Food stamp benefits also can, in some cases, be paid as cash—in a lim-
ited 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 ($1.3 billion in FY2001), and the program serves some 1.1 million persons. The programs in American Samoa and the Northern Marianas also are limited to 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, 29 percent by the most recent count (1999). This compares with a participation rate of 57 percent among all those eligible. Based on preliminary Agriculture Department survey data for FY2000, households with at least one elderly member account for 21 percent of food stamp households. But, because the elderly generally live in small households (e.g., 80 percent live in single-person households, typically single women), 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. Using FY1999 estimates, 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 monthly average household benefit is 37 percent of 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 against the standard is significantly less because the various deductions (nearly $300 a month on average) have been subtracted out.

- A more liberal asset limit is used in judging eligibility. 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 $340 a month.

- When calculating benefits and income eligibility, elderly (and disabled) households can claim a deduction for any out-of-pocket medical costs above $35 a month; this deduction is not available to others. For those claiming this deduction, it is typically over $100 a month, translating into a monthly benefit increase of some $30.

- 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: all eligible households of 1 or 2 persons are guaranteed a minimum monthly benefit of $10 (other households can be eligible for either no food stamp benefit after the benefit calculation is finished or a benefit as small as $2 a month); 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, 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 22 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, 76 percent of its recipients now are elderly—294,000 out of 389,000 in FY2000. 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.

Participating 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 costs for administration and food storage and distribution. 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.

FY2000 spending for the Commodity Supplemental Food program was $92 million ($20 million of which represented support for administrative and distribution/storage costs); in addition, almost $10 million worth of commodities donated from excess Federal stocks were made available. While elderly participants made up
about three-quarters of participants, the value of the food packages distributed to them (about $15 a person) is significantly less than for packages provided to women, infants, and children (just over $19 a person).

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 Richard B. Russell 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 2001-June 2002, the subsidy rates range from $2.09 for lunches/suppers served free to those with income below 130 percent of the Federal poverty income guidelines to 5 cents for snacks served to those with income above 185 percent of the poverty guidelines. In FY2000, average daily attendance at the 2,000 sites operated by 1,300 sponsors was just over 68,000 persons, and Federal subsidies totaled $43 million.

B. LEGISLATIVE DEVELOPMENTS: 1999–2000

The FY2001 Agriculture Department appropriations law (P.L. 106–387) included three amendments to the Food Stamp Act—

- The most important change liberalized the treatment of vehicles as assets when determining applicants' eligibility for food stamps. It allowed states to consider vehicles as an asset in food stamp eligibility determination using the rules applied in their Temporary Assistant for Needed Families (TANF) programs—if their TANF rules are more liberal than the regular food stamp rules. As a result, in most states, it is expected that at least one vehicle per household will be disregarded for food stamp eligibility purposes; under the regular food stamp rule, the fair market value of any vehicle would be counted as an asset to the extent it exceeds $4,650.

- A second revision liberalized the treatment of shelter expenses when determining food stamp benefits. Food stamp law increases benefits for those with very high shelter expenses in relation to their income; it allows the cost of shelter above a threshold equal to roughly one-third of total household income to be disregarded (“deducted”) when judging the amount of income a household has available for food spending. For households without an elderly or disabled member, prior law limited the disregarded/deducted amount to $300 a month, thereby restricting the shelter-expense-related benefit increase available to non-elderly, non-disabled households (primarily families with children). The amendment in the appropriations law

\[4\] Food-stamp-eligible households are limited to $2,000 in liquid assets ($3,000 for elderly households).
raised this limit to $340 a month and indexed it annually begin-
ing with FY 2002.
- The third change required that Puerto Rico's nutrition as-
sistance block grant (operated in lieu of the Food Stamp pro-
gram) be indexed for food-price inflation.

The Agriculture Risk Protection Act (P.L. 106–224) incorporated
a number of amendments aimed at improving the integrity and
management of the Child and Adult Care Food program, primarily
in response to 1999 reports by the Agriculture Department's In-
spector General and the General Accounting Office criticizing pro-
gram operations. Major program integrity-management provisions
of the new law, which are particularly directed at oversight of pro-
viders and sponsors of day care homes for children: (1) disqualify
institutions determined ineligible for any other publicly funded pro-
gram because they violated requirements of that program, (2) es-

tablish specific eligibility criteria for applicant institutions (particu-
larly with regard to their administrative and financial managemnet
 capabilities), (3) tighten tax-exemption requirements for private
nonprofit institutions, (4) give State oversight agencies greater con-
trol over the approval process for applicant institutions, (5)
strengthen requirements for site visits to participating institutions,
and (6) allow withholding of administrative funds from States fail-
ing to provide sufficient training, technical assistance, and monitor-
ing of the program.

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 va-

tiety 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 characteris-
tics 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 as children. As a group, the elderly seem to be more reticent
to admit to being hungry and needing any type of assistance. Fixed
incomes, a variety of health problems and loss of independence can
all contribute to general health, nutrition and food security prob-
lems 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 initi-
ated during the Johnson administration and heard witnesses de-
scribe 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 thiamine, 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 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 in the early 1970s 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 the 1970s. 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 there 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 assistance. 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 advocacy group, 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. More than one 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 nothing 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 and confined to bed. Twenty percent responded affirmatively to at least five of the risk questions, which put them into nutritional risk category and this risk 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.

In June 1992, the General Accounting Office reported on elderly Americans and the health, housing and nutrition gaps between the poor and nonpoor. GAO suggested that while the information on the relationship between poverty and nutrition among the elderly was limited, 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 nutritional status of the poor elderly.

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 per-
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 coping behaviors to meet their basic food needs. About 10.2 percent of households were food insecure. 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.

The U.S. Conference of Mayors recent 25 cities survey entitled “A Status Report on Hunger and Homelessness in America’s Cities: 2000,” indicated that estimates for the past year for emergency food assistance increased by an average of 17 percent. Requests for such assistance by elderly persons increased by an average of 9 percent during the same period, with 75 percent of the cities reporting an increase.

Several recent studies have examined the definitions of food insecurity with regard to the elderly. The term food insecurity has been generally reviewed as whenever the availability of nutritionally adequate and safe foods or the ability to acquire acceptable foods in socially acceptable ways is limited or uncertain. While that definition is applicable to the elderly, there are now recognized addi-
tional aspects that consider the functional impairments that need to be evaluated when determining the extent of food insecurity with this age group. The additional criteria to be considered are altered food use as a result of different physical and socioeconomic conditions, perceptions, attitudes and experiences throughout their life toward food problems, along with poverty, disease, living arrangement, age, gender, race-ethnicity and education. Many elderly are seemingly unwilling to report food problems consistent with their situations. There is also a reticence among the elderly to use available feeding programs, even when they are knowledgeable about their eligibility to participate.

Any of these aspects can contribute to low nutrient intake which can impact overall health. Persistent or intermittent food insecurity that existed in the past among the elderly may lead them to consume lower nutrient intakes and even change their body composition and eating habits. Elderly food insecurity also seems to follow a progression of severity, beginning with compromised diet quality; it then progresses to food anxiety, socially unacceptable meals, use of emergency food strategies, and finally actual hunger. Furthermore poorer health status in this age group may contribute to food insecurity because of higher medical bills and higher costs for medications. Because most older Americans do not report consuming nutritionally adequate diets, consideration may need to be given to whether assistance programs need to target middle-aged and older adults that are at higher risk for poor dietary quality including women, persons over 65 years, non-Hispanic and African American men, individuals with less education, smokers, alcohol users, those who do not exercise, and those with low energy intakes. There is a need for additional research in this age group to fully characterize the nature, extent and prevention of food insecurity in the elderly.
CHAPTER 7

HEALTH CARE

A. NATIONAL HEALTH CARE EXPENDITURES

1. INTRODUCTION

In 1960, national health care expenditures amounted to $26.7 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 $695.6 billion, or 12.0 percent of the GDP. Increases in health care spending during the late 1980's and early 1990's focused attention on the problems of rising costs and led to unsuccessful health care reform efforts in the 103d Congress to expand access to health insurance and control spending.

In the mid-1990's, 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 1999 was lower than in previous years. Health spending growth was only 4.8 percent in 1998, the lowest rate in more than 3½ decades. Spending as a percent of the economy remained relatively constant at around 13.0 percent; for the first time this could be attributed to a slowdown in the rate of growth of health care spending and not just growth in the overall economy. There are concerns, however, as to whether these trends in health care expenditures and costs will continue. The Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration) projects larger increases in health care spending in the coming years. CMS expects national health spending to reach over $2 trillion by 2006, or approximately 15.1 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, consumers, and third-party payers. The aging of the population contributes significantly to the increase in health care expenditures.
In 1999, spending for health care in the United States totaled $1.2 trillion, with 87.4 percent of expenditures on personal health care, or services used to prevent or treat diseases in the individual. The remaining 12.6 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 (48.4 percent) of all health expenditures were paid out-of-pocket by consumers, while private health insurance represented only 22.0 percent and public funds (Federal, state, and local governments) 24.8 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 1999, individual out-of-pocket spending (including coinsurance, deductibles, and any direct payments for services not covered by an insurer) represented only 15.4 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 59.4 percent and public programs funded 40.6 percent. While all private sources combined continued to finance most health care spending in 1999 ($662.1 billion, or 54.7 percent), public program funding increased to 45.3 percent ($548.5 billion). Federal spending is the second largest single contributor, financing 31.8 percent of all spending. This share is slightly smaller than the 33.1 percent funded by the largest single payer, private insurance. 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 10.6 percent of all health expenditures; by 1970, the Federal Government's share increased to 24.0 percent. Federal spending continued to rise as a percent of all expenditures until 1976, when it represented about 29 cents of each health dollar. Between 1976 and 1991, the share of health spending paid by the Federal Government hovered between 27.7 percent and 29.1 percent. During much of the 1990's, Federal spending on health has grown from this plateau to represent 1/3 of all health spending in 1997. This increase was likely due to the ability of private managed care organizations to decrease its share of costs. Subsequently, the Federal Government's share of health expenditures has decreased somewhat. In 1999, the Federal Government spent $384.7 billion, 31.8 percent of total national health expenditures. The Federal Government is expected to spend over $500 billion for health care in the year 2003, amounting to 30.4 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 and other 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 fiscal year 1967, the first full year of the program, total Medicare outlays amounted to $3.4 billion. In fiscal year 1999, Medicare expenditures totaled $212.0 billion. This increase in outlays since the program's first year represents an average annual growth rate of 13.8 percent. Much of the growth in spending occurred in the early years of the program, however. From fiscal year 1967 to fiscal year 1980, total program expenditures grew from $3.4 billion to $35.0 billion, for an average annual growth rate of 19.6 percent. Over the fiscal year 1980 to fiscal year 1990 period, total outlays grew from $35.0 billion to $109.7 billion, for an average annual rate of growth of 12.1 percent. For the fiscal year 1990 to fiscal year 1999 period, total outlays grew from $109.7 billion to $212.0 billion, for an average annual growth rate of only 7.6 percent. The low growth rate in total outlays in recent years can be attributed to both a decrease in Part A spending and small increases in Part B spending. Between fiscal year 1997 and fiscal year 1999, Part A outlays decreased from $137.8 billion to $131.4 billion, for an annual average growth rate of -2.3 percent. Over this same time period, Part B spending increased from $72.6 billion to $80.5 billion, for an annual average increase of 5.3 percent.

The Balanced Budget Act of 1997 provided for structural changes to the Medicare program and slowed the rate of growth in reimbursements for providers, and this slower growth is reflected in projections of Medicare expenditures. According to CBO's April 2001 baseline projections, total Medicare outlays will be $426.6 bil-
lion in FY2009. This represents an average annual overall rate of growth of 7.2 percent for the time period FY1999-FY2009.

Medicaid expenditures have historically been one of the fastest growing components of both Federal and state budgets. From fiscal year 1975 to fiscal year 1984, Medicaid spending almost tripled, increasing from $12.6 billion to $37.6 billion. Spending rose even more dramatically in the late 1980's and early 1990's, 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 fiscal year 1993 to fiscal year 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 fiscal year 1999 were $190.9 billion. The Federal Government pays about 57 percent of total Medicaid costs. CBO projects that Federal outlays for Medicaid will grow from $117.9 billion in fiscal year 2000 to $266.5 billion in fiscal year 2010, an average growth rate of 8.5 percent.

According to the 1996 Medicare Current Beneficiary Survey, Medicare covers about 67.5 percent of the total medical costs of the non-institutionalized elderly. About 15.1 percent of total 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 institutionalized beneficiaries (such as those in nursing homes), Medicare pays about 19.4 percent of total personal health costs, and Medicaid, funded by both the Federal and state governments, pays an additional 39.8 percent of costs. Institutionalized beneficiaries pay 30.0 percent of the costs of care out-of-pocket. Private health insurance pays for a greater proportion of costs among the non-institutionalized elderly (12.6 percent) than among the institutionalized (1.1 percent) since relatively few beneficiaries 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 1999, an estimated 32.3 percent, or $390.9 billion, of national health care expenditures was paid to hospitals. From 1971 to 1980, spending on hospital care increased at an average rate of 13.9 percent per year, and in 1980, hospital care expenditures had reached 41.3 percent of total health expenditures. 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 36.5 percent in 1990. The rate of growth in hospital spending has also decreased since the implementation of PPS. From 1984 to 1990, hospital expenditures grew at an average annual rate of 8.5 percent. From 1991 to 1994, hospital expenditures grew at an average annual rate of 7.0 percent. From 1995 to 1999, hospital spending increased at an average an-
nual rate of only 3.3 percent. Hospital expenditures increased only 2.6 percent in 1998, but grew at a slightly higher rate of 3.7 percent in 1999.

In 1999, public (Federal, state, and local) sources accounted for 59.5 percent of hospital service expenditures. The Federal Government’s share has grown from 16.8 percent in 1960 to 47.4 percent in 1999, making it the single largest payer. Medicare spending for hospitals dropped by 1.8 percent in 1998, and dropped 0.3 percent in 1999. Medicaid spending for hospital services, however, grew by 9.4 percent, more than twice as fast as overall hospital spending in 1999.

In 1999, private health insurance was responsible for about 31.7 percent of all hospital spending. In 1990, its portion was 38.3 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 20.8 percent of payments for hospital care before the enactment of Medicare and Medicaid; they represented only 3.2 percent in 1999.

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 1.4 percent over the previous year, the largest increase in 15 years. In 1997, hospital admissions increased by 0.4 percent.

Between 1978 and 1993, hospital inpatient admissions for persons 65 and over increased an average of 4.8 percent per year. After introduction of PPS, admissions among the older population decreased at an average annual rate of 3.0 percent during the 1984–1986 period. However, after this period, hospital admissions for the elderly increased. From 1987 to 1992, inpatient admissions for persons age 65 and older increased at an average annual rate of 1.6 percent. 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 only 0.4 percent in the number of hospital admissions for the elderly. Admissions for the elderly grew at a slightly higher rate (1.4 percent) in 1997.

The average length of stay in a hospital for elderly patients is higher than that for patients under the age of 65. In 1997, the average length of stay for a person over the age of 65 was 6.5 days; the average length of stay for a person under the age of 65 was 4.7 days, a difference of almost 2 days. This difference is narrower than in the past, however. In 1978, the average length of stay for those over the age of 65 versus those under the age of 65 was 10.6 days and 6.0 days, respectively (a difference of over 4 days). While the average stay for both groups has declined over time, the narrowing of the gap between them can be attributed to the larger decreases in the average stay for elderly patients. Between 1992 and 1997, the average hospital stay for a patient over age 65 declined from 8.3 days to 6.5 days, a decrease of 21.6 percent. During this
same time period, the average stay for a patient under age 65 declined from 5.2 days to 4.7 days, a decrease of only 9.6 percent.

4. Physicians' Services

Utilization of physicians' services increases with age. In 1998, the population as a whole made over 1 billion ambulatory care visits to physicians, which translates to 378 visits per 100 persons. Visits by patients age 65 and over amounted to 697 visits per 100 persons, and those by patients age 75 and over amounted to 764 visits per 100 persons. For each of these groups, over 80 percent of visits occurred at a physician's office, as opposed to a hospital outpatient department or a hospital emergency departments.

Physician services is the second largest component of personal health care expenditures. In 1999, $269.4 billion was spent on this category of health care, representing 22.2 percent of all health care expenditures. In 1960, $5.4 billion was spent on physician services, and by 1970, spending had reached $47.1 billion. This increase represents an average annual growth rate of 10.1 percent. Growth in physician expenditures was slightly higher in the following two decades. From 1971 to 1980, spending on physician services grew at an average annual rate of 12.9 percent, and from 1981 to 1990, spending on physician services grew at an average annual rate of 12.8 percent. In the 1990's, however, the annual rate of growth in payments for physician services was slower than the previous three decades. From 1991 to 1999, expenditures on physician services grew at an average annual rate of only 6.1 percent, a rate that is less than half of that experienced during the 1970's and 1980's. 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 1999, approximately 11.4 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 expenditures for hospital services, the share of physician costs paid directly by individuals has declined sharply since the 1960's. 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 29.8 percent of the total; by 1990, this figure had reached 43.0 percent. In 1999, private health insurers paid for 47.8 percent of all physician services.

Medicare spending for physician services was $54.7 billion in 1999, or 20.3 percent of total funding for care by physicians. In comparison, Medicare paid for only 11.8 percent, or $1.6 billion, of total physician service expenditures in 1970. Between 1971 and 1990, the average annual rate of growth in Medicare payments for physician services was 15.7 percent. National payments for physician services in this time period grew at an average annual rate of 12.9 percent. Because of changes in the Medicare physician payment system, the growth of Medicare spending for physician services has decelerated substantially. Medicare physician payments grew at an average annual rate of 6.1 percent between 1990 and
1999, compared with 5.5 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 health expenditures, CMS includes spending for nursing home and home health care. The total for these two categories of services amounted to $123.1 billion in 1999, and includes all age groups needing long-term care. However, this amount excludes $11 billion spent under the Medicaid Home and Community Based Waiver program.

In 1999, 73.1 percent of long-term care spending, or $90.0 billion, was for nursing home care. Nursing home care represented 7.4 percent and home care services represented 2.7 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 26.6 percent of nursing home spending in 1999. Private insurance coverage of nursing home services is currently very limited, and covered only 8.4 percent of spending in 1999. 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—47.0 percent in 1999. Medicare's role as a payer for nursing home care has also increased in the last several years, from 3.2 percent in 1990 to 10.7 percent in 1999. This accounts for much of the increase in the Federal Government's share of nursing home spending, which rose from 30.0 percent in 1990 to 39.5 percent in 1999.

About 1.5 million Americans over the age of 65 were receiving nursing home care in 1997. This represented only 4.3 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 $33.1 billion in 1999. In calendar year 1999, Medicare paid $8.7 billion for home health services, or 26.4 percent of the total. It should be noted that this total for home health excludes spending for non-medical 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, public 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 1999, there were 34.5 million people aged 65 and over, representing 12.7 percent of the population. According to Census projections, there will be 82.0 million people ages 65 and over (representing 20.3 percent of the population) by the year 2050.

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 4.2 million (1.5 percent of the population) in 1999 to 8.9 million (2.5 percent) in 2030, then to more than double again in size to 19.4 million (4.8 percent) in 2050.

6. PRESCRIPTION DRUGS

(A) BACKGROUND

According to data from CMS's National Health Expenditures, in 1999, prescription drug expenditures in the United States were approximately $99.6 billion, or about 8.2 percent of total health care spending. This figure measures spending for prescription drugs purchased from retail pharmacies, including community pharmacies, grocery store pharmacies, mail-order facilities, and mass-merchandising establishments. The spending figure is also adjusted to account for manufacturers' rebates to third-party payers. However, it does not include the value of drugs 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 categories of health care spending. For example, between 1996 and 1999, spending on hospital care grew 9.8 percent, physician services spending rose 17.4 percent, and dental services spending grew 19.7 percent. Spending on prescription drugs in the same period grew 48.2 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 payments are made under Part B of the program. In 1999, Medicare, which covered approximately 40 million beneficiaries (35 million of whom were elderly), paid $2.0 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 3 years following an organ transplant paid for by Medicare, certain oral cancer and associated anti-nausea drugs, and certain immunizations.

Most beneficiaries have some form of private or public health insurance coverage to supplement Medicare. In 1998, 93 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. In 1998, 73 percent of beneficiaries had some drug insurance coverage. According to an analysis of the 1998 Medicare Current Beneficiary Survey, 92 percent of beneficiaries enrolled in Medicare HMOs, 89 percent of beneficiaries with Medicaid, 90 percent of beneficiaries with employer-sponsored plans, and 43 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 1998, persons with coverage used an average of 24.4 prescriptions per year while those without coverage used an average of 16.7 prescriptions per year. 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

In 1998, spending for prescription drugs by persons aged 65 and over amounted to about $30 billion. On a per capita basis, the average Medicare beneficiary in the community consumed $878 worth of drugs. Of this amount, beneficiaries paid, on average, $384 (43.8 percent) out-of-pocket. For the population as a whole, 36.7 percent of all drug expenditures in 1998 were paid out-of-pocket.

The elderly devote a larger share of their household expenditures to prescription drugs than other segments of the population. In 1998, persons over age 65 spent 2.7 percent of their total household expenditures on drugs. Persons between ages 25 and 34 spent 0.4 percent; persons between ages 35 and 44 spent 0.6 percent; persons between ages 45 and 54 spent 0.8 percent; and persons between ages 55 and 64 spent 1.1 percent. The higher percentage of household expenditures spent on drugs by the elderly reflects the fact that this group has both higher average drug spending and lower total household expenditures than the rest of the population.

Out-of-pocket spending varies depending on the beneficiary’s coverage by supplemental health insurance. The National Academy of Social Insurance (NASI) examined 1999 out-of-pocket drug expenditures for non-institutionalized Medicare beneficiaries who are not in Medicare+Choice plans. NASI 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 esti-
mated 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.

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Prices for Bulk Buyers</th>
<th>Retail prices paid by senior citizens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synthroid</td>
<td>$1.75</td>
<td>$27.05</td>
</tr>
<tr>
<td>Micronase</td>
<td>$10.05</td>
<td>$46.50</td>
</tr>
<tr>
<td>Zocor</td>
<td>$42.95</td>
<td>$104.80</td>
</tr>
<tr>
<td>Prilosec</td>
<td>$56.38</td>
<td>$111.94</td>
</tr>
<tr>
<td>Norvasc</td>
<td>$58.83</td>
<td>$113.77</td>
</tr>
<tr>
<td>Procardia XL</td>
<td>$67.35</td>
<td>$126.86</td>
</tr>
<tr>
<td>Zolofit</td>
<td>$123.88</td>
<td>$213.72</td>
</tr>
</tbody>
</table>

Source: House Government Reform and Oversight Committee, Democratic Staff Report

(B) DRUG INDUSTRY ISSUES

(1) Growth in Prescription Drug Expenditures

Spending on prescription drugs grew 16.9 percent in 1999. Ac-
ccording to the Bureau of Labor Statistics, a relatively small portion
of this aggregate spending growth was due to price inflation. A
much larger portion of the growth in spending was due to non-price
factors, such as increased volume of purchases of existing drugs
and the introduction of new products. In 1999, the consumer price
index (CPI) for prescription drugs increased 5.7 percent, while vol-
ume and other non-price factors increased 10.6 percent. In fact,
drug price inflation, on average, has been slightly less than that for
medical care as a whole. Between 1991 and 1999, prescription drug
prices increased at an average annual rate of 4.0 percent whereas
overall medical care prices increased at an average annual rate of
4.4 percent.

Health plan sponsors have experienced large increases in their
prescription drug costs. A recent Newsweek article stated that the
automaker General Motors spent $1.1 billion on prescription drugs
in 2000, accounting for more than 25 percent of its medical spend-
ing. It is expected that the company's drug expenditures will in-
crease 22 percent in 2001.

Profit margins for the pharmaceutical industry are relatively
high. In 1999 the pharmaceutical industry had the highest return
on revenues of any industry, as measured by *Fortune* magazine. According to *Fortune*, the pharmaceutical profits were 18.6 percent of revenues in 1999; by comparison, the median return on revenue for the top 500 companies was 5.0 percent. However, this measure of profitability is based on conventional accounting practices that do not account for the risk involved in conducting research and development. 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. Estimates of the costs of developing a successful drug range from $116 million to $500 million (in 1990 dollars). The drug development process, including the pre-clinical trial phase, clinical trials, and the approval phase, can take over 15 years. From the large number of potential drugs that exist at the beginning of the development process, only a relatively small percentage go on the market. New drugs have up to 20 years of patent protection, 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 their ability to recover the cost 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. 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. 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.
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.

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.

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 1991 and 1999, DTC advertising increased from $55.3 million to $1.9 billion.

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.
10.8 percent of the 85+ group reported their health as poor. Age is not the only factor affecting health status. Among individuals aged 65-74, 18.7 percent of whites and 15.1 percent of Hispanics reported their health as excellent, compared to 11.6 percent of blacks. Only 10.5 percent of whites and 10.8 percent of Hispanics aged 85 and over reported their health as poor; 14.9 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, 62.2 percent reported their health as excellent, very good, or good; 15.1 percent reported poor health. Those percentages for beneficiaries in Medicare managed care were 79.1 percent and 5.9 percent. Beneficiaries with Medicaid as their insurance to supplement Medicare reported poorer health: 48.7 percent reported excellent, very good, or good health, and 20.5 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 1998: 84.4 percent in the good-very good-excellent category, and only 4.4 percent in the poor category.

Although most elderly Medicare beneficiaries consider their health good, 68.5 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 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 1998 increased with age, from only 31.5 percent of persons aged 65 to 74 up to 79.4 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 1998, 65.4 percent of elderly beneficiaries reported incomes of less than $25,000, and 25.3 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. Much of Medicare payments on behalf of elderly beneficiaries are directed toward those beneficiaries with modest incomes: 29.7 percent of elderly spending is on behalf of those with incomes of less than $10,000 and 72.5 percent of elderly spending is on behalf of those with incomes of less than $25,000.

Most persons devote a portion of their household expenditures to health care. This spending includes payments for health insurance, medical services, prescription drugs, and medical supplies not covered by Medicare. The elderly, however, direct more of their house-
hold expenditures toward health care than any other segment of the population. In 1999, persons age 65 and over spent 11.4 percent of their household expenditures on health care. By contrast, persons between ages 25 and 34 spent 3.2 percent; persons between ages 35 and 44 spent 3.8 percent; persons between ages 45 and 54 spent 4.7 percent; and persons between ages 55 and 64 spent 6.2 percent. The higher percentage spent by the elderly reflects several factors, including their higher usage of health care services, payments for long-term care services, the premiums paid by those who purchase supplemental insurance (i.e., “Medigap”) policies, and their lower household spending on goods and services in general.

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.
Several proposals were introduced in the 106th Congress affecting prescription drugs for Medicare beneficiaries, some of which have been re-introduced in the 107th Congress. Most of the proposals introduced in the 106th Congress would have relied on pharmacy benefit managers or similar entities to administer the benefit and negotiate with manufacturers. Some would have extended coverage to the entire population while others would have limited coverage to low-income beneficiaries. A few measures would not have added a new benefit, but rather would have focused on reducing the price beneficiaries pay for drugs.

In July 2001, President Bush unveiled a voluntary program to encourage seniors to enroll in prescription drug card plans. Under the plan, the government would approve plans that meet minimum criteria. Seniors would pay a one-time fee not to exceed $25 to enroll in a plan. In return, the seniors would receive discounts on prescription drugs similar to those received by health plans and other third-party buyers. The program is intended to provide an interim solution until a drug benefit for the elderly is enacted.

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

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 consid-
ered 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, 50 percent coinsurance, an annual cap on out-of-pocket costs of $4,000, and beneficiary premiums that would cover 50 percent of the program’s costs would cost the Federal Government $29.6 billion in 2004. NASI has estimated that a drug benefit could add between 7–13 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 projections. 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 1998, the average life expectancy at birth increased from 46.4 years to 73.9 years for men, and from 49.0 to 79.4 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 12.7 percent of the population. By 2015, they will constitute 14.7 percent, and will be 20.0 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 4.8 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 1998 Medicare Current Beneficiary Survey, 78.9 percent of the elderly aged 65 to 74 rated their health as good, very good, or excellent. However, this number falls to 63.9 percent in the 85+ group. While only 6.4 percent of the 65–74 age group reported that their health was poor,
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 FY2000, Medicare insured approximately 39 million aged and disabled individuals at an estimated cost of $201.2 billion ($221.8 billion in gross outlays, offset by $20.6 billion in beneficiary premium payments). Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program. It is administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA).

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 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).

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 cover some of these expenses, largely cost-sharing charges required under the program, in 1998, approximately 76.7 percent of Medicare beneficiaries had supplemental coverage, including employer-based coverage, individually purchased protection (known as Medigap), and Medicaid. Another 16.5 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. The 105th Congress passed the Balanced Budget Act of 1997 which achieved estimated Medicare savings of $116 billion over the
period of FY1998 to FY2002. It provided for new payment systems for skilled nursing facilities, home health agencies, and other service categories and expanded Medicare's coverage of preventive services. It modified payment methods for managed care organizations and established the Medicare+Choice program which added new managed care options for beneficiaries, including preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. It also provided for a demonstration project allowing a limited number of beneficiaries to establish medical savings accounts in conjunction with a high deductible health insurance plan.

In the first years following the passage of the Balanced Budget Act of 1997, Medicare spending set records for low or declining rates of program growth. In fiscal year 1998, the Medicare growth rate slowed to a then record low of just 1.5 percent for the entire year, an amount less than would be expected allowing for increases in enrollment and for inflation. The following year set a new record, when, for the first time in the program’s history, Medicare spending dropped from 1 year to the next.

Congress first addressed the issue of slower rates of growth in Medicare spending with the passage of the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106–113). At the time of passage, the Congressional Budget Office (CBO) estimated that the BBRA would add approximately $16 billion back into the Medicare program for 2001–2005. At the end of the 106th Congress, a second piece of legislation was passed, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106–554), that CBO estimates will increase Medicare spending by $32.3 billion over the 5-year period (2001–2005) and $81.5 billion over the 10-year period (2001–2010). The Medicare legislative proposals were designed to increase payments for many of the services covered by the Medicare program, such as hospitals, Medicare+Choice organizations, home health agencies, and skilled nursing facilities. The legislation also included limited expansions of certain preventive benefits and modified the appeals and coverage processes, but did not address the issue of prescription drug coverage.

1. HOSPITAL INSURANCE PROGRAM (PART A)

Most Americans age 65 and older are automatically entitled to benefits under Part A. Those who are not automatically entitled (that is, those not eligible for monthly Social Security or Railroad Retirement cash benefits) may obtain Part A coverage by paying a monthly premium covering the full actuarial cost of such coverage. The maximum monthly premium for those persons is $300 in 2001. Also eligible for Part A coverage are individuals who for 2 years have been receiving monthly Social Security disability benefits or Railroad Retirement disability payments.

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 the HI tax of 1.45 percent on covered earnings. The self-employed pay both the employer and employee shares. In FY2000, payroll taxes for the HI Trust Fund amounted to an estimated $137.7 billion, accounting for 86
percent of HI income. An estimated $127.9 billion in Part A benefit payments were made in fiscal year 2000.

Benefits included under Part A, in addition to inpatient hospital care, are skilled nursing facility (SNF) care, some home health care, and hospice care. Beneficiaries are subject to deductible and coinsurance amounts for these services. For 2001, these amounts are:

- for inpatient hospital care, the beneficiary is subject to a deductible of $792 for the first 60 days of care in each benefit period; for days 61 through 90, a daily coinsurance payment of $198 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 $396 is required for each lifetime reserve day.
- for skilled nursing facility (SNF) services, for each benefit period, there is no coinsurance payment required for the first 20 days, and a daily $99 coinsurance payment for the 21st through the 100th day. No SNF coverage is provided after 100 days.
- for hospice care, a limited coinsurance payment is required for prescription drug coverage and inpatient respite care.
- for the home health benefit, no beneficiary cost sharing is required.

A full discussion of SNF and home health benefits is provided in the next chapter.

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 before the services are provided. The payments are based on the average costs for treating a specific diagnosis. For each beneficiary discharged from a hospital, Medicare pays one lump sum amount depending on the patient’s primary diagnosis during the hospital stay. There are approximately 500 diagnosis-related group (DRG) payment rates. 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. Because the amount a hospital receives from Medicare does not depend on the amount or type of services delivered to the patient, there are no incentives to overuse services.

The base PPS rate is 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 68 percent of total Part A benefit payments, reductions in the growth of Medicare payments to hospitals provides significant budgetary savings.

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.

Outside of the PPS, Medicare makes additional payments to teaching hospitals for the direct costs of graduate medical education (GME), such as the salaries of residents and faculty. These payments are hospital-specific and include hospital-specific caps on the number of residents. Incentive payments are made to hospitals which voluntarily reduce their number of residents. Also outside of the PPS, Medicare pays hospitals for the cost of bad debts attributable to beneficiaries' not making their deductible or coinsurance payments.

There are five types of specialty hospitals (psychiatric, rehabilitation, children's, long-term care, and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) that are paid on the basis of reasonable costs, subject to ceilings or upper target amounts, and the DRG system does not apply.

2. SUPPLEMENTARY MEDICAL INSURANCE (PART B)

Part B of Medicare, also called Supplementary Medical Insurance (SMI), is a voluntary program. Anyone eligible for Part A and anyone over age 65 can obtain Part B coverage by paying a monthly premium ($50 in 2001). 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, some home health care, 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 physicians, 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 (office rents, employee wages), and malpractice costs. These relative values are adjusted for approximately 90 different geographic locations. Geographically adjusted relative values are converted into a dollar payment amount by a figure known as the conversion factor. It is updated by the "sustainable growth rate" formula based on real gross domestic product growth. This rate is intended to constrain total spending for physician care.

A physician may choose whether or not to accept assignment on a claim. Accepting assignment means that the physician agrees to accept Medicare's fee schedule amount as payment in full. Medicare pays the physician 80 percent of the fee schedule amount, and the beneficiary pays the remaining 20 percent. When a physician agrees to accept assignment of all Medicare claims in a given year, the physician is referred to as a participating physician. Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as nonparticipating physicians.
There are a number of incentives for physicians to become participating physicians, chief of which is that the fee schedule payment amount for nonparticipating physicians is only 95 percent of the recognized amount for participating physicians. Nonparticipating physicians may charge beneficiaries more than the fee schedule amount on nonassigned claims; these balance billing charges are subject to certain limits. The limit is 115 percent of the fee schedule amount for nonparticipating physicians (which is only 9.25 percent higher than the amount recognized for participating physicians, i.e., 115 percent x .95 = 1.0925).

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 for services covered by Medicare. Prior to BBA 97, the law was interpreted to prohibit physicians from entering into private contracts with Medicare beneficiaries to provide services which would normally be paid for by Medicare, but 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, signed by the physician and filed with the Secretary of Health and Human Services, must be in effect at the time the services are provided. Physicians entering into private contracts may not receive any Medicare reimbursements for 2 years. The beneficiary is not subject to the 2-year limit.

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. Unlike most other Part B services where beneficiary cost sharing is 20 percent of the approved Medicare payment, for OPD services, beneficiary copayment may be 20 percent of the OPD's actual charges. Because actual charges are higher than approved payments, beneficiaries' "effective copayment" is often much higher than 20 percent of the Medicare approved payment. Both BBA 97 and BIPA included provisions to eventually correct this situation. BIPA limited the copayment to no more than the hospital inpatient deductible for that year. Additionally, beginning in 2001, the beneficiary effective copayment rate for outpatient services would be capped at 57 percent and would steadily reduce until it reached 40 percent in 2006, eventually declining to 20 percent in subsequent years.

Preventive care benefits.—Medicare covers health services which are reasonable and necessary for the diagnosis and treatment of illness of injury. Originally, the program did not cover preventive services. However, in recent years, Congress has responded to concerns about the lack of this coverage by adding specific benefits to Medicare law. 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. The benefit covers 100 percent (i.e., not subject to deductible or coinsurance) of the reasonable costs of the vaccine and its administration when prescribed by a doctor.

• Hepatitis B vaccination. Medicare covers hepatitis B vaccinations for high- or intermediate-risk beneficiaries when prescribed by a doctor.

• Influenza vaccination. The benefit covers 100 percent of the cost of influenza virus vaccine and its administration. Coverage does not require a physician's prescription or supervision.

• Screening Pap smears and pelvic examinations for early detection of cervical and vaginal cancer. The benefit includes the test, which must be prescribed by a physician, its interpretation by a doctor, and a screening pelvic examination (defined to include a clinical breast examination), once every 2 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 for early detection of breast cancer. The test is covered annually for all women over age 39. It is not subject to the deductible.

• Prostate cancer screening. Medicare covers annual prostate cancer screening tests for men over age 50. The benefit covers 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. 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 are covered every 2 years for high-risk beneficiaries. For those not at high risk, screening colonoscopies are covered not more often than 10 years after a previous screening colonoscopy or 4 years after a previous screening sigmoidoscopy. Barium enema tests can be substituted for either of the two last procedures.

• Diabetes self-management. 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. Medicare covers the cost of procedures used to measure bone mass, bone loss, or bone quality for certain high-risk beneficiaries.

• Glaucoma screening. The tests, performed under the supervision of an ophthalmologist or optometrist, is covered annually for individuals at high-risk for glaucoma. Tests include dilated eye examinations with interocular pressure measurement and a direct ophthalmoscopy or a slit-lamp biomicroscopic examination.
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. 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), which use competitive bidding processes to establish payment levels. 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. Currently, there are demonstration sites in Polk County, Florida, and San Antonio, Texas.

3. Medicare+Choice (Part C)

The Medicare+Choice program (M+C) was established by the Balanced Budget Act of 1997. It provides expanded managed care options for Medicare beneficiaries who are enrolled in both Parts A and B. Beneficiaries may remain in the traditional fee-for-service program or enroll in one of several managed care and other health plan options:

- 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.)

- 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.

- 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.

- 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.

- 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 pay-
ing this additional amount. The beneficiary might also be responsible for additional premiums.

- 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 beneficiary protections were established. These include a guarantee of beneficiary access to emergency care, quality assurance and informational requirements for M+C organizations, and external review, grievance, and appeal requirements.

Payments to plans.—Payment is made in advance on a monthly basis to M+C organizations for each enrolled beneficiary in a payment area (generally a county). The annual M+C per capita rate for a payment area is the highest of three amounts calculated for each county:

- A “blended” rate equal to a combination of an area-specific (local, generally county) and a national rate. Blending is designed to reduce payments in counties where adjusted average per capita costs (AAPCCs) \(^1\) were historically higher and to increase payments where AAPCCs were 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.

- A minimum, or floor, payment was $402 for 2000. For 2001, the floor is $525 for aged enrollees within the 50 states and the District of Columbia residing in a Metropolitan Statistical Area (MSA) with a population of more than 250,000. For all other areas within the 50 states and the District of Columbia, the floor is $475. For any area outside the 50 states and the District of Columbia, the $525 and $475 floor amounts is also applied, except that the 2001 floor cannot exceed 120 percent of the 2000 floor amount. The payment amount is increased annually by a measure of growth in program spending known as the national growth percentage. The floor rate is designed to increase payments to certain counties more quickly than would occur under the blended rate.

- A “minimum update” rate protects counties that would otherwise receive only a small (if any) increase. In 1998, the minimum rate for any payment area was 102 percent of its 1997 AAPCC. For 1999 and 2000, the increase was 102 percent of the annual M+C per capita rate for the previous year. BIPA applied a 3 percent minimum update for 2001, beginning in March. For subsequent years, the minimum increase will return to an annual January update of an additional 2 percent over the previous year’s amount.

\(^1\) 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.
Rates must produce budget-neutral payments. This means that total M+C spending in a given year must be equal to the total payments that would be made if they were based solely on area-specific rates. Because floor and minimum percentage rates cannot be reduced to meet budget neutrality, only blended rates can be adjusted. If the budget neutrality target would be exceeded, counties scheduled to receive a blended rate would have their rates reduced, but never below the higher of the floor or minimum update rate. When this occurred in 1998, 1999, and 2001, CMS chose to waive the budget-neutrality rule rather than waiving the floor or minimum rate rule.

The M+C program was established to increase the number of plans available around the country and to encourage beneficiaries to enroll in them. However, the M+C program has not been successful at expanding coverage; the initial moderate growth in enrollment between 1998 and 2000 has since taken a downward turn. By September 2001, there were approximately 180 M+C plans available to almost two-thirds of Medicare beneficiaries. Approximately 14 percent of all beneficiaries were enrolled, about the same percentage as were enrolled in Medicare managed care plans prior to the enactment of BBA 97. The majority of enrollees are in California, Florida, New York, and Pennsylvania. Beneficiaries living in urban areas have greater access to M+C plans.

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 the frail elderly or 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 some form of supplemental health insurance. Approximately 36.1 percent of beneficiaries get this coverage through their employers or through retiree plans. Medicaid provides coverage for 13.2 percent, about 16.1 percent are enrolled in M+C organizations, and 3.8 percent getting coverage through other sources.

Approximately 26 percent get their supplemental coverage through privately purchased plans such as Medigap. These plans offer coverage for Medicare's deductibles and coinsurance and pay for some services not covered by Medicare. In 1990, Congress 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. Plans H, I, and J offer limited prescription drug coverage. BBA 97 added two additional high-deductible plans which offer the same benefits as either Plan F or J. The deductible was $1,500 for 1999 and is increased 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 are regulated by the state in which they are sold. 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.

Other beneficiary protections include:

- Before selling a Medigap policy to a beneficiary, sellers must make certain that the policy does not duplicate Medicare, Medicaid, or private health insurance benefits to which a beneficiary is otherwise entitled.
- Medigap policies are required to be guaranteed renewable.
- Sellers are required to offer a 6-month open enrollment period for persons turning 65; there is no open enrollment guarantee for the under-65 disabled population.
- Sellers are permitted to limit or exclude coverage of pre-existing conditions for no longer than 6 months. However, the law guarantees issuance of specified plans without a pre-existing condition exclusion for certain continuously enrolled individuals. The plans, generally, are Plans A, B, C, and F.
- 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.

B. ISSUES

A number of observers have stated that the Medicare program is now at a critical juncture. One concern is that Medicare’s financing mechanisms will be unable to sustain it in the long run. Many are also concerned that the program’s structure has failed to keep pace with the changes in the health care delivery system. Some persons suggest that major structural reforms are required, while others contend that the existing system should be improved rather than replaced. In recent years, the major focus has been on providing prescription drug coverage for beneficiaries. On this issue, some observers state that it would be inappropriate to add a new costly benefit before structural reforms are enacted; others state that seniors, particularly low-income seniors, should not have to wait for drug coverage until the entire restructuring issue is resolved.

1. MEDICARE SOLVENCY AND COST CONTAINMENT

Ensuring the solvency of the Medicare trust funds continues to be a high priority issue in the Medicare reform debate. The Part A (HI) trust fund is financed primarily by current workers and their employers through a payroll tax. The Part B (SMI) trust fund is financed by a combination of monthly premiums levied on current beneficiaries (25 percent of program costs) and Federal general revenues tax dollars (75 percent of program costs). 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.
Since 1970, the Part A trustees have been projecting the impending insolvency of the HI trust fund. At the present time, income to the fund exceeds outgo. However, this situation is predicted to reverse in the future. At some point, the assets in the program will be insufficient to pay benefits. The 2001 trustees report projects that income will continue to exceed expenditures for another 20 years. After that point, the program would draw down on trust fund assets for 8 years until the fund was depleted in 2029. These dates represent a significant improvement over projections made in previous years. This is due to a number of factors including robust economic growth; lower expenditures reflecting, in part, the implementation of changes made by the Balanced Budget Act of 1997; low increases in health care costs generally; continuing fraud and abuse control efforts; and a decline in the use of skilled nursing facility and home health services.

Despite the short term improvements, the long range (75 years) trust fund deficit is significant. A number of factors affect the long-range solvency of the fund. Beginning in 2011, the program will begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946–1964) begin turning age 65. The baby boom population is likely to live longer than previous generations. This will mean an increase in the number of “old old” beneficiaries (i.e., those 85 and over). The combination of these factors is estimated to increase the size of the aged Medicare population from 34.2 million in 2000 to 38.7 million in 2010 and 61.0 million in 2025. Total Medicare enrollees will increase from 39.6 million in 2000 to 46.0 million in 2010 to 69.7 million in 2025. Second, there will be a shift in the number of covered workers supporting each HI enrollee. In 2000, there were 4.0; in 2030 there will only be an estimated 2.3. This number will continue to decline.

The 2001 trustees’ report stated that to achieve long-term financial solvency, outlays would have to be reduced by 37 percent or income increased by 60 percent (or some combination of the two) throughout the 75-year period. To achieve this, the payroll tax rate for employees and employers combined would have to be immediately increased from 2.9 percent to 4.87 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 to 2027 period. Proponents of raising Medicare’s eligibility age argue that it would result in needed program savings, and is reasonable given the increase in life expectancy and improvements in health status which have occurred since Medicare was created in 1965. In 1997, CBO estimated that such a provision would have saved $10.2 billion over the FY2003-FY2007 period. Opponents argue that it would place some seniors at risk. They refer to problems faced by the population aged 62–64, 15 percent of whom were uninsured in 1998. Of these, 26 per-
cent were poor and 52 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 some employers who currently offer health insurance
to their retirees might decide that it would be too expensive to ex-
tend 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 as-
sumed by Medicare, resulting in some Medicare savings being
transferred to Federal and state Medicaid costs.

Means Testing.—Medicare is not a means-tested program. There
are no income or assets tests for eligibility and no distinctions in
benefits or cost-sharing requirements. The Senate-passed version of
BBA 97 would have provided for an income-related Part B pre-
mium. It was estimated that approximately 5 percent of the non-
institutionalized aged beneficiaries 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 CMS. Some argued that es-
tablishing such a system in CMS would require a large resource
commitment and that the IRS should administer an income-related
premium. Others were concerned that, if the IRS administered the
income-related premium, it would be perceived as a tax.

Increased Beneficiary Cost-Sharing.—Various proposals have
been offered to increase beneficiary cost-sharing, including increas-
ing Part B coinsurance from 20 to 25 percent, increasing the Part
B deductible from $100 to a level more comparable to that in pri-
ivate insurance plans ($200 to $250), and imposing coinsurance on
services not currently subject to such charges (such as home health
care and lab services). It is argued that increased cost-sharing
would make beneficiaries more cost conscious in their use of serv-
ces. However, some observers are concerned that those most likely
to be affected by increased cost-sharing are beneficiaries who have
the traditional fee-for-service coverage with no supplementary in-
surance. Many of these individuals have incomes above the levels
which would qualify them for government assistance programs, but
not high enough to afford supplementary coverage.

Medigap Modifications.—Beneficiaries with Medigap or other
supplemental 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 such coverage.
Some observers have suggested that incentives to use care present
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 covering
the Part B deductible. This could have the effect of making bene-
ficiaries 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, originally designed to reflect the structure of private insurance in 1965, has not kept pace with changes in the health care delivery system as a whole. Some suggest redesigning the benefit package to reflect current employment-based coverage. This might include a prescription drug benefit or a catastrophic limit on out-of-pocket expenses. However, such expansions have the potential for significantly increasing Medicare's costs. A number of options for restructuring have been discussed.

**Premium Support/Defined Contribution.**—The premium support concept is a leading proposal for restructuring Medicare. Under this system, a predetermined payment amount, consistent for all participants, would be given to beneficiaries. They would use this payment to subsidize the premiums they pay for privately purchased health insurance coverage available from a set of competing plans; the premiums for the plans would vary based on the benefits offered. More generous plans would presumably have higher premiums. The beneficiary would pay the plan the difference between the Federal contribution and the plan's premium; low-income beneficiaries' payments would be subsidized. The goal of the premium support approach is to shift risk from the Federal Government to private insurers while giving individuals flexibility to choose the health insurance coverage that best meets their medical needs, along with incentives to choose plans that are the best value for them within their financial ability to supplement the premium support subsidy. A number of issues must be decided in order to implement a premium support program, including the degree to which plans should cover the same benefits, determining an appropriate Federal contribution (a fixed dollar amount or a fixed percentage of a weighted national average), and ensuring that plans continue to participate in the program. 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.

**Fee-for-Service (FFS) Modernizations.**—Some have suggested that Medicare's FFS program should incorporate certain managed care techniques which are currently used by private insurers. Some examples are:

- disease and case management programs that identify and enroll individuals with certain health conditions in order to provide higher quality of care at lower costs. The programs would employ tools such as data analysis to help identify and target beneficiaries, bundled payments to physicians and other providers, and prior authorization or review of services.
- selective contracting or providing beneficiaries with incentives to use selected providers. This might entail restricting beneficiaries to providers who meet certain cost or quality
standards, or giving them financial incentives to choose preferred providers.

- competitive pricing or improved procurement practices when paying for both health care and administrative services. Private health plans use their buying power in the marketplace to realize savings in the cost of goods and services through negotiated pricing. The Medicare program currently uses different rate-setting methods rather than competition between health care providers.

Combine Parts A and B.—Many have suggested that Medicare's two-part structure is no longer appropriate. They note that the vast majority of beneficiaries enroll in both programs and, indeed, in the case of the M+C program, they are required to enroll in both. Further, efforts to reform one part of the Medicare program necessarily involves the other part as well. For example, if a benefit were added under Part B (e.g., an additional preventive care service), while it might raise expenditures under that part, it could result in fewer hospitalizations, thus lowering costs under Part A. Under the current system, Part B would not realize these cost savings. Combining the two parts could allow savings in one area to offset costs in another and thus more flexibility in adjusting benefits packages. A number of problems must be considered, however. Of particular concern are the two different financing structures. Under current law, no general revenue financing is available for Part A. Combining the programs could potentially alter this situation. Many are concerned that if general revenues were available to both parts, there would be less incentive to control costs. Alternatively, requiring general revenue financing for both parts could weaken the commitment of legislators to maintain the entitlement nature of the program.

4. PRESCRIPTION DRUGS

Medicare provides very limited prescription drug coverage. The cost of prescription drugs is included in the payments made for inpatient stays in hospitals or skilled nursing facilities. Physicians are paid for drugs which cannot be self-administered, i.e., generally those administered by injection. (The payment rate is 95 percent of the average wholesale price.) However, if the injection is generally self-administered (such as insulin), it is not covered. Coverage for some self-administered outpatient drugs are specifically authorized by law:

- 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 used in immunosuppressive therapy, such as cyclosporin, after an individual receives a Medicare-approved organ transplant;
- oral anti-cancer drugs used in chemotherapy, provided they have the same indications as a chemotherapy drug that could not be self-administered;
- acute oral anti-emetic (anti-nausea) drugs used as part of an chemotherapeutic regimen.
- hemophilia clotting factors
Many Medicare beneficiaries have other supplemental coverage that includes prescription drug benefits. In 2000, approximately 92 percent of Medicare beneficiaries enrolled in Medicare managed care organizations had some level of prescription drug coverage; about 16.5 percent of beneficiaries were enrolled in these organizations. Beneficiaries who get their supplementary coverage through employer-based plans (36.1 percent) may also have drug coverage. However, the number of employers who offer these plans has been declining in recent years. Some employers exclude drug coverage from the plan they offer Medicare-eligible retirees. Beneficiaries may also purchase one of the Medigap policies that offers partial prescription drug coverage (Plans H, I, and J). However, these plans require a $250 deductible. Plans H and I then cover 50 percent of the next $2500 up to the maximum benefit of $1,250; Plan J covers 50 percent of the next $6,000 up to the maximum benefit of $3,000. Approximately 43 percent of Medigap enrollees had drug coverage in 1998. About 6.8 percent of Medicare beneficiaries have no other coverage and rely strictly on the limited coverage provided under the traditional fee-for-service program.

Beneficiaries also can receive drug coverage through Federal and state government programs. Those who are eligible for full Medicaid coverage have prescription drug coverage through that program. Those with a military service connection may receive coverage through the Department of Defense or Department of Veterans Affairs programs. This coverage was considerably expanded by legislation passed in 2000, which allowed Medicare-eligible military retirees access to TRICARE, the military health care system. Some beneficiaries also have coverage through state-sponsored pharmaceutical assistance programs. In April 2000, there was some type of program operational in 24 states; programs were authorized in two additional states.

The cost of prescription drugs can significantly affect the elderly. Although 73 percent of beneficiaries had some drug coverage in 1998, they paid approximately 44 percent of their total drug expenses out-of-pocket. The total average annual drug expenditure for beneficiaries living in the community was $878 in 1998. Total spending for persons with some drug coverage was $999 compared with $546 for those with no coverage. Out-of-pocket costs were higher for those without coverage ($546) than those with coverage ($325).

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. The efforts of the National Bipartisan Commission on the Future of Medicare, created by BBA 97 to make recommendations on a number of program issues, drew attention to the lack of a drug benefit. A number of bills were introduced in the 106th Congress that would have added a prescription drug benefit to the Medicare program itself; others would have created a separate benefit outside the program. Some bills would have limited the benefit to the low-income Medicare population. In the 107th Congress, these efforts continue.
There are a number of design issues facing the development of a drug benefit. These include organizational and administrative issues: whether a benefit should be added before or as a part of reforming the Medicare program; whether the benefit should be part of the Medicare program itself or a separate program; and the degree of involvement for the private sector, both for administering the benefit and assuming a portion of the financial risk. The design of the benefit must also be addressed: whether it should cover the entire Medicare population or be limited to specific groups such as low-income persons or those with catastrophic expenses; the level and structure of beneficiary cost-sharing; the level of assistance for low-income beneficiaries; and the definition of covered drugs. Finally, the cost of the program must be considered as well as what cost-control strategies might be implemented.
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. 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 average cost of institutionalized care at about $40,000 per year, or $110 per day, long-term care expenses can be unaffordable to most families.

Among many older people, and other persons with disabilities, 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. At the same time, many older people and their families prefer to receive services in home and community-based settings. Support for this approach has also been expressed by groups who affirm that aging-in-place and living in community-based settings enable elderly and disabled individuals to maximize their independence and lead more meaningful lives. Some health care practitioners and policymakers also purport that the expansion of home and community-based care may be a more affordable alternative to institutional care, if such care can assist families in their caregiving efforts.

Most long-term care assistance, including assistance in an individual’s home, is provided by unpaid caregivers. Almost 60 percent of the functionally impaired elderly receiving care, for example, rely exclusively on informal, unpaid assistance. Data from the 1994 National Long-Term Care Survey (NLTCS) sponsored by the Department of Health and Human Services (DHHS) indicate that over 7 million persons provide 120 million hours of unpaid care to about 4.2 million functionally disabled older persons each week. Typically, this care is provided by adult children to elderly parents (41 percent) and by other relatives (26 percent). Spouses (24 percent)


(161)
and non-relatives (9 percent) also volunteer to provide care to frail elderly individuals.²

Despite efforts by family members to care for their older family members at home and help pay for uncovered expenses, many older 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. According to the Center for Medicare and Medicaid Services (CMS) Office of the Actuary, in 1999 Federal, state and local spending for nursing home care, mostly through the Medicaid program, was $90 billion; and an additional $33.1 billion was spent for home care.³ For many states long-term care has become the fastest growing part of State budgets. In the wake of increasing long-term care costs, as a result of the aging of the baby boom generation and general increases in longevity throughout the population, both Federal and State governments recognize the urgency in controlling the ever-growing costs of Medicaid long-term care.

Policymakers have not reached consensus as to how to finance long-term care. With the trend toward reducing the growth of entitlement programs and the fact that institutional long-term care costs are simply too high for most American families to pay out-of-pocket, it seems likely that both public and private financing will be critical in supporting the long-term care needs of our nation’s elderly population. Although in recent years, there has been a growth in the private long-term care insurance market (as of 2000, 6 million individual and employer-sponsored policies had been sold), 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 legislatures throughout the country.

This chapter will describe the various types of long-term care services, the populations served, the settings in which services are provided, and the providers and payers of long-term care services. Some of the special issues addressed in this chapter include inconsistency in the long-term care system, the role of care management, especially as it pertains to individuals with chronic illness, long-term care insurance, and ethical issues.

A. BACKGROUND

1. WHAT IS LONG-TERM CARE?

Long-term care refers to a wide range of supportive and health services for persons who have lost the capacity for self-care due to illness, frailty, or a disabling condition. It differs from other types of 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. The need for long-term care services ranges from skilled medical and therapeutic services for the treatment and

²Doty, 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 or IADL limitations.
³CMS is the agency formerly known as the Health Care Finance Administration (HCFA).
management of these conditions to assistance with basic activities and routines of daily living, such as bathing, dressing, eating, and housekeeping. The provision of these services involves a continuum of health and social services in a variety of settings, ranging from care in nursing homes to care at home through home health, personal care, homemaker services, and services in the community, such as adult day care. It may also be delivered in a variety of other settings that provide health and supportive services along with housing, such as intermediate care facilities for the mentally retarded (ICFs/MR), assisted living and board and care facilities. 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

Adult day care programs provide health and social services in a group setting to frail older persons and other persons with physical, emotional, or mental impairments on a part-time basis. Adult day care programs have grown from a handful of federally supported research and demonstrations projects in the late 1960's and early 1970's to key components in community-based long-term services today.

The National Adult Daycare Services Association of the National Council on Aging (NADSA/NCOA), a voluntary organization of adult day care providers, defines adult day care as a community-based group program designed to meet the needs of adults with functional and/or cognitive impairments through an individual plan of care. Day care is a structured, comprehensive program that provides health, social and related support services in a protective setting on less than a 24-hour a day basis (usually around 8–10 hours per day). Services that are generally provided include client assessment; nursing; social services; personal care; physical, occupational, and speech therapies; rehabilitation; nutrition; counseling; and transportation.

Adult day care is supported by participant fees and private funds, as well as by a variety of Federal and state funding sources. The average funding breakdown is estimated to be: one-third from third-party reimbursements (including all state and Federal reimbursement programs as well as private insurance reimbursement); one-third from contributions, donations, and grants; and one-third from private payers.

Although adult day care centers are supported by Federal funds, Federal standards for adult day care centers do not exist. Thirty-four states do offer licensing and/or certification for adult day centers; however, requirements for licensure and certification vary widely among states. Additionally, many states have requirements for licensure and/or certification to assess the eligibility of centers.

Other sources of Federal support are the Older Americans Act, the Social Services Block Grant, the Department of Veterans Affairs, Medicare (under limited circumstances), and the U.S. Department of Agriculture child and adult care food programs. However, Medicare and Medicaid and the Department of Veterans Affairs fund some services that are offered in adult day care centers only
if they are licensed to participate in the programs. Medicaid does not fund it at all. Despite the popularity of adult day care as a means to assist frail older persons and persons with disabilities to remain in their own homes, some believe that the fragmented nature of funding sources may hamper the development of new programs.

(B) HOME CARE

In general, home care refers to services that are provided to individuals in their homes. Patients requiring home care may or may not require medical care, but almost always require assistance with activities of daily living (ADLs), including bathing, eating, dressing, toileting, transferring, and continence. Other categories of services provided in home settings, include skilled nursing, various types of rehabilitative therapy and assistance with instrumental activities of daily living (IADLs), including shopping, light housework, telephoning, money management, and meal preparation. Not all of the above services are provided exclusively in the home. For example, personal assistance services for individuals with disabilities can be provided in any setting, including a workplace.

In addition to the critical role played by unpaid caregivers in the provision of home care, Medicare, Medicaid, other government programs and the private sector (such as private health insurance) provide a variety of paid services to individuals in their homes. In 1999, Medicare was the largest single payer of home care services, comprising about 26 percent (about $8.6 billion) of total home health care payments made to home health agencies in 1999 ($33 billion). Medicaid payments comprised about 17 percent ($5.6 billion). Out-of-pocket and private health insurance payments to home health agencies totaled 27 percent ($8.9 billion) and 19 percent ($6.3 billion) respectively. The remaining 11 percent ($3.6 billion) was paid for by other public and private sources, such as local charities.4

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.

A variety of other Federal programs also support home care, including long-term care services funded through the Older Americans Act, the Social Services Block Grant and the Department of Veterans Affairs. In addition, many states provide supplementary services through programs that are often paid for through state general revenue allocations. In general, these programs target specific groups of low-income elderly and disabled persons. The majority of state-only funded programs provide such services as personal care, homemaker, home health aid, home-delivered meals, chore, respite, case management, adult day care and transportation.

---

4 The sum of percentages pertaining to payments made to home health agencies does not total 100 percent due to rounding. Data source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, 1999.
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. In November 2000, Congress reauthorized the Older Americans Act (P.L. 106–501) and created a new National Caregiver Support Program funded at $125 million in fiscal year 2001. Respite services to provide families temporary relief from caregiving responsibilities is one of the services that states are allowed to provide with this funding. In addition, some states provide respite care to certain individuals or families using state-only funds. 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 the pooling of time and resources by family caregivers of patients with Alzheimer's Disease to provide voluntary services.

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 supportive services for the elderly and disabled. 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.

The various supportive housing options are characterized by the availability of services to frail residents on an as-needed basis. Many such facilities offer certain congregate services such as meals and recreational 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.

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. Generally, assisted living facilities are residential settings that offer a variety of services, including room and board, personal care, and supportive services for persons needing assistance due to functional or cognitive impairments while also providing some health-related care. They range from tony, hotel-like buildings to small group homes providing services to persons with low income. In large part, assisted living facilities have 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 per-
sons with moderate incomes. However, there has been concern regarding quality of care in some assisted living facilities. Only states, not the Federal Government, regulate assisted living facilities. Residents must pay out-of-pocket for most of the cost of assisted living and other supportive housing. The high costs of such housing, can quickly lead residents to deplete their life savings and then, if they are unable to find a nursing home willing to take a Medicaid patient, have no funds or any place to go. A GAO report entitled Assisted Living found that there is little protection from eviction if residents run out of money. Assisted living and other private housing facilities may summarily evict a resident if the administration decides that they are no longer able to care for the individual.

(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 and then pay a monthly fee. In exchange for these payments, 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) ASSISTED LIVING

There is no common definition for ALFs. Generally, they are residential settings that offer a variety of services, including room and board, personal care, and supportive services for persons needing assistance due to functional or cognitive impairments while also providing some health-related care. They range from tony, hotel-like buildings to small group homes that provide services to persons with low income.

Assisted living evolved during the 80's from "board-and-care" facilities that basically served low-income persons with disabilities, including the elderly, persons with mental retardation or cognitive impairments, and alcohol or drug abusers. Board-and-care facilities provide housekeeping, meals, some protective oversight, but often doesn't offer the health-related services like assisted living facilities (ALFs). Nearly two-thirds of persons in board-and-care are elderly. These facilities are generally small (4–25 residents) "mom and pop" operations in a group home setting with shared rooms.

Today, a range of senior residential facilities that offer supportive services are referred to as assisted living. These include: congregate housing (apartment rentals or ownership); independent liv-

---


ing (upscale apartments/condominiums for younger, healthier seniors); and residential care facilities (provide support/supervision, optional services for additional fees, have individual rooms). Generally, little or no medical care is provided in these facilities. Residents usually don’t have cognitive or functional impairments or qualify for admission to a nursing home. In addition, continuing care retirement communities (CCRCs) often provide independent living, assisted living, and nursing home care all in one location, and residents move from one level to another as their health needs change.

A typical resident is female, frail, but mobile, averaging 83 years of age, and needs help with two or more activities of daily living (ADL), such as bathing or dressing (nursing home residents usually have four or more ADLs.). Residents need some assistance, but generally are not in need of comprehensive nursing care, needing the most help with managing medication (about 70 percent) and bathing.

As of July 2000, states reported a total of 32,886 licensed facilities with 795,391 units or beds. Over 36 percent of beds are located in three states: California, Florida, and Pennsylvania. Costs vary depending on size, service, and location. Rates range from $1,000 to more than $4,000 per month. Nursing homes can average $4,000 per month. Most ALFs usually offer basic services that are included in the monthly fee, but the number of such services will vary by facility. For example, some offer bathing assistance once a week while others offer it twice weekly. Medication reminders are usually included in the basic rate, but actual dispensing of medication could be an additional fee. A-la-carte service (the resident pays for each service separately and as needed) are offered in addition to basic service. ALFs may increase fees if the individual becomes sicker, requires more services or staff time (often billed in 15-minute increments) such as medication reminders three times a day instead of once or complete assistance with bathing instead of stand-by service. Most residents pay out of pocket for the cost of their care.

Medicare does not provide any funds for assisted living. As of June, 2000, 38 states used Medicaid to provide assistance to persons in ALFs, generally through Medicaid home and community-based waiver programs (HCBWs) or through optional services offered under a state’s Medicaid plan. Medicaid is the Federal-state, means-tested health program for low-income persons or persons who have become poor as a result of needing medical and health-related care.

The HCBWs allow the Health Care Financing Administration (HCFA) to waive certain Federal requirements so states may cover ALF services for persons who would otherwise be eligible for nursing home care. Costs may not exceed costs Medicaid would pay for persons in nursing home care.

State Medicaid plans also cover services through their “personal care” benefit. Nursing home eligibility is not a requirement, al-

---

4 Ibid.
though states require that a minimum level of functional impairments be present for persons to become eligible.

Medicaid pays for room and board and service costs in nursing homes (and hospitals), but Medicaid only pays for the personal and supportive care costs in assisted living. Room and board in ALFs is paid by the resident usually using their Supplemental Security Income (SSI) benefit. Only 58,544 Medicaid beneficiaries were served in ALFs as of April 2000. This is the result of a number of factors. As noted, Medicaid is a means-tested program and requires beneficiaries to have low incomes and assets. In addition, ALFs may not be satisfied with rates paid by the Medicaid program.

Other Federal involvement includes the FY2000 Veterans Administration (VA) and Housing and Urban Development (HUD) appropriations law (P.L. 106-74) which earmarked $50 million for grants to convert existing HUD Section 202 projects to assisted living facilities.

Unlike for nursing homes, there are no Federal regulations governing ALFs. Each state defines the level of need to be provided by facilities and services offered. Most require that residents have stable medical conditions, not need 24-hour skilled nursing care, or not have specific conditions (such as be ventilator-dependent, need tube feeding, or intravenous medication).

Many ALFs allow residents eligible for nursing home care to stay when their health declines because evolving regulations have allowed providers to make more services available. However, state regulations generally define the level at which an individual must leave an ALF and enter a nursing facility.

GAO found that about 90 percent of residents pay out of pocket. A hearing by the Special Committee on Aging revealed that nearly two-thirds of persons aged 75 and older had incomes below $15,000 in 1997 and could not afford the most common rate of $1,458 per month or $17,496 per year for assisted living. ALFs found to be affordable for this income group offered low service/low privacy or minimal service/minimal privacy.

There are no Federal requirements regarding quality of care in ALFs. State departments of health do periodic inspections and state licensing agencies and adult protective services also investigate complaints. The Long-Term Care Ombudsmen Program, authorized by the Older Americans Act, provides advocates for the elderly in every state. They are required to investigate and resolve complaints of residents of nursing homes and other adult care facilities. They receive complaints from residents, family or friends or may initiate complaints based on their own observations.

---

6 Assisted Living. GAO.
7 Testimony of Catherine Hawes, Myers Research Institute, at hearing before the Senate Special Committee on Aging, Shopping for Assisted Living: What Consumers Need to Make the Best Buy. April 26, 1999.
(G) 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 are defined as facilities with three or more beds that routinely provide skilled nursing and other health and supportive services. They can have special units to manage certain illnesses like Alzheimer’s Disease or other types of dementia. Facilities may participate in Medicare, or Medicaid or receive only private funding. As of 1997, there were about 1.5 million elderly nursing home residents living in about 17,000 nursing homes nationwide. 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, especially care that is provided in the community.

(H) ACCESS SERVICES

A host of other services are considered to be part of the long-term care continuum because they enable individuals to access the long-term care services they need. 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 populations reside. 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.

(I) NUTRITION SERVICES

Nutrition services, including both congregate and home-delivered meals, are also considered to be a part of the long-term care contin-

---

uum because they support older people living in the community by providing one to three nutritious meals per day. The Older Americans Act enables 240 million congregate and home-delivered meals to be distributed to over 3 million older persons annually. Meals are also provided to elderly individuals by the Social Services Block Grant (SSBG), state-funded programs and charitable non-profits. 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. These programs help ensure that frail older people, particularly those living alone, have an adequate supply of calories and important nutrients.

Congregate meals add a social component to the standard nutrition service. In addition to providing a hot nutritious meal, the dining site also offers socialization. Dining sites in the congregate nutrition program are also important access points for other services, e.g., health promotion activities, insurance and financial counseling, and recreation activities.

2. WHO RECEIVES LONG-TERM CARE?

In 2000, there were an estimated 35.5 million elderly persons living in the United States age 65 and over. Of these persons, approximately 7 million experienced a chronic disability. This constitutes about 20 percent of the elderly population, although not all of these individuals require long-term care assistance. 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 5.3 million elderly persons required assistance with ADLs or IADLs in 1994.

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. In 1994, an estimated 3.9 million elderly, or almost 74 percent of the total 5.3 million elderly receiving long-term care assistance, live in their own homes or other community.

---


based settings. Among these individuals, an estimated 1.2 million elderly persons experienced severe disabilities. These individuals need help with at least three ADLs or require substantial supervision due to cognitive impairment or other behavioral problems.\(^9\)

The need for long-term care assistance by the elderly is expected to become more pressing in years to come. Demographic projections show growth in the elderly population at record rates. By 2020, the population age 65 and older is expected to increase by about 50 percent—from 35.5 million persons in 2000 to 52.6 million persons. This number is expected to more than double over the next half century. The provision of long-term care will be most greatly influenced however by the expected increase in the size of the population age 85 and older. This group is at greatest risk of needing long-term care assistance. The age 85 and older cohort is expected to increase by 26 percent, from 4.6 million persons in 2000 to 5.8 million persons in 2020. By 2050, it will more than triple to 14 million persons.\(^10\)

These snapshot estimates are one way of looking at the prevalence of nursing home use among the elderly. Another way to look at this issue is to predict future nursing home use for a given cohort of elderly people. From the standpoint of public policy and personal planning, this provides a more important look into the need for nursing home care. While only 4 percent of the elderly reside in nursing homes (1.5 million as of 1994),\(^11\) research has shown that many more are expected to use nursing home care at some time in their lives. Researchers estimate that short-term nursing home placement rates for elderly individuals is about 2.4 percent and 3.8 percent per year and long-term care placement rates for elderly individuals ranges from 1.9 percent to 4.6 percent per year.\(^12\)

Analysis of nursing home utilization has found a high degree of variance in length-of-stay patterns among nursing home residents. In recent years, hospitals have increased the practice of discharging medically complex patients or individuals needing intensive rehabilitation to less costly, skilled nursing facilities. These individuals use nursing homes as a source of extended care, following hospitalization, and tend to have shorter lengths of stay than those individuals with chronic disabilities and little prospect of improvement. Individuals using nursing homes following hospitalization tend to stay for less than 1 year, about 290 days as of 1997. The average length of stay for those individuals who use nursing homes for the purpose of caring for their chronic conditions was about 2.4 years, as of 1997. Nursing home residents are more likely to be very old and female. In 1997, residents age 85 and older comprised

---

\(^9\) Ibid.

\(^10\) Ibid.


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. In addition, many elderly individuals prefer to receive long-term care assistance in the community as they and their advocates affirm that aging-in-place (i.e. in one's home or in a community setting) enables the elderly to maximize their independence and lead more meaningful lives.

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 an adult day care center, a senior center or drop-in center, or in a residential setting such as a nursing home or other facility.

4. WHO PROVIDES LONG-TERM CARE?

Because of the wide assortment of long-term care services available to elderly individuals, it is difficult to present a comprehensive breakdown of all personnel delivering these services across the entire long-term care continuum. However, the majority of paid direct care providers include registered nurses (RNs), licensed practical nurses (LPNs) and paraprofessionals (home health aides, nursing aides, personal care and home care aides).

As of 1998, there were nearly 2.1 million licensed registered nurses in the United States. Registered nurses are responsible for assisting physicians, administering medications, and helping patients in the convalescence and rehabilitation processes. Most RNs (60 percent) work in hospitals and 7 percent work in nursing/personal care and private facilities. An estimated 8 percent work in physicians' offices, 6 percent work in home health care services and the remaining 19 percent work in a diverse range of public/


community and private settings, such as educational organizations, private homes, and schools.\textsuperscript{15}

In 1998, there were more than 692,000 licensed practical nurses (LPNs). LPNs provide routine care (taking vital signs, applying dressings, supervising the care provided by nursing assistants) under the direction of physicians and RNs. They may also help develop care plans. Thirty-two percent worked in hospitals, 28 percent in nursing facilities, 26 percent in home health agencies and residential care facilities, and 14 percent in doctors' offices and clinics.\textsuperscript{16}

Long-term care paraprofessionals include home health aides, personal care aides, and nurse aides. They work in a variety of settings and play an important role in the provision of long-term care, providing eight out of every 10 hours of paid long-term care.\textsuperscript{17} In 1998, more than 746,000 home health aides, personal care attendants, and home care aides provided a variety of long-term care services to individuals living in the community and 1.4 million nurses aides provided personal and health-related services to patients in hospitals and nursing homes.\textsuperscript{18} Home health and nurse aides' responsibilities include taking temperatures, assisting individuals with bathing, dressing, eating, toileting and other services under a physician's or nurse's orders.\textsuperscript{19}

In recent years, there have been widespread accounts of hospitals, nursing homes and other facilities having great difficulty attracting and retaining nursing and paraprofessional personnel. This problem may be the result of a variety of factors, including the strong economy which has increased competition among providers within the health care sector and expanded opportunities for work in other sectors. Studies have shown that such difficulties can also be attributed to relatively low wages, limited or no employee benefits, and insufficient opportunities for professional development (such as promotions and training opportunities) offered to paraprofessionals.\textsuperscript{20} These problems are especially acute in the long-term care sector where nursing homes and home health agencies play a major role.\textsuperscript{21}

Any discussion of individuals who deliver long-term care services would be incomplete without a discussion of unpaid 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. Research has docu-

\textsuperscript{16} Ibid.
\textsuperscript{17} Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care. The Aspen Institute, January 2001, p. 1.
\textsuperscript{19} Nursing Staff in Hospitals and Nursing Homes: Is it Adequate? Institute of Medicine, 1996, p. 68 and Improving the Quality of Care in Nursing Outcomes, p. 52.
\textsuperscript{21} Other long-term care providers, whose nurses and paraprofessionals are not regulated under Medicare or Medicaid, include assisted living facilities and other congregate residential facilities.
mented the enormous responsibilities that families face in caring for relatives who have significant impairments. For example, data from the 1994 National Long-Term Care Survey (NLTCS) sponsored by the Department of Health and Human Services (DHHS) found that caregivers of the elderly with certain functional limitations provide an average of 20 hours of unpaid help each week. The study also found that over 7 million persons provide 120 million hours of unpaid care to about 4.2 million functionally disabled older persons each week. Typically, this care is provided by adult children to elderly parents (41 percent) and by other relatives (26 percent). Spouses (24 percent) and non-relatives (9 percent) also volunteer to provide care to frail elderly individuals. About 37 million caregivers provide informal, or unpaid, care to family members of all ages. Unpaid work, if replaced by paid home care, would cost an estimated $45 billion to $94 billion annually.22

5. WHO PAYS FOR LONG-TERM CARE?

A variety of 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. 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. 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.

Creation of Federal task forces on long-term care issues, as well as Federal investment in research and demonstration efforts to identify cost-effective “alternatives to institutional care,” date back to the late 1960’s and early 1970’s when payments for nursing home care began consuming a growing proportion of Medicaid expenditures. The awareness that public programs provided only limited support for community-based care, as well as concern about the fragmentation and lack of coordination in Federal support for long-term care, led to the development of a number of legislative proposals in 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, about $123 billion in 1999. Federal and State governments account for the bulk of this spending, about $70 billion or 57 percent of the total.

---

Approximately 73 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 74 percent of this total.

Medicaid is a Federal-State matching entitlement program that provides medical assistance for certain groups of low-income individuals. The program was established under Title XIX of the Social Security Act in 1965 and has become the largest single source of financing both private and public for long-term care and medical services for the elderly who are low-income or who have depleted their income and assets on medical and long-term care expenses. Of the 40.3 million individuals who received services under Medicaid in fiscal year 1998 (FY98), approximately 4 million (10.1 percent) qualified on the basis of being elderly.

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 the average cost in excess of $40,000 per year. It is largely 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.

Table 1 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 8.3 percent of total spending for nursing home care in 1999. 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

---

Table 1. Personal Health Care Expenditures, by Type of Expenditures and Source of Funds, 1999

<table>
<thead>
<tr>
<th>Source of funds</th>
<th>Nursing Home Care</th>
<th>Home Health Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Long-Term Health Care Expenditures For Services</td>
<td>$90</td>
<td>33.1</td>
</tr>
<tr>
<td>Out-of-Pocket</td>
<td>23.9</td>
<td>9</td>
</tr>
<tr>
<td>Third-Party Payments</td>
<td>66.1</td>
<td>24.1</td>
</tr>
<tr>
<td>Private Health Insurance</td>
<td>7.5</td>
<td>6.3</td>
</tr>
<tr>
<td>Other Private</td>
<td>4.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Federal</td>
<td>35.6</td>
<td>11.9</td>
</tr>
<tr>
<td>Medicare</td>
<td>9.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Medicaid</td>
<td>1.9</td>
<td>0.1</td>
</tr>
<tr>
<td>Other state and local</td>
<td>18.6</td>
<td>4.2</td>
</tr>
<tr>
<td>Medicaid</td>
<td>18.3</td>
<td>2.6</td>
</tr>
<tr>
<td>Other</td>
<td>0.2</td>
<td>1.7</td>
</tr>
</tbody>
</table>

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 alternative 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 1999, spending for home care services for the elderly amounted to $33.1 billion, or almost 27 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. Data from the 1994 National Long-Term Care Survey (NLTCS) sponsored by the Department of Health and Human Services (DHHS) indicate that over 7 million persons provide 120 million hours of unpaid care to about 4.2 million functionally disabled older persons each week. 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.

Table 1 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 about 11 percent of the elderly's nursing home spending in 1999.

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 15 percent of total public and private long-term care spending in 1999, 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 three major Federal programs are described below:

- Title XX of the Social Security Act authorizes Social Services Block Grants (SSBG) to states to help them provide a wide range of social services for the elderly, as well as for younger adults and children with disabilities. Using SSBG funds, states may provide home-based services, adult day care, home-delivered meals, case management services, health related and home health services, transportation as well as a variety of other support services that are not part of the long-term care continuum. Funds are allotted to states on the basis of state population demographics and do not require state matching funds. In 1999, SSBG programs received $3 billion in Federal appropriation funding. Funding has decreased in each year since 1998. In 2001, the SSBG Federal appropriation decreased to $1.7 billion.

- The Older Americans Act (OAA) is the major vehicle for the delivery of social and nutrition services for older persons. Originally enacted in 1965, the Act supports a wide range of services for older persons, a community service employment program, and research, training, and demonstration activities, among other programs. Authorization of appropriations for the Act were extended through FY2005 by P.L. 106-501 signed into law on November 13, 2000. For FY2001, $1.7 billion was appropriated for OAA programs administered by the Departments of Labor, Health and Human Services, and Agriculture. The Older Americans Act also funds a broad range of in-home services for the elderly, including home-delivered meals and respite care, and authorizes a specific program for other in-home supportive services for the frail elderly; and

- The Supplemental Security Income (SSI) program, authorized by Title XVI of the Social Security Act, is a means-tested income assistance program financed from general tax revenues. Under SSI, disabled, blind, or aged individuals who have low incomes and limited resources are eligible for benefits regardless of their work histories. In November 2000, about 6.6 million individuals received SSI benefits. In FY2000, total SSI benefits were $34.4 billion. The maximum Federal SSI benefit for an individual living independently is $530 per month and $796 per month for a couple in 2001. Many states, recognizing that the SSI benefit standard may provide too little income to meet an individual's living expenses, supplement SSI with additional cash assistance payments made solely with state funds. These supplemental payments may be used by individuals to pay for a range of community-based care, such as adult foster care.

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 have affected States' abilities to support home care services for the frail elderly. The Older Americans Act National Family Caregiver Pro-
gram will assist some families in their caregiving efforts; however, many advocates want to see the program’s funding increase.

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 established the framework for how long-term care is provided in the United States. Federal expenditures make up the majority of long-term care spending in the Nation, with the remaining expenditures paid for by individuals and private insurance. The following is a discussion of the primary public sources of Federal 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. In addition, eligibility criteria for services under these programs vary, resulting in a patchwork of covered services provided to diverse groups of individuals. 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, and is jointly funded by Federal and State Governments. Each State designs and administers its own Medicaid Program, determining eligibility and benefit packages 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 FY1998, CMS estimates that Medicaid enrolled 40.3 million persons at a total cost of almost $176.9 billion. The Federal share of the cost was $99.9 billion. Combined Federal and State expenditures in FY2000 total $206.7 billion, with the Federal share nearly $117.4 billion.

Although Medicaid was originally intended to provide basic medical services to the poor and disabled, it has become the Nation’s single largest payer for nursing home care, accounting for nearly 50 percent of the total $90 billion spent by the Nation for this care in 1999. The aged and disabled totaled about 27 percent of Medicaid recipients, but accounted for about 67.5 percent of spending for covered services in FY1998. This disparity is due largely to Medici-

26 Data on enrollees in FY2000 is not yet available.
aid's coverage of long-term care services, the fact that elderly and disabled persons need and use these services more 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.

Though Medicaid's long-term care payments are primarily for institutional care (including nursing home care for the elderly), 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 the option of offering targeted community-based long-term care services to qualifying individuals who prefer community-based rather than institutional care. 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.

Other community-based long-term care services provided through Medicaid include home health and personal care. States are required to provide home health services to persons who qualify for Medicaid based on being elderly or disabled and who meet all requirements for nursing facility coverage except for the level-of-care criteria. In order to receive Federal reimbursement, home health services must be medically necessary and ordered by a physician under a plan of care. In addition, States have the option of offering personal care services in their benefit packages for Medicaid beneficiaries who need assistance with ADLs and IADLs. Personal care services are defined as services furnished to an individual at home or in another location (excluding hospital, nursing facility, ICF/MR, or institution for mental diseases) that are authorized by a physician, or at state option, otherwise authorized under a plan of care.

Due to the high costs of long-term care, 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. 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.
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 FY2001, 9 States had matching rates of 50 percent. Sixteen States had matching rates between 50 percent and 60 percent. Twelve States and the District of Columbia had matching rates at or above 70 percent. Mississippi had the highest rate in effect, 76.82 percent. Overall, in FY2000 the Federal Government finances about 57 percent of all Medicaid costs.

Each State establishes its own eligibility rules within 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 39 percent of persons in poverty in 1999. 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. Some of the mandatory services include: physicians’ and hospital services, and care

---

in nursing facilities. Some of the 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. Within broad Federal guidelines, states set payment methodologies and determine the payment rates for services provided. Therefore, state reimbursement levels to providers of Medicaid covered services vary from State to State. Medicaid law requires states to publish their rates as well as the underlying methodologies and justifications for the rates.

(C) LOW-INCOME BENEFICIARIES ALSO ELIGIBLE FOR MEDICARE

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.

Federal law specifies several population groups that are entitled to Medicaid coverage of some or all of Medicare's cost-sharing and premium charges. These are qualified Medicare beneficiaries (QMBs), specified low income beneficiaries (SLIMBs), and certain qualified individuals. QMBs and SLIMBs may be entitled to full Medicaid coverage under their state's Medicaid program. Persons entitled to full Medicaid protection generally have all of their health care expenses met by a combination of Medicare and Medicaid. For these "dual eligibles" Medicare pays first for services both programs cover. Medicaid picks up Medicare cost-sharing charges and provides protections against the costs of services generally not covered by Medicare. Other groups, including qualifying individuals, are not entitled to full Medicaid benefits. The following is a description of the four coverage groups:

Qualified Medicare Beneficiaries (QMBs).—QMBs are aged and disabled persons with incomes at or below the Federal poverty line ($8,832 for a single individual and $11,856 for a couple in 1999) 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. Medicare Part B provides coverage for physicians' services, laboratory services, durable medical equipment, hospital outpatient department services, and other medical services. 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 Beneficiary.—SLIMB benefits are available to Medicare recipients whose income is no greater than 120 percent of FPL. In 2001, this means that income at or below

---

28 The Qualified Medicare Beneficiary (QMB) Program was enacted in 1988. Additional categories were added by the Balanced Budget Act of 1997.

29 The Federal poverty level in Alaska is $10,980 for an individual per year and $14,760 for a couple. For Hawaii, the Federal poverty level is $8,45 for an individual and 10,140 for a couple.
$879 per month for an individual and $1,181 for a couple. The asset test is the same as that for QMB. Under this Medicaid pathway, benefits include only the monthly Medicare Part B premiums.

Medicaid coverage for QMBs and SLMBs is limited to Medicare cost-sharing charges. Other Medicaid plan services, such as nursing facility care, prescription drugs and primary and acute care services, are not covered for these individuals unless they qualify through other eligibility pathways into Medicaid (e.g. via SSI, medically needy or special income rule).

**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.

**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 ($3.09 in 2001).

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, “nation-ally, 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. CMS has embarked on an outreach program to enroll those who may be eligible and CMS also screens newly entitled Medicare beneficiaries to determine their QMB eligibility.

**D) SPOUSAL IMPOVERISHMENT**

Rules are used to prevent what is often referred to as spousal impoverishment—a situation that leaves the spouse who lives at home in the community with little or no income or resources when the other spouse requires institutional or home and community-based long-term care. Spousal impoverishment was largely a con-

---

30 The Federal poverty level in Alaska is $1,093 for an individual per year and $1,471 for a couple. For Hawaii, the Federal poverty level is $1,009 for an individual per year and $1,356 for a couple.

31 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 the Medicare Part B trust fund) up to the 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 FY 1998, $250 million for FY 1999, $300 million for FY 2000, $350 million for FY 2001, and $450 million for FY 2002. Assistance under the QI-1 and QI-2 programs is available for the period January 1, 1998 to December 31, 2002.

32 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.
Concern before Congress passed the Medicare Catastrophic Coverage Act (MCCA) of 1988. Before MCCA, states could consider all of the assets of the community spouse, as well as the institutionalized spouse, available to pay for the cost of medical care for an institutionalized spouse under Medicaid. This rule created hardships for the spouse living in the community who was forced to spend down virtually all of the couple's assets to Medicaid eligibility levels so that the institutionalized spouse could qualify for Medicaid. MCCA established new rules for the treatment of income and resources of married couples to determine how much income or resources a community spouse must contribute toward the cost of care for the spouse requiring the care, and how much of the institutionalized spouse's income and resources is actually protected for use by 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. CMS' 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 individuals' estates amounts paid by Medicaid for long-term care nursing home and home and community-based care as well as other services. Recovery may only be made after the death of the beneficiary and his or her surviving spouse, if any, and only at a time when there is no surviving child under age 21 or a child who is blind or permanently and totally disabled.

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 of $87,000 in 2001, or the state standard. Federal law stipulates that state standards may be no lower than $17,400 in 2001. Maximum and minimum Community Spouse Resource Allowance (CSRA) amounts are adjusted annually at the Federal level by the same percentage as 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.

Treatment of Income.—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 2001, the minimum is $1,451.25 per month. States can set the maintenance needs allowance as high as $2,175 per month. States can increase this amount, depending on the amount of the community spouse’s actual shelter costs and whether the minor or dependent adult children or certain other persons are living with the community spouse. Both of these minimum and maximum amounts are adjusted at the Federal level to reflect increases 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. 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. States have the option of supplementing the Federal minimum PNA with state funds. As of November 2000, 35 States did, with the combined PNA plus State supplement ranging from $35 in Florida, Nevada and New Jersey to $76.80 in Arizona. Personal Needs Allowances are not adjusted to reflect changes in the annual cost of living, although some states, Connecticut and Minnesota, increase their PNA levels annually. There is no provision for a cost-of-living adjustment (COLA) in the PNA, even though noninstitutionalized recipients of Social Security and SSI benefits have received annual COLAs to their benefits since 1974.

For impoverished nursing home residents, the PNA represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, 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 pre-determined amount of days for hospitalization or “therapeutic leave” such as a home visit, or vacation days and all other absent days are considered

34 Congressional Research Survey of Selected Medicaid Eligibility and Post-Eligibility for Aged, Blind, Disabled (ABD) Groups, November 2000. State reported responses via email, telephone and fax.
noncovered expenses. When a resident cannot pay this fee, he/she is likely to lose his/her 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.

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 seeking Medicaid coverage for nursing home care or 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 related 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.

The Center for Medicare and Medicaid Services reported in 1999 that states recovered approximately $200 million through their Medicaid Estate Recovery programs. At the national level, this comprised about one tenth of 1 percent of total Medicaid expenditures for covered benefits.

(F) 1915(C) WAIVER PROGRAM

Despite the availability of home health and personal care attendants under Medicaid’s general program, the majority of community-based care is provided under 1915(c) and (d) Home and Community-Based Services Waiver (HCBW) 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 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.


36 Recovered funds in FY 1999 are based on Medicaid expenditures during beneficiaries’ lifetimes, and are not limited to amounts spent by the program in FY 1999. Total Medicaid expenditures for FY 1999 refer to expenditures made during that federal fiscal year. There is therefore not a one-to-one correspondence between dollars spent in 1999 to dollars recovered in 1999.
States use diverse models of care delivery, management and financing for waiver programs. There are three Medicaid requirements that may be waived: (1) statewideness; (2) comparability of services; and (3) income and resource eligibility rules. Unlike other Medicaid services, HCBW authority enables states to target specific groups of individuals who live within a defined geographical area, such as a county. Despite the implementation of waiver programs, service availability remains uneven both within and across states. This is partly a result that states have a great deal of flexibility in the design of their waiver programs; therefore, the populations covered by the waivers vary greatly among states.

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 CMS, in FY2000, total expenditures for HCBW were $12 billion, a $10.2 billion increase from FY1990 expenditures of $1.2 billion. In 1997, aged and disabled individuals comprised the largest group of waiver recipients—326,615 people (58.2 percent of all recipients). This is a 95 percent increase from 1992’s aged and disabled recipients of 167,779.

2. MEDICARE

(A) INTRODUCTION

The Medicare program, which insures almost 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. Coverage is provided for up to 100 days per spell of illness. Beneficiaries are required to pay a daily coinsurance charge for days 21–100 ($97 in 2000). To be eligible for SNF care, 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. A physician must certify that the beneficiary needs daily skilled rehabilitation services that

37 For more information see CRS Report RL31163: Long-Term Care: A Profile of 1915(c) Home and Community-Based Services Waivers, by Carol O'Shaughnessy and Rachel Kelly.

38 Part A Medicare covers inpatient hospital services, SNF care, home health services, and hospice care. Almost all persons over age 65 are automatically entitled to Part A. Part B is voluntary, and covers physicians’ services, laboratory services, durable medical equipment, outpatient hospital services, and other medical services. Over 96 percent of Part A-covered beneficiaries elect Part B coverage.

39 A spell of illness is that period which begins when a beneficiary is furnished inpatient hospital or covered SNF care and ends when the beneficiary has not been an inpatient of a hospital or in a Part A covered SNF stay for 60 consecutive days. A beneficiary may have more than one spell of illness per year.
are related to the hospitalization, and that these services, as a practical matter, can only be provided on an inpatient basis.

Covered SNF services include the following: nursing care provided by or under the supervision of a registered nurse; room and board; physical or occupational therapy or speech-language pathology; medical social services; drugs, biologicals, supplies, appliances, and equipment ordinarily furnished by a SNF for the care of patients; and other services necessary to the health of patients as are generally provided by SNFs.

Medicare spending for SNFs, which totaled less than $1 billion in 1988, increased dramatically beginning in 1989, rising at an average annual rate of 17 percent, and $13.5 billion in 1998. This was due, in large part, to two events. First, before 1988, due to a lack of Federal guidance, regional administration of the program led to inconsistencies in coverage decisions. Therefore, many SNFs were hesitant to accept Medicare beneficiaries. In 1988, new coverage guidelines became effective which clarified beneficiary qualifying criteria, thus alleviating this problem.

Second, with passage of the Medicare Catastrophic Act (P.L. 100-360, MCCA), effective beginning in 1989, the requirement that beneficiaries have a prior hospitalization was eliminated. Although the hospitalization requirement was reinstated the following year, studies suggest that the temporary MCCA expansions and the coverage guidelines causes a long-run shift in nursing home industry toward accepting Medicare patients. The number of beneficiaries receiving SNF care has increased measurably, rising from 384,000 in 1988 to 1,630,000 in 1998.

Other factors affecting this spending growth and increased SNF care use include declining lengths of stay in hospitals leading to increased admissions to SNFs, and an increase in the number of participating facilities. Between 1989 and 1997, the number of SNFs participating in the program increased from 8,638 to 14,619.

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 changed the reimbursement system to a prospective payment system (PPS) for SNFs, beginning a 3-year phase-in which started July 1, 1998.

Prospective payment for SNF care involves setting a rate for a specific amount of services before the service is provided. It uses a day of care as the unit of payment. Under this daily rate system, the facility receives a fixed payment for each Medicare-covered day a beneficiary spends in a SNF. The amount of the Federal per diem payment is based on the national average cost of resources (type and intensity of care) SNF residents use per day as determined by CMS analysis of SNF cost data.

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 over-
head; (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. 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.

(C) THE HOME HEALTH BENEFIT

Medicare beneficiaries may qualify for Medicare coverage of home health care services if they are homebound and a physician determines the services are medically reasonable and necessary for the treatment of illness or injury. Homebound individuals are eligible for intermittent skilled nursing care, physical therapy, or speech-language pathology services. Beneficiaries needing one or more of these three services may also receive occupational therapy, the services of a medical social worker, or a home health aide if such additional services are ordered by the physician. Occupational therapy may continue to be provided after the need for skilled nursing care, physical therapy ends, but social work or aide services may not.

A homebound individual is defined as one who cannot leave home without a considerable and taxing effort and only with the aid of devices such as a wheelchair, a walker, or through use of special transportation. Absences from home may occur infrequently for short periods of time for such purposes as to receive medical treatment or to attend a licensed adult day care program for therapeutic, psychosocial, or medical treatment purposes. (Participation in adult day care was included in the Benefits Improvement and Protection Act, “BIPA” of 2000.)

Although the number of home health visits a beneficiary may receive is unlimited, services must be provided pursuant to a plan of care that is prescribed and reviewed by a physician at least every 60 days. In general, Medicare’s home health benefit is intended to serve beneficiaries needing acute medical care that is prescribed and reviewed by a physician at least every 60 days. It was never envisioned as a benefit that would provide coverage for the nonmedical supportive care and personal care assistance needed by chronically impaired persons. Although Medicare’s home health benefit is part of the continuum of care provided to frail or disabled elderly
individuals, it does not provide long-term assistance for non-acute medical or personal care needs.

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). Under this system, the unit of payment is a 60-day episode of care ordered by a physician and provided by an HHA. Payment for an episode of care covers an HHA's costs for all home health services and all visits provided within the 60-day period. There is no limit to the number of 60-day episodes that may be prescribed by a physician as long as the individual continues to be homebound and continues to need intermittent skilled nursing and/or therapy services.

Since the enactment of BBA 97, Congress has been concerned about the effects of PPS on access to home health care under Medicare. In July 2001, the Office of Inspector General, Department of Health and Human Services, produced a report based on a 2001 national survey of hospital discharge planners. In response to a series of questions concerning access to home health care, 89 percent of discharge planners reported being able to place all of their Medicare beneficiaries who were discharged from the hospital and 7 percent reported being able to place all but 5 percent of Medicare patients. Of all discharge planners who responded to the survey (including rural and urban), 4 percent reported being unable to place more than 5 percent of Medicare patients who were discharged. In addition, OIG also found that the rate at which discharge planners could place Medicare beneficiaries in home health care were similar to those rates before the enactment of BBA 97. Finally, urban and rural hospitals were found to have similar rates of home health care placement.\(^{40}\)

In a second investigation on home health care since BBA 97, the OIG found that 93 percent of Medicare beneficiaries who began receiving home health care in January 2001 reported being satisfied with their care. Of all OIG's survey respondents, most reported a positive relationship with their home health caregivers and 4 percent reported concerns about the quality or adequacy of their home health care. These concerns generally pertain to problems with missed appointments or inconsistencies among home health workers. Among survey respondents, 20 percent believe they need more services than they are receiving, although many of these individuals are not eligible for the services they want, or they want services that are not covered by Medicare.\(^{41}\)

For a number of years the home health benefit was one of Medicare's fastest growing benefits. Home health spending rose from $2.1 billion in 1988 to $18.1 billion in 1996, an average annual increase of over 31 percent. This growth in spending was driven by the increase in the number of beneficiaries served and the average number of visits per beneficiary serviced. The number of beneficiaries nearly doubled during this time period. Due in part to the...
new interpretation that a beneficiary could receive daily visits for part of a day, the average number of visits per home care patient increased more than threefold, from 23 visits in each of 1987 and 1988 to 82 visits in 1997. The number of home health agencies participating in Medicare also increased sharply, growing from 5,686 agencies in 1989 to 10,492 in 1997.

The Balanced Budget Act (BBA) of 1997 made several changes to home health eligibility, coverage, and payment rules. In general, through these changes, Congress sought to curtail the steep annual rates of increase in the volume of Medicare home health services and payments. By 1998, Medicare payments for home health decreased by 33.4 percent, from $17 billion in 1997 to $12 billion in 1998. In 2000, Medicare paid $8.5 billion for home health care, about 53 percent less than in 1997.

(D) THE HOSPICE BENEFIT

Medicare also covers a range of home care services for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care emphasizes palliative medical care, that is, relief from pain, and supportive social and counseling services for terminally ill and their families. Services are provided primarily in the patient's home.

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.

Although a small portion of total Medicare outlays (an estimated 1.1 percent in 2001), the benefit has grown in recent years. The number of Medicare-certified hospices increased from 553 in 1988 to 2,293 in 1998. Medicare outlays for hospices has increased from $118.4 million in 1988 to an estimated $2.7 billion in 2001. Medicare beneficiaries receiving hospice services has increased from 40,356 in 1988 to 401,140 in 1998.

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 $15,916.98 for the period November 1, 2000, through October 31, 2001. This cap is calculated annually at the aggregate, rather than individual, level by each hospice provider. Enrollees are liable for limited copayments for outpatient drugs and respite care.
The Balanced Budget Act of 1997 (P.L. 105-33) made a permanent benefit category under Medicare and an option for States under Medicaid to create the Program for All-Inclusive Care for the Elderly (PACE) for low-income individuals who would otherwise require nursing home care. This program allows 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 necessary by the PACE provider.

As part of the program, each participants' plan of care is overseen by a case management team. These teams consist of physicians, nurses, social workers, dietitians, physical and occupational therapists, activity coordinators, and other health and transportation workers. PACE providers receive Medicare and Medicaid payments 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.

PACE programs are designed to keep people in their homes and out of institutions for as long as possible. According to the National PACE Association, as of July 2000, there were 19 states operating 36 PACE programs. As of December 2000, PACE programs reported a census of 7,956.

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.

Funds are allotted to states on the basis of relative state populations and do not require state matching funds. 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. On June 9, 1998, President Clinton signed the Transportation Equity Act (TEA) into law (P.L. 105-178), which permanently reduces the SSBG entitlement ceiling to $1.7 billion, beginning in FY2001 (however, the appropriation for FY2001 (H.R. 4577) exceeded $1.7 by $25 million.)

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 uni-
form format and do not indicate the states' actual use of funds. An analysis of the state expenditure reports for FY1999 by the DHHS showed that of the states' FY1999 funds of $1.89 billion, 11 percent was spent for home-based services for both adults and children, 7.7 percent for special services for the disabled, less than 1 percent was spent for adult day care services, and less than 1 percent was spent for home-delivered meals. Of the many services supported by the SSBG, the largest spending categories are for child day care (13 percent of FY1999 funds) and child foster care services (11 percent of FY1999 funds). Older persons with long-term care needs must compete with other eligible population groups for SSBG services.

C. SPECIAL ISSUES

1. NURSING HOME QUALITY

The Senate Aging Committee, the committee responsible for oversight of quality of care provided by nursing homes, held hearings in 1999 on nursing home enforcement and complaint investigations. During the hearings, Congressional Members discussed the issues raised by a series of Office of the Inspector General's (OIG) reports pertaining to quality of care issues in nursing homes published in 1999. The reports found that quality of care problems persist in nursing homes. Some of the problems found through OIG investigations included inadequate supervision to prevent accidents, improper care to prevent or treat pressure sores, and lack of proper assistance with activities of daily living.

Included in the findings in the 1999 OIG reports, was that deficiencies in nursing homes could largely be attributed to a lack of adequate staffing supervision to prevent accidents, properly care for pressure sores, and assist resident in conducting activities of daily living. Other personal care problems in numerous nursing homes were also revealed—such as lack of nutrition and poor care for incontinence. OIG also found that the Long-Term Care Ombudsman Program, funded through the Older Americans Act and state funds, was limited in its effectiveness and reach largely because of inadequate funding and staffing as well as a lack of common standards for complaint responses and resolution, inconsistent advocacy efforts, lack of support and limited collaboration with nursing home surveyors. Among other findings, OIG also found weaknesses in state efforts to protect nursing home residents from abuse.

In March 1999, the Clinton Administration took action to enforce current standards for the 1.5 million elderly and disabled Americans in nearly 17,000 nursing homes. Under the Administration, CMS strengthened complaint-investigation, launched a national education campaign on how to identify, report, and stop neglect in nursing homes and designed more than 30 initiatives to improve the quality of care in America's nursing homes. In June 2001, GAO

published a report that evaluated CMS’ progress on achieving the goals outlined by the initiatives. GAO reported that CMS had made progress on only 3 initiatives. On the first, CMS reported that the prevalence of restraints used in nursing homes decreased in FY2000. On the second, CMS reported that it had established performance targets for reducing the prevalence of pressure sores among nursing home residents. On the third, CMS has set out to improve the survey and certification budgeting process of nursing homes. By developing national standard measures and costs, CMS hopes to more effectively price each state’s survey workload to assess the quality of nursing home surveys performed by each state.

In another attempt to improve nursing home quality, some states provide, or plan to provide, technical assistance to nursing homes. Technical assistance involves providing nursing homes with information about existing and potential violations to state and Federal requirements as well as training in the remediation of such problems. Controversy has arisen over the role of the state agency in technical assistance. Whereas some groups hope technical assistance will either replace the survey and enforcement process or lessen its punitive measures, others hope it will serve only as a supplement to a process that is necessary in order to ensure quality patient care. As of July 2001, several states had created, or plan to create, technical assistance programs, including Washington, New Jersey, Wisconsin, Maryland, California, Florida and Texas.

In 1998, Congress enacted P.L. 105–277, giving nursing facilities and home health care agencies the option to request the U.S. Attorney General to conduct criminal background checks of applicants for employment in facilities or agencies using records from the Criminal Justice Information Services Division of the Federal Bureau of Investigation. Under the law, information regarding criminal history records of an applicant shall be provided to the appropriate state agency and used only for the purpose of determining the suitability of the applicant for employment by the facility or agency in a position involved in direct patient care. In recent years, most states have also created their own laws. Although most of these laws require or allow only home health agencies to investigate the backgrounds of potential employees for previous criminal activities, some also require or allow nursing homes to conduct investigations.

Even more recently, Congress has grown concerned that inadequate staffing and training of nursing personnel may impact patient health outcomes. The Department of Health and Human Services’ (DHHS) Inspector General confirmed that staffing deficiencies and inadequate staff expertise were major factors in many chronic and recurring quality problems in nursing facilities.

---


due to the aging of the baby-boomers are important issues to Congress. Legislative options to address staffing inadequacies include: changing payment rates under Medicaid and Medicare; funding new programs targeted toward specific goals; facilitating the use of foreign nurses; and enhancing the role of family caregivers through tax incentives.

2. 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 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 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 makes it difficult for individuals and families 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) and institutionalization, often undesirable and costly, can be avoided.

3. 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 basic part of their long-term care systems development. The availability of Medicaid funds under the home and community-based waiver (Section 1915(c)) programs has spurred the development of case management services, but other sources of funds also have been used by States to develop case management systems, including State-only funds, the SSBG, and the OAA programs.
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 December 20, 2001 coordination of long-term care services, particularly in community settings. In communities where an older person might save 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 individuals 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 considers health care reform.
CHAPTER 10
HEALTH BENEFITS FOR RETIREES OF PRIVATE SECTOR EMPLOYERS

A. BACKGROUND

Employer-based retiree health benefits were originally offered in the late 1940's and 1950's 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 1980's, however, retiree health benefits became more expensive for employers, due to rising health care costs and changing demographics of the workforce. The United States saw double-digit health care inflation, and employers experienced higher retiree-to-active worker ratios as employees retired earlier and had longer life expectancy. Older Americans approaching or at retirement age consume a higher level of medical services, and as a result, their health care is more expensive. Employers also became more conscious of retiree health plan costs since a financial accounting standard, known as FAS106, began requiring recognition of post retirement benefit liabilities on balance sheets. With the increase in liability for health care costs, employers began to reduce or eliminate health care coverage for retirees.

Employee benefit surveys have shown a significant decline in employer sponsorship of retiree health benefits since the early 1990's. The Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000 indicates that the percentage of large employers (500+ employees) that provide health coverage to retirees 65 or over has fallen from 40 percent in 1993 to 24 percent in 2000. For early retirees, not yet eligible for Medicare, coverage declined from 46 percent in 1993 to 31 percent in 2000. (These figures refer to continuing plans that will cover all future as well as current retirees.) The Employer Health Benefits 2001 Annual Survey, conducted by the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET), estimates that the percentage of all large firms (200+ workers) that offers retiree health coverage continued to fall from 37 percent in 2000 to 34 percent in 2001. The decline was even more dramatic for small firms (3–199 workers), from 9 percent in 2000 to 3 percent in 2001. According to the
Employee Benefits Research Institute (EBRI), while it appears that employers are dropping retiree health benefits, the decline can also be attributed to the number of new large employers that never offer retiree health benefits at all.

Employer-sponsored retiree health insurance benefits are also eroding as employers tighten eligibility requirements or shift costs to retirees. According to the Kaiser/HRET 2001 survey, over the last 2 years, 26 percent of companies have increased the retiree’s share of the premium, and 33 percent indicate they have increased the amount enrollees pay for prescription drugs. Employers are also considering providing a defined employer contribution toward the cost of retiree health insurance instead of paying the premiums for whatever plan coverage an employee has chosen.

Some of these curtailments have prompted class-action lawsuits from retirees who face higher costs and restrictions on providers or have to obtain and pay for individual insurance policies. By law, employers are under no obligation to provide retiree health benefits, except to those who can prove they were previously promised a specific benefit. Even if employees are promised coverage, the scope of benefits and employer premium contributions may not be specified and could erode over time. In order to avoid court challenges over benefit changes, almost all employers now explicitly reserve the right in plan documents to modify those benefits. Companies are more likely to change or terminate benefits for future rather than current retirees. This reduces their future liability without causing a large disruption in health coverage for those who are retired. The Kaiser/HRET survey found that only 4 percent of companies now offering retiree coverage are likely to eliminate that coverage entirely in the next 2 years, but 7 percent will eliminate retiree benefits for new employees or existing workers.

1. Who Receives Retiree Health Benefits?

Though there has been a decline in employer sponsorship of retiree health benefits since the early 1990’s, the percentage of retirees obtaining health benefits through a former employer has remained relatively stable since 1994. According to Employer Benefits Research Institute (EBRI) estimates of the March 2000 Current Population Survey, about 36 percent of early retirees (ages 55 to 64) have health benefits from prior employment; 20 percent have employment coverage through another family member. Almost 37 percent have another form of insurance such as private policies, veteran’s health care, or Medicaid; and 17 percent are uninsured. For those age 65 and over in 1999, 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.) The General Accounting Office (GAO) and EBRI attribute this stability in the percentage of retirees with health benefits through a former employer to the tendency of firms to reduce coverage for future rather than current retirees.

While near-elderly workers are not necessarily more likely to be uninsured, if they should become unemployed because of illness, disability, early retirement, or loss of a job, they are less able than younger workers to obtain affordable health insurance because of
a greater prevalence of health problems. According to a Monheit and Vistnes report in Health Affairs March/April 2001, even when older workers with health problems are insured and have access to needed health services, they have average annual expenditures of $5,000, nearly twice the level of their counterparts in excellent or very good health ($2,548).

Employment-based insurance spreads these costs over all workers in the same plan, but private non-group insurance premiums generally reflect the higher risk attributable to the policyholder's age and health status. A 2001 Commonwealth Fund study found that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers. An analysis of premium costs in 15 cities showed a median cost of nearly $6,000 for a 60-year-old (Health Affairs July/August 2001). The cost of purchasing an individual health care policy following retirement is often prohibitive for many retirees who are not yet eligible for Medicare, and uninsured 55-to-64 year olds are subject to deteriorating health as a result of not having insurance coverage.

For those 65 or older living on a fixed income, employer-based benefits are an important source for filling coverage gaps in Medicare, such as deductibles and copayments or prescription drug benefits. Another recent Commonwealth Fund study estimates that the elderly spent 22 percent of their income, on average, for health care services and premiums in 2000. Seniors in poor health and without supplemental insurance, however, spent about 44 percent of their income on health care.

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.)

The method of integrating with Medicare can have significant effects on the amount the employer plan pays to supplement Medicare, as well as on retiree out-of-pocket costs. When the Medicare program was first implemented, the most popular method of integrating benefit payments with fee-for-service 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.

According to 2000 Hewitt Associates data, 57 percent of large employers now use the “carve out” 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.” This shift to carve out decreases plan costs and increases retiree out-of-pocket-expenses. Retirees who were used to having 100 percent of their health care costs covered by the combination of retiree plan and Medicare now have out-of-pocket costs that are comparable to having the employer plan without Medicare.

Employers have also turned to the Medicare managed care program to control rising retiree health care costs. Mercer/Foster Higgins survey data indicate that among large employers that provide retiree health coverage, the number that offer a Medicare HMO increased from 7 percent in 1993 to 43 percent in 2000. Of Medicare-eligible retirees, 11 percent are enrolled in one of these plans and are typically provided with additional services such as routine physicals, immunizations, and prescription drug coverage not available through traditional Medicare. Cost sharing is also generally lower. This is not an option, however, for retirees who travel extensively or live for more than 90 days in an area not covered by the HMO. Recent plan withdrawals from Medicare+Choice and premium increases are also causing some beneficiaries to return to the traditional Medicare program.

3. RECOGNITION OF EMPLOYER LIABILITY

Companies that provide health benefits to their retirees face substantial claims on their future resources. The Financial Accounting Standards Board (FASB), the independent, nongovernmental authority that establishes private sector accounting standards in the United States, became concerned in the 1980’s that employers were not adequately accounting for their post retirement health care liabilities. Companies’ financial statements reflected only actual cash payments made to fund current retirees’ benefits. The FASB was particularly worried about investor ability to gauge the effect of anticipated retiree medical benefits on the financial viability of a company and to compare financial statements of different companies.

After 8 years of debate, the FASB released final rules in December 1990 requiring corporations to recognize accrued expenses for retiree health benefits in their financial statements. Companies must now include estimates of future liabilities for retiree health benefits on their balance sheets and must also charge the estimated dollar value of future benefits earned by workers that year against their operating income as shown on their income statements. 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. FAS 106 requirements became applicable to smaller firms after December 15, 1994. A similar requirement known as GASB–26 became effective for state and local governments in June 1996.

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. Some companies cited FAS 106 as a reason for modifying retiree health benefits, including the phasing out of coverage. Others have considered prefunding retiree health benefits.
4. PREFUNDING

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 may have better uses for the funds, and some cannot afford to put money aside.

In contrast to 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 prefunding retiree health benefits: 401(h) trusts and voluntary employees benefit association plans (VEBAs) allow employers to make tax deductible contributions to an account for health insurance benefits for retirees, their spouses, and dependents and tax-deferred contributions to an account for 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) added Section 420 of the Internal Revenue Code, which permits single employers to transfer excess pension assets into a separate 401(h) account to pay for retiree health care expenses and avoid a tax on reversion of qualified plan assets to employers. Statutory restrictions and recordkeeping requirements, however, 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, and employers are limited to contributing to the trust no more than 25 percent of annual total contributions to retiree benefits. In addition, the pension plan has to remain at least 125 percent funded; plan participants' accrued benefits must be immediately and fully vested; and employers have to commit that they will not reduce their expenditures for retiree health care coverage for 5 years after the transfer. Section 420 was extended by P.L. 103-465 through December 31, 2000, and again through 2005 by the Tax Relief Extension Act of 1999 (P.L. 106-170). Final regulations issued on June 19, 2001, amended a "Maintenance of Cost" provision to prevent employers from reducing the number of retirees eligible for coverage and provide guidance on meeting this requirement if subsidiaries or divisions are sold.

VEBAs are tax-exempt plans or trusts established under 501(c)(9) of the Internal Revenue Service Code. A VEBA provides health and other benefits to members who share an "employment-related bond" and must be controlled by its membership or independent trustee. 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 potentially providing 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.

Prefunding of retiree health benefits will not become an attractive option for employers unless tax incentives are provided, similar to those available for pensions. The Department of Labor's Advisory Council on Employee Welfare and Pension Benefits recommended in November 1999 that Section 420 be expanded to allow prefunding of current retirees' entire future medical obligations.

According to EBRI, some employers are interested in prefunding retiree health benefits through a defined contribution model. Active employees would accumulate funds in an account to prefund retiree health benefits during their working life. After workers retire, the funds in the account could be used to purchase health insurance from their former employer or union or directly from an insurer. Employers could contribute a specified dollar amount to the account, rather than offering coverage for a specific package of benefits.

B. BENEFIT PROTECTION UNDER EXISTING FEDERAL LAWS

1. EMPLOYEE RETIREMENT INCOME SECURITY ACT (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. 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 benefit plans (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 less protected 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, where an employer has clearly stated 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, the courts have sustained the right of the employer to cut back or cancel all benefits.

2. CONSOLIDATED BUDGET RECONCILIATION ACT OF 1985 (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 (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 hours worked, or retires, the continued coverage of the employee and any qualified beneficiaries must be available 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 63 and continue with employer based group coverage until they become Medicare-eligible at age 65.

COBRA offers no help, however, if the employer discontinues the health plan for all employees, or if an employer terminates or reduces benefits provided under its retiree health insurance plan. The only event that triggers coverage for an individual receiving health benefits under a retiree health plan is the loss of health insurance coverage due to the former employer's bankruptcy. 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. 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 percent to 80 percent of the premium before retirement.
Finally, 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 according to a Commonwealth Fund report, even premiums for high-risk pool participants range from 125 percent to as high as 200 percent of the average standard rates for individual policies outside the risk pool.

C. OUTLOOK

Many employers question whether they can continue providing the current level of retiree health benefits in the face of increasing health care costs and the fast approaching retirement of the baby-boom generation. The 2000 Mercer/Foster Higgins Survey found that, over the past 2 years, employer costs for providing health benefits for pre-Medicare eligible retirees rose 10.6 percent. For Medicare-eligible retirees, this figure increased 17 percent. 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.

The impact of potential Medicare reform and other Federal legislation 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 for potential solutions. The Commission failed to reach agreement on reform, but several of the proposals it considered have served as the basis for subsequent discussion of the issues.

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. There are concerns, however, that any expansion in Federal coverage might merely result in a dollar-for-dollar offset in coverage provided by employers. Under this scenario, Federal dollars might increase, but overall benefits for beneficiaries would remain relatively unchanged. Several prescription drug proposals have attempted to address this concern by providing employers with financial incentives to maintain their prescription drug programs and have their retirees continue to receive services through these plans rather than a new Federal program. Proposals to raise the Medicare eligibility age from 65 to 67 might also exacerbate the number of employers who restrict or drop coverage because of increasing costs. While many employers now pay for health benefits until re-
tirees qualify for Medicare, these early retirees are twice as expensive for employers to cover as older retirees who receive Medicare.

Legislation has also been considered 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. The cost of buying into Medicare or continuing COBRA coverage, however, 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 107th Congress, the Emergency Retiree Health Benefits Protection Act of 2001 (H.R. 1322) would more directly address loss of retiree coverage by prohibiting employers from making any changes to retiree health benefits once an employee retires. The bill would require plan sponsors to restore benefits for retirees whose health coverage was reduced before enactment of the bill, but does not restrict employers from changing retiree health benefits for current employees. This could result in employers dropping retiree health insurance for newly hired employees and providing protections for retirees that do not exist for current workers.

Recent court cases and regulatory guidelines on the application of the Age Discrimination in Employment Act (ADEA) to employer-sponsored retiree health benefit plans could also adversely affect retiree health care coverage. In August 2000, the Third Circuit Court of Appeals held that Medicare-eligible retirees have a valid claim of age discrimination under ADEA when their employers provide them with health insurance coverage inferior to that provided to retirees not yet eligible for Medicare (Erie County, Pa. v. Erie County Retirees Assoc.) The Equal Employment Opportunity Commission (EEOC) followed with guidance that the ADEA is violated if retiree health plans are reduced or eliminated on the basis of age or Medicare-eligibility. In August 2001, however, the EEOC responded to concerns from employers, employee, and labor groups and announced that it was rescinding its policy, suspending enforcement activities, and re-examining its policy. The EEOC will “focus on the development of a new policy, consistent with the ADEA, that does not discourage employers from providing this valuable benefit.”

The actual impact of the Erie County court case and the EEOC decision is uncertain. While the legal ruling applies only to employers in the Third Circuit (Pennsylvania, New Jersey, Delaware, and the Virgin Islands), employers in other jurisdictions may be wary of offering a benefit to older workers that could potentially expose them to liability. At this time, it is also not clear how employers can design retiree health care plans without violating the ADEA. Companies that want to encourage workers to retire early typically bridge the gap between early retirement and Medicare by providing coverage and then reducing or dropping it when the retiree reaches 65. To comply, employers may either have to improve benefits for
Medicare-eligible retirees or add a new health care plan for older retirees which would likely be expensive. Most analysts believe that it is more likely that employers would cut back on benefits for early retirees until the program meets the “equal cost” or “equal benefit” safe harbor provisions of ADEA. It could also include paying retirees the same defined contribution to purchase retiree health coverage whether or not they are Medicare-eligible, or eliminating retiree health benefits entirely.

While the percentage of retirees who obtain health benefits through a former employer is stable at this time, the rate of uninsurance among the near elderly may become more evident as the population ages. Many individuals may never qualify for retiree health benefits if their employers offer coverage only to workers hired before a specific date. Any proposed Federal legislation will likely be considered in light of the possible impact on the voluntary system of employer-provided benefits and the relationship between current employee and retiree benefits. The strength of the economy and employment levels will also play an important part in employer decisions about the value of offering retiree health benefits in recruiting and retaining employees.
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 continue the expansion of 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. 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. They are projected to number 20 million by 2050.

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. Continuing the second and third years of a 5-year effort to double the NIH budget, Congress gave NIH a fiscal year 2000 appropriation of $17.8 billion, a 14.2 percent increase over the fiscal year 1999 funding. In December 2000, Congress voted a 14.3 percent increase for fiscal year 2001, giving NIH $20.4 billion to spend this fiscal year.

The National Institute on Aging (NIA) is the largest single recipient of funds for aging research. Fiscal year 2001 NIA appropriations have increased 14.2 percent over fiscal year 2000 funding levels, from $688.0 million in fiscal year 2000 to $785.6 million in fiscal year 2001. 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.

(207)
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 multi-year, 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 19 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
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. 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. Started in 1958, the study includes more than 1,000 men and women, ranging in age from their twenties to nineties, who participate every 2 years in more than 100 physiological and psychological assessments, which are used to provide a scientific description of aging. The study seeks to measure biological and behavioral changes as people age, and to distinguish normal aging processes from those associated with disease or environmental effects. The study has established that aging does not necessarily result in a general decline of all physical and psychological functions, but that many of the so-called age changes might be prevented.

NIA has collaborated with the National Advisory Council on Aging and other groups to develop a 5-year strategic plan for aging research, identifying scientific areas of most promise. Another NIA strategic plan, on reducing health disparities among older Americans of different racial and ethnic backgrounds, will also influence all areas of research.
The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection, and treatment of cancer. In 1999, 71 percent of all persons in the U.S. who died of cancer were 65 years of age or over.

The incidence of cancer increases with age. Aging may not be a cause of cancer, but it is an important risk factor for many types of cancer. 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 34 percent of deaths in 1999. 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.

NCI has recently reported progress in treating the most common form of adult leukemia, use of hormonal therapy for prostate cancer, discovery of genetic markers for lung cancer, and development of a new diagnostic imaging system. In addition to basic and clinical, diagnostic, and treatment research, NCI supports prevention and control programs, such as programs to stop smoking.

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 1999, approximately 1.2 million deaths were reported from all of the diseases under the purview of the Institute (half of all U.S. deaths that year). The projected economic cost in 2002 for these diseases is expected to be $456 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.

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 af-
fecting 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 7,800 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 17 million Americans, or 6.2 percent of the population. Among Americans age 65 and older, 7 million or 20 percent of people in this age group 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. The Institute also has a long-range plan for research on the treatment and prevention of kidney disease and kidney failure, which affect a growing number of elderly persons, especially diabetics.

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, Parkinson's disease, and amyotrophic lateral sclerosis, as well as conditions such as chronic pain, epilepsy, and trauma that affect the elderly. 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 pre-
disposition; altered motor circuitry and neurochemistry, and new therapeutic interventions such as surgical procedures to reduce tremor. A 5-year NIH Parkinson’s Disease Research Agenda was released in March 2000.

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, on a shingles vaccine, 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. In October 1999, NEI launched its Low Vision Education Program, aimed at helping people with visual impairment, primarily the elderly, to make the most of their remaining sight.

(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 34 specialized and comprehensive research centers.

Approximately 43 million Americans are affected by the more than 100 types of arthritis and related disorders. Older adults are particularly affected. Half of all persons over age 65 suffer from some form of chronic arthritis. An estimated 10 million Americans, most of them elderly, have osteoporosis, with another 34 million at increased risk for the disease. It is estimated that by the year 2020, nearly 60 million Americans will be affected by arthritis and other rheumatic conditions.

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 age-related 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.
NIDCD has recently collaborated with the Department of Veterans Affairs to test new types of hearing aids, and with NIDCR to research the genes that control taste.

(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.

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

The National Institute of Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. 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: preserving cognition and ability to function; 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, and that lower doses of estrogen may be just as effective as higher doses in preventing post-menopausal osteoporosis. 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.

(R) NATIONAL CENTER FOR COMPLEMENTARY AND ALTERNATIVE MEDICINE

Newly operational in 1999, the National Center for Complementary and Alternative Medicine (NCCAM) is the focus at NIH for the scientific exploration of complementary and alternative medicine (CAM) and healing practices. Since many CAM therapies are associated with chronic conditions, NCCAM research addresses conditions particularly impacting the elderly population, including dementia, arthritis, cancer, cardiovascular disease, and pain. Current studies exploring CAM use by the elderly find that, like the population at large, about 40 percent of seniors report using CAM, but that most do not disclose their use of CAM therapies to their physicians. NCCAM tries to increase awareness of CAM among conventional physicians.

(S) NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES

Legislation at the end of 2000 provided for the establishment of the new National Center on Minority Health and Health Disparities (NCMHD). Effective in January 2001, the programs of the Office of Research on Minority Health were transferred from the Of-
Office of the NIH Director to the new Center. NCMHD is responsible for coordinating all NIH research that seeks to reduce the disproportionately high incidence and prevalence of disease, burden of illness, and mortality among some groups of Americans, including racial and ethnic minorities, and urban and rural poor. Health status and health disparities among senior citizens of various socioeconomic levels will be of interest to the Center.

C. ISSUES AND CONGRESSIONAL RESPONSE

1. NIH APPROPRIATIONS

Congress has passed a fiscal year 2001 appropriation for NIH of $20.4 billion. The agency has enjoyed strong bipartisan support for many years, reflecting the interest of the American public in promoting medical research. Even in the face of pressure to reduce the deficit, Congress approximately doubled NIH's appropriation in the decade between FY1988 and FY1998. Starting with the FY1999 appropriation, Congress has for 3 years increased NIH's budget at an even faster rate, approaching a pace to double in 5 years. From the FY1998 level of $13.6 billion, the appropriation increased by $2.0 billion or 14.6 percent to $15.6 billion in FY1999. For FY2000, the increase was $2.2 billion or 14.2 percent to a total of $17.8 billion, and for FY2001, the appropriation was $20.4 billion, an increase of $2.6 billion or 14.3 percent.

In their reports accompanying the FY2001 appropriation, the appropriations committees discussed their high regard for NIH and its accomplishments, and their intent to distribute the appropriations largely according to NIH's recommendations. To this end, specific amounts were not provided for particular diseases or funding mechanisms, although report language relating to some areas of research in some institutes is quite detailed.

NIH's own budget documents had highlighted a number of activities slated to receive additional resources. They represent opportunities across all institutes and centers for new scientific knowledge and applications to strategies for diagnosing, treating, and preventing disease. These areas of research potential include: (1) genetic medicine/exploiting genomic discoveries (DNA sequencing, identification of disease genes, development of animal models); (2) reinvigorating clinical research (strengthening clinical research centers, clinical trials, and clinical training); (3) infrastructure and enabling technologies, including interdisciplinary research (advanced instrumentation, biocomputing and bioinformatics, engaging other scientific disciplines in medical research on drug design, imaging studies, and biomaterials); and (4) eliminating health disparities in minorities and other medically underserved populations.

Programs receiving particular emphasis by Congress in the FY2001 appropriation include grants to institutions in states with historically low levels of NIH support, research on complementary and alternative medicine, and research on Parkinson's disease and autism.

Out of its total appropriation of $20.36 billion for fiscal year 2001, NIH estimates that it will spend $1.66 billion on research related to aging. Appropriations levels for the NIH institutes, including estimates for aging research, are as follows:
2. NIH Authorizations and Related Issues

Congress has provided the first three “installments” for the 5-year doubling of the NIH budget, putting it on a path to a fiscal year 2003 target of approximately $27.2 billion. The new resources have been accompanied by much debate over the degree to which Congress should direct scientific exploration and influence the setting of research priorities. In the last two decades, often after lobbying by disease advocacy groups, Congress has created seven new institutes and centers at NIH and has added numerous mandates for support of specific types of research, including use of particular funding mechanisms, such as centers of excellence.

At the end of the 106th Congress, several acts were passed which collectively provided NIH with many new authorities. The laws addressed children’s health and pediatric research (P.L. 106–310); clinical research enhancement and research laboratory infrastructure (P.L. 106–505); minority health and health disparities research, with creation of the new Center (P.L. 106–525); and creation of a new National Institute of Biomedical Imaging and Bioengineering (P.L. 106–580). In addition, report language accompanying the appropriations bills shapes NIH’s research priorities, although almost always without specific dollar earmarks.

Sponsors and advocates for such legislation see it as a legitimate way to ensure that NIH is responding to the public’s health needs; critics warn that attempts to micromanage NIH’s research portfolio may divert funding from the most promising scientific opportuni-
ties. The Senate appropriations report accompanying the FY2001 Labor-HHS bill questioned the proliferation of new entities at NIH and expressed concern about the current NIH structure and organization. Funds were provided for a study of the NIH structure, due 1 year after confirmation of a new NIH Director (the post has been vacant since January 2000).

Potential topics for debate in the next Congress include whether to place restrictions on some types of research that hold promise for combating disease, but which raise contentious ethical issues. These 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 a progressive and, at present, irreversible brain disorder that occurs gradually and results in memory loss, behavior and personality changes, and a decline in cognitive abilities. AD patients eventually become dependent on others for every aspect of their care. On average, patients with AD live for 8–10 years after they are diagnosed, though the disease can last for up to 20 years. Scientists do not yet fully understand what causes AD, but it is clear that the disease develops as a result of a complex cascade of events, influenced by genetic and environmental factors, taking place over time in the brain. These events lead to the breakdown of the connections between nerve cells in a process that eventually interferes with normal brain function.

AD is the most common form of dementia among people age 65 and older. It represents a major public health problem in the United States because of its enormous impact on individuals, families, and the health care system. An estimated four million Americans now suffer from AD. Epidemiologic studies indicate that the prevalence of AD approximately doubles every 5 years beyond the age of 65. 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. More than two-thirds of AD patients live at home, where families provide most of their care. According to the 1996 National Caregiver Survey, dementia caregivers spend significantly more time on caregiving tasks than do people caring for those with other types of illnesses and experience greater employment complications, mental and physical health problems, and caregiver strain than do those engaged in other types of caregiving activities. The annual cost of caring for an AD patient at home is estimated at $12,500. Nursing home care for dementia patients, by comparison, costs an average of $42,000, according to the Alzheimer's Association. Overall, AD costs the Nation an estimated $100 billion a year in medical expenses, round-the-clock care, and lost productivity.
Major developments in genetic, molecular, and epidemiologic research over the past decade, almost all of it funded by NIH, have rapidly expanded our understanding of AD. In FY2001, NIH will spend an estimated $521 million on AD research. The National Institute on Aging (NIA) accounts for about three-quarters of NIH's Alzheimer's research funding and coordinates AD-related activities throughout NIH. 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). With Congress on track to double NIH's budget over a 5-year period beginning in FY1998, AD research funding is expected to total about $650 million by FY2003.

AD is characterized by two abnormal structures in the brain: amyloid plaques and neurofibrillary tangles. The plaques consist of deposits of beta-amyloid—a protein fragment snipped from a larger cell-surface protein called amyloid precursor protein (APP)—intermingled with the remnants of glial cells, which support and nourish nerve cells. Plaques are found in the spaces between the brain's nerve cells. Although researchers do not yet know whether the plaques themselves cause AD or are a by-product of the disease, there is increasing evidence that beta-amyloid deposition may be a central process in the development of AD. Neurofibrillary tangles, the second hallmark of AD, consist of abnormal collections of twisted threads found inside nerve cells. The principal component of these tangles is a protein called tau, which is an important component of the nerve cell's internal support structure. In AD tau is changed chemically and this alteration causes it to tangle, which leads to a breakdown in communication between nerve cells.

Researchers have identified four genes linked to AD. One of the genes is associated with the typical late-onset form of the disease that strikes the elderly. The other three genes are linked to the rare (about 5–10 percent of cases) early onset disease that generally affects people aged 30 to 60. Identification of these genes has led to other insights into biochemical pathways that appear to be important in the early preclinical stages of AD development. For example, one of the early onset AD genes codes for the APP protein. A number of transgenic mouse models of AD have been developed by inserting mutated human APP genes into mice. These mice express features of the human disease, including formation of beta-amyloid plaques.

In an important recent development, researchers isolated three enzymes—alpha, beta, and gamma secretase—that are involved in clipping beta-amyloid out of APP. Studies strongly suggest that gamma secretase is the product of one of the other early onset AD genes. The discovery of these enzymes, together with the availability of animal models of AD, will be critical to the development and testing of effective and safe amyloid-preventing drugs. Research on tau, the protein that forms neurofibrillary tangles, is also yielding important clues about the pathology of AD and creating new opportunities for developing drug treatments. Mutations in the tau gene have been shown to cause other (non-AD) forms of late-onset dementia. In the past year, a transgenic mouse strain has been devel-
oped that expresses one of the human tau mutations and develops AD-like tangles.

In 1999, at the instruction of Congress, the NIH established the AD Prevention Initiative to accelerate basic research and the movement of research findings into clinical practice. The core goals of the initiative are to invigorate discovery and testing of new treatments, identify risk and protective factors, enhance methods of early detection and diagnosis, and advance basic science to understand AD. The initiative also seeks to improve patient care strategies and to alleviate caregiver burden.

The ability to determine the effectiveness of early treatments or interventions, such as those being tested in the AD Prevention Initiative, depends crucially on being able to identify patients in the initial stages of AD. Recent advances in imaging and patient assessment have focused on identifying patients with mild cognitive impairment (MCI), a condition characterized by significant memory deficit without dementia. In one study, 80 percent of persons diagnosed with MCI developed AD within 8 years. The NIA is supporting several large-scale clinical trials to evaluate the effectiveness of various agents in slowing or stopping the conversion from MCI to AD. Many of the agents being tested in these trials have been suggested as possible interventions based on basic research findings and long-term epidemiological studies. Agents currently under study include aspirin, antioxidants such as vitamin E, estrogen, anti-inflammatory drugs, and ginkgo biloba.

While there is no effective way to treat or prevent Alzheimer's disease, the FDA has approved three drugs for the treatment of AD: tacrine (Cognex); donepezil (Aricept); and rivastigmine (Exelon). These drugs help boost level of acetylcholine—the chemical messenger involved in memory—which falls sharply as AD progresses. The three drugs have been shown to produce modest improvements in cognitive ability in some patients with mild to moderate symptoms, though they do not alter the underlying course of the disease. Several new drugs are currently under development, targeting specific pathways in plaque and tangle formation, and dysfunction and death of brain cells.

To help facilitate AD research and clinical trials, the NIA funds 28 AD Centers (ADCs) at major medical research institutions across the country. The centers provide clinical services to Alzheimer's patients, conduct basic and clinical research, disseminate professional and public information, and sponsor educational activities. Many of the ADCs have satellite clinics that target minority, rural, and other under-served groups in order to increase the number and diversity of patients who participate in research protocols and clinical drug trials associated with the parent center. The NIA has also established the AD Cooperative Study, an organizational structure that enables ADCs across the country to cooperate in developing and running clinical trials. Finally, the National Alzheimer's Coordinating Center, created by the NIA in 1999, provides for the analysis of combined data collected from all the ADCs as well as other sources.

Recent epidemiological studies have focused attention on cardiovascular risk factors such as high blood pressure in middle age and elevated cholesterol as possible risk factors for AD. Further animal
and humans studies and clinical trials will be required to determine if AD and cardiovascular disease share common risk factors. Socioeconomic and environmental variables in early life may affect brain growth and development, perhaps influencing the development of AD in later life. Exposure to environmental toxins or head traumas may also increase susceptibility to cognitive decline and neurodegenerative disease later in life.

While research on the prevention and treatment of AD is progressing rapidly, there is also a critical need to develop more effective behavioral and therapeutic strategies to help maintain function, prevent illness, and limit disability among AD patients, and to alleviate caregiver burden. Two clinical trials are testing whether drugs can reduce agitation and sleep disturbance, two of the major behavioral problems in AD patients that increase caregiver burden. As part of the AD Prevention Initiative, the NIA, in collaboration with the NINR, is supporting the Resources for Enhancing Alzheimer's Caregiver Health (REACH) program. This large, multi-site intervention trial is testing the effectiveness of different culturally sensitive home and community-based interventions for families providing care to AD patients. The interventions include psychological education support groups, behavioral skills training, environmental modifications, and computer-based information and communications systems. About 1,000 families are enrolled in the REACH program, including large numbers of African-Americans and Hispanics.

In addition to the AD research programs supported by NIH, two other Federal agencies support AD programs. First, the Alzheimer's Disease Demonstration Grants to States program, which is administered by the Administration on Aging, provides funds to 15 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. Second, the Safe Return Program, funded by the Justice Department, works with local law enforcement agencies throughout the country to assist in locating AD patients who wander and become lost.

The Alzheimer's Association [http://www.alz.org] funds research and provides information and assistance to AD patients and their families through its nationwide network of approximately 200 local chapters. The Association has organized its advocacy efforts around four issues: increasing Federal AD research funding; developing a national caregiver support program that builds on existing state and community respite, adult day care, and caregiver support programs; reforming Medicare to cover prescription drugs and pay for the chronic health care needs of AD patients; and financing long term care.

The Alzheimer's Disease Education and Referral (ADEAR) Center, a service of the 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. ADEAR, which may be accessed online at [http://www.alzheimers.org], produces and distributes a variety of educational
materials such as brochures, fact sheets, and technical publications.

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. Additional research on 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 Institute of Diabetes and Digestive and Kidney Diseases, 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 44 million Americans, 10 million of whom already have osteoporosis. The other 34 million have low bone mass and are at increased risk for the disease. Osteoporotic and associated fractures are estimated to cost the Nation $17 billion in 2001. 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. NIAMS has recently funded additional specialized centers for research in osteoporosis. The Institute was also one of several sponsors of a consensus development conference on osteoporosis to develop recommendations for future diagnosis, prevention, and treatment approaches. 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 43 million Americans, one in every six persons, has some form of rheumatic disease, making it one of the most prevalent diseases in the United States and the leading cause of disability among adults age 65 and older. 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. Besides the physical toll, arthritis costs the country nearly $65 billion annually in medical costs and lost productivity. Al-
though 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. NIAMS is collaborating with NCCAM to study the efficacy of the dietary supplements glucosamine and chondroitin sulfate for the treatment of OA of the knee.

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. A new research registry on RA in the African-American population has recently been funded.

5. GERIATRIC TRAINING AND EDUCATION

The Health Professions Education Partnerships Act of 1998 amended the Public Health Service Act (PHSA) to consolidate and reauthorize 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 Behavioral and Mental Health Professionals; and (3) Geriatric Faculty Fellowships under the Geriatric Academic Career Awards (GACA) Program. The programs are administered by the Bureau of Health Professions at the Health Resources and Services Administration (HRSA) of DHHS.

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.

Under 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 GACA program provides geriatric faculty 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 FY2002 that the goal of the three geriatric programs was to increase access to health care for America's elderly by competently training health professionals in geriatrics who may come from a variety of disciplines. To date the GECs have trained over 385,000 practitioners in 27 health-related disciplines and developed over 1,000 curricular materials on topics such as adverse drug reactions, Alzheimer's disease, depression, elder abuse, ethnogeriatrics, and teleconferencing.

Concerned alliances for the elderly have estimated the number of geriatricians needed by the year 2030 to be 36,000. There are 9,000 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.

Approximately 230 fellows have completed the Geriatric Faculty Fellowship Program, of which 90 percent hold faculty positions and 84 percent work with underserved populations.

Appropriations for FY2001 totaled $12.4 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. Research has shown that caregiver stress can be decreased by providing skills training in assessing and monitoring patients' problems, managing symptoms, and taking care of the caregiver's own health.

The employed caregiver is becoming an increasingly common long-term care issue. This issue came to the forefront several years ago 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 on ways 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 flextime, 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. Much credit for this success belongs 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 surpass the $500 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. 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 107th Congress. In addition, Congress is searching for ways to provide affordable housing with supportive services for low-income elderly tenants, so that they may continue to live independently as long as possible. In the near future, 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 2000 the nearly 2.6 million units up for renewal will require budget authority of $13.6 billion, according to HUD. This will increase to 2.7 million units and $15.7 billion in fiscal year 2002.

Housing reform bills.—In the 105th Congress, a new reform bill was introduced. This bill, H.R. 2, The Housing Opportunity and Responsibility Act of 1997, addressed public housing and project-based Section 8 admission preferences who should get priority. 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 promoted increased residential choice and mobility by increasing opportunities for residents to use tenant-based assistance (vouchers), and it instituted reforms such as ceiling rents, earned income adjustments, and minimum rents which encourage and reward work. Conferences 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 authorization bill was greater flexibility for local housing authorities, more demolitions of obsolete public housing units, and a merger of the Section 8 voucher and certificate programs.

(227)
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 called “mark-to-market” to test for a satisfactory resolution to this problem. Under the restructuring program, rents would be reduced in return for the government forgiving some of the mortgage debt. HUD has created a new office within its agency to oversee this restructuring, the Office of Multifamily Housing Assistance Restructuring (OMHAR). This office had some difficulty at the beginning of its organization and the restructuring program did not progress as quickly as HUD had anticipated. The program is scheduled to sunset on September 30, 2001, but it is expected to be reauthorized.

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. One 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 into the economic mainstream.

A continuing flow of new immigrants, both legal and illegal, also guarantees that there will be an increasing number of households in need of housing assistance. Focus on this increased need has led some legislators to reexamine the new construction programs for assisted housing programs of the 1970’s. While it has been the consensus of many Congressmen for several years that low income households could find housing if they were given financial assistance, many now agree that financial assistance is not enough. They recognize a need for the construction of multifamily housing developments as well, and several bills have been introduced in the 107th Congress which encourage the production of assisted rental housing.

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.

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 2000 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 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 cov-
230

ered 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.

In the first session of the 106th Congress, several bills were introduced to provide affordable housing for senior citizens which would permit them to age in place. One of these bills, H.R. 202, was included in Title V of the VA-HUD Appropriations Act for FY2000 (P.L. 106–74). Title V authorized the use of Section 202 funds to repair and convert housing projects for the elderly into assisted living facilities. HUD was directed to award grants only to sponsors who had a firm commitment for the funding of services from sources other than the Federal Government. Also, in awarding grants, HUD is to consider the extent to which a conversion is needed or expected to be needed, based on the age and income of the tenants in the project, community support, commitment by the sponsor to promote independence of the tenants to be assisted, and the ability to provide services, 24-hour staffing, and health care.

During the second session of the 106th Congress, interest was once again shown in making housing affordable, including homeownership for low-income families. Several bills were introduced and one of them, (H.R. 5640 became Public Law 106–569, “The Affordable Housing for Seniors and Families Act”. This Act authorized HUD to approve the prepayment of Section 202 properties if the owner of the property agrees to operate the project until the maturity date of the original loan, in a manner at least as advantageous to existing and future tenants as the terms of the original agreement. This prepayment could include refinancing which would result in a reduction in debt service. If this occurs, the result could be a savings in rental assistance payments made by HUD. The law says that if an owner refinances his loan and a savings to HUD does occur, HUD is to make at least 50 percent of the savings available to the property owner to use in some way which would be beneficial to the tenants of the project where the savings are realized. This can include rehabilitation or modernization activities, as well as the construction of an addition to a project such as assisted living facilities. In addition the law permits owners to keep any residual receipts in excess of $500 per unit to help cover the cost of supportive services for the residents.

P.L.106–569 also permits the location and operation of commercial facilities in Section 202 projects, as long as the business is not being subsidized by Section 202 funds. Businesses located on Section 202 properties should be beneficial to tenants of the project and the surrounding communities. Examples of encouraged businesses include grocery stores and pharmacies.

At the end of fiscal year 2000, there were approximately 267,000 Sec.202 units eligible for payment. The appropriations for fiscal
year 2001 provide $779 million which, according to HUD, should finance 7,200 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). Title V of the VA-HUD Appropriations Act for FY2000 (P.L.106–74) authorized the renewal of all grants made in prior years for service coordinators and congregate services in Public Housing for FY2000. Both the FY2000 and the FY2001 HUD appropriations bills earmarked $50 million of Section 202 appro-
priated funds for service coordinators and the provision of congregate services in assisted housing.

Title VIII of the Affordable Housing For Seniors and Families Act (P.L.106-659) authorized appropriations for grants for service coordinators who link residents of projects with medical and supportive services in the community. Eligible residents of this service would be elderly tenants of public housing, Section 202, Section 8, Section 236, Section 514, and Section 515 projects. The law also extends the services of the coordinator into the surrounding vicinity of the eligible federally assisted project. This provision is seen as an effort to make the project a focal point of the community.

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 240 projects that receive Federal assistance under the Congregate Housing Services Program.

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 33 percent of public housing units are occupied by elderly persons.

The Public Housing Program is the oldest Federal program providing housing for the elderly. It is a federally financed program operated by State-chartered local public housing authorities (PHA's). Each PHA usually owns its own projects. By law, a PHA can acquire or lease any property appropriate for low-income housing. They are also authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects. When the program began, it was assumed that tenant's rents would cover project operating costs for such items as management, maintenance, and utilities. Rent payments are now set at 30 percent of tenant's adjusted income. However, since 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 onsite 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 sub-
sidies. 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 was 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) made many changes to the 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 tenant-based voucher program. The VA-HUD Appropriations Act for FY1999 (105-276) combined Section 8 assistance under the voucher system as project-based vouchers and tenant-based vouchers, eliminating the term “certificate.”

5. PROJECT-BASED AND TENANT-BASED VOUCHERS

There is one major difference between Section 8 project-based and tenant-based assistance. Under the Section 8 project-based 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 Sec-
tion 8 tenant-based 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 tenant-based program argue that this system avoids segregation and warehousing of the poor in housing projects, and allows them to live where they choose. Critics of the tenant-based program question whether it would really help those most in need, and they believe that the tenant-based program presents 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, as is necessary in the tenant-based program.

In fiscal year 2001, Congress appropriated $13.94 billion for the Section 8 program, including $12.97 billion for the renewal of contracts; $453 million for new families to receive vouchers; $266 million for vouchers to prevent families from being displaced by pre-payments or other actions of Federal housing programs; and $40 million for vouchers for non-elderly disabled persons.

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 (Sections 515 or 514) to enable eligible tenants to pay no more than 25 percent of their income in rent. Under current law, rent payments by eligible families may equal the greater of (1) 30 percent of monthly adjusted family income, (2) 10 percent of monthly income, or (3) for welfare recipients, the portion of the family's welfare payment that is designated for housing costs. Monthly adjusted income is adjusted income divided by 12.

The rental assistance payments, which are made directly to the borrowers, make up the difference between the tenants' payments and the rent for the units approved by USDA. Borrowers must agree to operate the property on a limited profit or nonprofit basis. The term of the rental assistance agreement is 20 years for new construction projects and 5 years for existing projects. Agreements may be renewed for up to 5 years. An eligible borrower who does not participate in the program may be petitioned to participate by 20 percent or more of the tenants eligible for rental assistance.

Section 523 authorizes technical assistance (TA) grants to States, political subdivisions, and nonprofit corporations. The TA grants are used to pay for all or part of the cost of developing, administering, and coordinating programs of technical and supervisory assistance to families that are building their homes by the mutual self-help method. Applicants may also receive site loans to develop the land on which the homes are to be built.
Sites financed through Section 523 may only be sold to families who are building homes by the mutual self-help method. The homes are usually financed through the Section 502 program.

Section 524 authorizes site loans for the purchase and development of land to be subdivided into building sites and sold on a non-profit 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 1 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 1 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 im-
portant to those who are building or rehabilitating apartment build-
ings. The elderly are often the occupants of such buildings.

Of particular importance to the elderly is the revision that Con-
gress made to Section 232 of the National Housing Act. This sec-
tion authorizes FHA to insure loans for Nursing Homes, Intermedi-
ate 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, propri-
etary 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 medica-
tions, 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 support-
ive services to residents of the facility.

The term “frail elderly” is defined as an elderly person who is un-
able to perform at least three activities of daily living adopted by
HUD.

An assisted living facility may be free-standing, or part of a com-
plex 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 30 years or longer. Al-
though initially approved on a temporary basis, it was made per-
manent in 1993. This $3.8 billion a year program (which is ex-
pected to increase to $4.6 billion by 2005) 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, and in the last few years, may have added about 75,000
units a year. Under Public Law 106–554 signed by President Clin-
ton on December 21, 2000, the housing tax credit program was in-
creased by 40 percent. This is expected to subsidize the construc-
tion and rehabilitation of an additional 30,000 affordable rental
units a year. A 1997 survey by the General Accounting Office found
that about 26 percent of tax credit projects placed in service be-
tween 1992 and 1994 were primarily intended to serve lower-in-
come elderly. 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. 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 the maximum 60 percent of local area median that 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 frequently, Section 8 rental assistance. The use of tax-exempt bond financing is also common.

Despite substantial political support, some housing analysts contend that this supply side construction program is an expensive way to provide housing assistance compared to alternatives such as housing vouchers. Little is known about how much the tax credit units cost to produce when all public subsidies are considered and how much the rents in these units are being reduced compared to similar unassisted apartments. The General Accounting Office is now completing a study on the comparative costs of the various Federal housing rental programs and the results should be available in late 2001. Even if tax credit units are more expensive than housing vouchers, as past evidence has indicated, vouchers may not always be a viable option for some of the elderly, particularly the frail elderly. Voucher holders must shop around for a landlord willing to take them, which may be difficult for some elderly. On the other hand, once a voucher holder finds an acceptable unit, they may not have to move for many years.

There is some concern, based on the past experience of other assisted rental projects, that service to renters in tax credit units 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 nearly 5 million very-low income households have serious housing problems, most paying more than 50 percent of their income for shelter.¹

**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 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. 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, known as PAE's (participating administrative entities) who will supervise the program. The restructuring program is voluntary and owners have the option of not renewing their HUD Section 8 contracts. Owners interested in participating in the restructuring program are screened 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.

C. HOMEOWNERSHIP

1. HOMEOWNERSHIP RATES

There was strong political support in the 1990's for efforts to increase the homeownership rate. Homeownership is thought to give families a stake in their neighborhood and a chance to accumulate wealth (an important part of retirement security.) The 1990's were particularly favorable years to become a homeowner. There was a strong job market and relatively low mortgage interest rates during most of the decade. The homeownership rate reached a record high of 67.7 percent by the third quarter of 2000, and by the end of the second quarter of 2001, a record 72.3 million families owned their home.

Table X.—Homeownership Rates by Age: 1990 and 2000

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>1990</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 25 years</td>
<td>15.7</td>
<td>21.7</td>
</tr>
<tr>
<td>25 to 29</td>
<td>35.2</td>
<td>38.1</td>
</tr>
<tr>
<td>30 to 34</td>
<td>51.8</td>
<td>54.6</td>
</tr>
<tr>
<td>35 to 44</td>
<td>66.3</td>
<td>67.9</td>
</tr>
<tr>
<td>45 to 54</td>
<td>75.2</td>
<td>76.5</td>
</tr>
<tr>
<td>55 to 64</td>
<td>79.3</td>
<td>80.3</td>
</tr>
<tr>
<td>Over 65</td>
<td>76.3</td>
<td>80.4</td>
</tr>
</tbody>
</table>


The latter half of the 1990's was 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. The vigorous enforcement of fair housing laws and the Community Reinvestment Act have made mortgage credit more available to lower-income and minority households. 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 homeownership rate for minorities increased substantially in percentage terms during the 1990's, more than 10 percent, they still remain much below that for whites. For the year 2000,
the rate for blacks was 47.6 percent (and reached a record high of 48.8 percent in the 2nd quarter of 2001). For Hispanics, the rate for 2000 was 46.3 percent. These rates compare to 73.8 percent for rate for white non-Hispanics.

However, the overall homeownership rate in central cities was a relatively low 51.4 percent, compared to 74.0 percent in suburban areas. Some metropolitan areas have homeownership rates much below the national average, for example, New York, N.Y., 34.1 percent; Los Angeles-Long Beach, 49.0 percent; San Francisco, 48.9 percent; Miami, 56.2 percent; Houston, 53.6 percent and Boston, 58.7 percent.

<table>
<thead>
<tr>
<th>Class</th>
<th>1990</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide</td>
<td>64.1</td>
<td>67.4</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>69.4</td>
<td>73.8</td>
</tr>
<tr>
<td>Black (Non-Hispanic)</td>
<td>42.6</td>
<td>47.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>41.2</td>
<td>46.3</td>
</tr>
<tr>
<td>Married Couples</td>
<td></td>
<td></td>
</tr>
<tr>
<td>with Children</td>
<td>73.5</td>
<td>78.3</td>
</tr>
<tr>
<td>w/o Children</td>
<td>82.2</td>
<td>86.1</td>
</tr>
<tr>
<td>Other Families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>with Children</td>
<td>36.0</td>
<td>43.2</td>
</tr>
<tr>
<td>w/o Children</td>
<td>64.3</td>
<td>65.8</td>
</tr>
</tbody>
</table>


Help for moderate-income homebuyers is available from a number of Federal sources, including the Mortgage Revenue Bond program, which lowers the mortgage rate for certain moderate-income buyers, and the Federal Housing Administration (FHA) and the Veterans Administration (VA) mortgage insurance programs which encourage private lenders to make loans to those who have little money for a downpayment or who have blemished credit records. The FHA has its Officer Next Door and Teacher Next Door programs that sell FHA-foreclosed single-family homes located in certain designated revitalization areas to police officers and teachers at a 50 percent discount.

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 purchased homes with very low downpayments and very little savings set aside to carry them through economic setbacks. Some are concerned that there may not be adequate safety nets in place when the economy turns downward. As of the middle of 2001, the economy had softened somewhat, but the 4.5 percent unemployment rate was still considered very low. 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 most important incentives for homeownership are the tax deductions allowed for mortgage interest and property taxes paid.
Upper-middle and upper income homeowners benefit most from these provisions. The Congressional Joint Committee on Taxation has estimated the cost of these two tax benefits for fiscal year 2001 to be $83.7 billion: $62.7 billion for the mortgage interest deduction and $21.0 billion for the deduction of property taxes. They are projected to increase to a total of $97.7 billion by the year 2005. These provisions are of little or no value to lower income households because most lower-income taxpayers take the standard deduction or are in low marginal tax brackets. These tax deductions are also of little value to many elderly homeowners since most own their home without a mortgage. Households with incomes below $50,000 receive 7 percent of these tax benefits, and those with incomes of $50,000 or more receive 93 percent.

While as noted, most elderly homeowners have no mortgage debt, and thus do not benefit much from mortgage interest and property tax deductions, there have been some important changes in the tax laws that have been particularly beneficial for owners approaching retirement age and beyond. Prior to 1997, most homeowners could avoid paying a tax on the gain from the sale of their residence by purchasing a more expensive home under the “rollover provision” in the tax code. However, this often meant that households had to buy a larger and 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. Instead, under the 1997 Act, a taxpayer who is single can exclude up to $250,000 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 in divorce proceedings or facing a serious financial setback that forces them to sell their home without purchasing another. 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 (IRAs) and homes. Under the Act, the 10 percent penalty tax on IRA withdrawals before age 59 1/2 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 children with a home purchase even though this might not be in their best interest.

3. LEGISLATIVE PROPOSALS TO INCREASE HOMEOWNERSHIP

A number of bills introduced in the 107th Congress would help homebuyers. Others would provide financial incentives to developers who build or rehabilitate housing that would be affordable to buyers with moderate incomes. President Bush has proposed a number of homeownership initiatives in his FY2002 budget. One would set aside $200 million within HUD's existing HOME program for the "American Dream Downpayment Fund." The fund would provide a $3-for-$1 match, up to a maximum of $1,500 when third parties contribute of to $500 to help low-income families finance the purchase of a first home. Another initiative would allow up to a year's worth of HUD Section 8 rental housing vouchers to be used either for a downpayment or to make mortgage payments when a qualified assisted renter purchases a home. Under a third initiative, HUD will seek authority to allow the FHA to offer low-income families "hybrid adjustable rate mortgages" that have lower rates for an initial number of years (3, 5, 7, or 10 years), and then adjust annually based on an index tied to U.S. Treasury securities. These kind of mortgages already exist in the conventional market and are reasonably popular among homebuyers who do not expect to live in their home for long periods of time.

A fourth Bush Administration homeownership initiative is a proposed change in the tax code. It would offer $1.7 billion of tax credits over 5 years to homebuilders to encourage the rehabilitation of existing properties (such as abandoned buildings in central cities) or new construction of 100,000 affordable single-family homes in urban or rural areas. The new homes would be targeted to census tracts with incomes no greater than 80 percent of the local area median and to families making 80 percent or less of the local area median income.

There are a number of other homeowner proposals before the 107th Congress. One would provide a tax credit equal to 10 percent of the purchase price of the home, up to a maximum of $5,000. Another would reduce the downpayment amount that a first-time homebuyer is required to pay if purchasing a home insured by the FHA. Several bills would modify the existing Mortgage Revenue Bond program to make more tax-exempt bond revenue available for this first-time homebuyer program.
4. HOME EQUITY CONVERSION

According to the 1999 American Housing Survey (AHS), 80.3 percent of the elderly own their own homes, and 76.2 percent of them are owned free of any mortgage debt. The median value of all homes owned by the elderly is $96,442 and the median value for homes with no mortgage is $92,880. 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.

The program has been made permanent and current law provides that up to 150,000 mortgages may be made under the program. The program was amended 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 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.

Since November 1996 the Federal National Mortgage Association (Fannie Mae) has also been using its own reverse mortgage product the "Home Keeper Mortgage." Fannie Mae expects to the program to result in more than $37 million mortgages over the next 5 years. This is the first conventional reverse mortgage that will be avail-
able on nearly a nationwide basis. Previously, reverse mortgages were not permitted in Texas, but a Fannie Mae press release on March 1, 2001 noted the origination of one of the first reverse mortgages in the state.

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. 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.

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. 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.

2. 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.

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. 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. An Urban Institute (UI) study dated February 2000, reveals that there are roughly 2.3 million to 3.5 million people who suffer from a spell of homelessness at one point during a year. This figure includes people who experience homelessness for a period as short as one day to the entire year; almost half (49 percent) of homeless clients have been homeless only once, but 22 percent have been homeless four or more times.
In an effort to obtain a "true number" of people who experience homelessness, Congress included a requirement in the FY2001 HUD appropriations (P.L. 106–377, codified at 42 USC §11383(a)(7)) that 1.5 percent of the Homeless Assistance Grants be used to develop an automated, client-level Annual Performance Report System. In the Senate report (107–43) on the FY2002 appropriations, the Appropriations Committee reiterated its support of HUD's efforts in working with communities to continue with data collection and analysis efforts to prevent duplicate counting of homeless persons, and to analyze their patterns of use of assistance, including how they enter and exit the homeless assistance system and the effectiveness of the system. The Committee stated that HUD should consider this activity to be a priority.

In 1996, the National Survey of Homeless Assistance Providers and Clients (NSHAPC) was conducted. This study was designed and funded by 12 Federal agencies with guidance provided by the Interagency Council on the Homeless and with data collected by the U.S. Bureau of Census and analyzed by the Urban Institute. NSHAPC indicated that 34 percent of homeless people found at homeless assistance programs were members of homeless families (one client and one or more of the client's minor children). Homeless clients were predominantly male (68 percent) and nonwhite (53 percent); 48 percent never married; and 38 percent had less than a high school diploma. Forty-two percent of homeless clients reported that finding a job was their top need followed by a need for help in finding affordable housing (38 percent). Thirty-eight percent of homeless clients reported alcohol problems during the past month; 26 percent had drug problems; and 39 percent had mental health problems during that period. Over one-quarter (27 percent) of homeless clients had lived in foster care, a group home or other institutional setting for part of their childhood. Twenty-five percent reported childhood physical or sexual abuse. Twenty-three percent of homeless clients were veterans: 21 percent served before the Vietnam era (before 1964); 47 percent served during the Vietnam era (between August, 1964 and April 1975); and 57 percent served since the Vietnam era; 33 percent of the male veterans were stationed in a war zone, and 28 percent were exposed to combat.

When homelessness gained prominence in the early 1980's, some observers felt that the problem was a temporary consequence of economic conditions fueled by the recession of 1981–1982. However, reports such as the NSHAPC indicate that, although extreme poverty is the virtually universal condition of clients who are homeless, accompanying factors such as low levels of education, few job skills, exhaustion of social supports or complete lack of family, problems with alcohol or drug use, severe mental illness, childhood and adult experiences of violence all increase a person's risk of becoming homeless. A shortage of affordable housing and increased skill levels needed for employment also increase the risk of homelessness.

According to the National Coalition for the Homeless (NCH), increased homelessness among elderly persons is largely the result of the declining availability of affordable housing and poverty among certain segments of the aging. Of the 12.5 million persons in households identified by HUD as having "worst case housing needs," 1.5
million are elderly people. Thirty-seven percent of very-low-income elderly people receive housing assistance. The NCH reported that between 1993 and 1995, the total number of elderly with very low incomes dropped by about 300,000. They added that this drop may reflect that a growing portion of the elderly population are protected from severe poverty by Social Security and private pensions. A recent analysis of Census data found that without Social Security, nearly half (47.6 percent) of Americans age 65 or over would have been poor in 1997. In fact, Social Security reduced the poverty rate among elderly people in 1997 by 11.9 percent and lifted 11.4 million elderly people out of poverty. However, Social Security benefits are often inadequate to cover the cost of housing. In addition, some homeless persons are unaware of their own eligibility for public assistance programs and face difficulties applying for and receiving benefits. According to the Bureau of Census, 1998, elderly people have a lower poverty rate than the general population (10.5 percent compared to 13.3 percent for all people) but are more likely than the nonelderly to have incomes just over the poverty threshold. Seventeen percent of elderly people had family incomes below 125 percent of poverty. Sixty-five percent of older renters, 71 percent of older single female renters, 71 percent of older Hispanic renters, and 69 percent of older African-American renters spend more than 30 percent of their income on housing which, combined with other living expenses, makes them particularly vulnerable to homelessness. Furthermore, overall economic growth may not alleviate the income and housing needs of elderly poor people, as they are not as likely to continue or return to work or gain income through marriage as are younger homeless persons.

NCH singled out various studies showing that once on the street, elderly homeless persons often find getting around difficult, and, distrusting the crowds at shelters and clinics, they are more likely to sleep on the street. The homeless elderly are prone to victimization and are more likely than other homeless persons to suffer from a variety of health problems, including chronic disease, functional disabilities and high blood pressure. To prevent elderly Americans from becoming homeless, NCH recommends an increase in low-income housing, income supports and health care services.

Presently, there are nearly two dozen Federal programs targeted to assist the homeless which are administered by seven different agencies within the Federal Government. In FY2001, they were funded at roughly $1.7 billion. In addition to the targeted homeless programs, assistance is potentially available to homeless people through nontargeted programs designed to provide services for low-income people generally, e.g., the food stamp program, Community Development Block Grants and Community Services Block Grants. Seven of the targeted homelessness programs are authorized by the McKinney-Vento Homeless Assistance Act. They are Education for Homeless Children and Youth; Emergency Food & Shelter; Homeless Veterans Reintegration Project; and four Homeless Assistance Grants Programs administered by HUD—Supportive Housing, Emergency Shelter Grants, Shelter Plus Care and Section 8 Moderate Rehabilitation Assistance for Single-Room Occupancy Dwellings.
Most of the McKinney-Vento Act programs provide funds through competitive and formula grants. An exception is the Emergency Food and Shelter Program, administered by the Federal Emergency Management Administration (FEMA), 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.

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 (CoC) 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. In varying degrees the HUD programs, i.e., the Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation Single Room Occupancy, contain a "supportive services" element such as child care, employment assistance, outpatient health services, food and case management. It has been estimated that over 50 percent of HUD homeless assistance grant funds are being spent on "services" rather than on housing. In 2001, HUD Secretary Martinez initiated a joint task force with the Secretary of Health and Human Services (HHS) to identify and target each agency's responsibilities concerning HUD's homeless programs, so that HUD could concentrate on the housing component and HHS could concentrate on the services component. In the House report (107-159) on the FY2002 appropriations, the Committee commended these efforts; the Committee required that a report of findings and progress be filed no later than February, 2002.

Congress appropriated the following funds for HUD Homeless Assistance Grants: FY1998—$823 million; FY1999—$975 million; FY2000—$1.020 billion; FY2001 $1.023 billion. Since FY1999 at least 30 percent of the appropriated funds are to be used for permanent housing.

There are seven targeted Federal programs that focus on homeless veterans to meet such needs as job training (administered by the Department of Labor) and health care, transitional housing and residential rehabilitation administered by the Department of Veterans Affairs (VA). In addition to the targeted programs, the VA engages in several activities not reported as separate funded pro-
grams to assist the homeless, such as Drop-in Centers, Comprehensive Homeless Centers, VA Excess Property for Homeless Veterans Initiative and a project with the Social Security Administration called SSA-VA Outreach where staff coordinate outreach and benefits certification to increase the number of veterans receiving SSA benefits.

Targeted VA program obligations for FY2001 are as follows:
- Health Care for Homeless Veterans—$59 million
- Homeless Providers Grants and Per Diem Program—$33 million
- Domiciliary Care for Homeless Veterans—$35 million
- Compensated Work Therapy/Therapeutic Residence Program—$8 million
- Loan Guaranty Transitional Housing for Homeless Veterans—$6 million
- HUD VA Supported Housing—$5 million

G. HOUSING COST BURDENS OF THE ELDERLY

Housing costs are a serious burden for many low- and moderate-income households, particularly for elderly households living on fixed incomes. Figures from the Department of Labor's Consumer Expenditure Survey from 1999 show that households headed by those age 65 and over, who had an average income of $26,581 in 1999, spent $8,944 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. 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, ($26,581 compared to the average household income of $43,951 in 1999), the amount of property taxes paid by the elderly is higher than that paid by the average household ($1149 in 1999 versus $1123 for the average household.) The elderly spend 4.3 percent of income for property taxes; the average household, about 2.1 percent.
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 assistance crisis benefits. By 2000, only an estimated 17 percent of eligible households received those benefits, however this was up from 13 percent in 1999.

(259)
According to HHS, in FY1998 (the most recent year for which detailed data are available), the average household had energy expenditures of $1,280, compared to $1,082 for low-income households (those at or below 150 percent of Federal poverty guidelines) and $1,063 for LIHEAP recipient households. The energy burden for LIHEAP recipients in FY1998 was over 15 percent, 9 percentage points higher than for all households, and 3 percentage points higher than low-income households.

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 had 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 survey of 19 states and the District of Columbia, conducted by the National Energy Assistance Directors' Association, reported that arrearages and threats of shut-offs increased to 4.3 million households in 2001. An estimated 5 million households received LIHEAP in 2000, an increase of 1 million over fiscal year 1999.

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.


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 for-
mula 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 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 recipiency by type of service are for fiscal year 1999. Those estimates, based on data reported by the states, indicate that in FY1999, 3.4 million households received regular heating cost assistance and 748,000 received winter crisis aid. These data do not reflect an unduplicated count of households, but rather an estimated count of households that received each category of assistance. In addition to heating assistance provided by LIHEAP funds, cooling aid was provided to an estimated 480,000 households, summer crisis aid to 194,000 households, and weatherization assistance to 87,000.

The most recently released data regarding average LIHEAP benefit amounts indicate that the average heating/winter crisis benefit amount in FY1998 was $213, approximately the same as the average for FY1997 ($214). The average cooling/summer crisis benefit for FY1998 was $248, an increase of 78 percent from FY1997. The percentage of federally eligible households assisted with LIHEAP benefits has risen from 13 percent in 1998 to 17 percent according to preliminary estimates for FY2000.

The fiscal year 1998 LIHEAP Home Energy Notebook, prepared for the U.S. Department of Health and Human Services in October, 2000 revealed:

On average, residential energy expenditures for all households decreased by 2.3 percent, from $1,310 in fiscal year 1997 to $1,280 in fiscal year 1998. LIHEAP recipient households decreased their average residential energy expenditures by almost 9 percent, from $1,167 in fiscal year 1997 to $1,063 in fiscal year 1998;

Low-income households overall (49.2 percent), and LIHEAP recipient households specifically (51.3 percent) use natural gas as their main heating fuel. Use of electricity as a main heating fuel has increased for LIHEAP recipient families, reaching almost 30 percent in 1997. Over 8 percent of LIHEAP households use fuel oil as their main heating source.

Average home heating expenditures for LIHEAP recipient households were about $347;

Home heating expenditures represented a higher percentage of annual household income for low-income households (about 3.8 percent; 5.2 percent for LIHEAP recipient households) than for all households (about 1.9 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 1998 for all households that cooled was about $143, and for LIHEAP recipients that cooled was about $122;

Cooling expenditures represented a higher percentage of average annual income for low-income households that cooled (1.3 percent) than for all households that cooled (0.6 percent).
(B) FUNDING

There has been a substantial reduction in the level of regular LIHEAP funding in the past two decades, from a high of $2.1 billion in fiscal year 1985 to the current level of $1.4 billion in fiscal year 2001. However, regular LIHEAP funds have, in recent years, been supplemented with increasing amounts of emergency LIHEAP funding. In FY2001, a total of $600 million in contingency LIHEAP funds was appropriated ($300 million as part of a FY2001 supplemental appropriation measure (P.L. 107–20), raising the total amount of LIHEAP funding to $2 billion.

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), provided $1.1 billion in LIHEAP funding for fiscal year 1999, plus $300 million in emergency funding. The bill also included $1.1 billion in advanced funding for fiscal year 2000. Ultimately, $2 billion was appropriated in FY2000, including $900 million in emergency funding.

Contingency LIHEAP funds have been utilized in recent years for both cold and hot weather emergencies. The most recent releases of emergency funds have been allocated to all states, to assist low-income households facing significant increases for heating oil, natural gas, and propane prices during the winter of 2000/2001. Overall, allotments have been weighted for states with a greater percentage of households using fuel oil, natural gas, and propane for heating. However, on August 23, 2000, President Clinton released $2.6 million in emergency LIHEAP funds to Southern California, for low-income households that had been facing substantially higher electricity rates. Likewise, most of the summer releases of FY2000 emergency funds targeted southern states, to help low-income families cool their homes during the extreme summer heat.

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, as amended. 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 persons with disabilities. 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 970 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 persons with disabilities. On December 8, 2000, the Department of Energy issued final rules amending the regulations for the weatherization program. "Households with a high energy burden" and "high residential energy users" were added as new categories for those receiving priority service.

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 allows a maximum average expenditure of $2,500 per household in fiscal year 2001, 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 2000, the weatherization program has served more than 5 million homes. In approximately 33 percent of the homes weatherized, at least one resident was 60 years of age or older. An estimated 67,340 homes were weatherized in fiscal year 1999 and 75,000 in fiscal year 2000.

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

The Weatherization Assistance Program has been operating without an appropriations authorization since 1990. Through the general appropriations process, Congress has continued to provide annual grants to support weatherization activities: $124.8 million in FY1998; $133 million in FY1999; $135 million in FY2000; and $153 million in FY2001.
CHAPTER 14

OLDER AMERICANS ACT

OVERVIEW

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 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 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 about 660 area agencies on aging (AAAs). It supports the only federally sponsored job creation program benefiting 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 administers all of the Act's programs except for the Senior Community Service Employment Program administered by the Department of Labor (DOL), and the commodity or cash-in-lieu of commodities portion of the nutrition program, administered by the U.S. Department of Agriculture (USDA).

The original legislation established AOA within HHS and established a State grant program for community planning and services programs, as well as authority for research, demonstration, and training programs. During the 1970's, Congress significantly improved the OAA by broadening its scope of operations and establishing the foundation for a "network" on aging under a Title III program umbrella. In 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. The service system encompasses services funded under the OAA, as well as 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. 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). The most recent amendments in 2000 created the National Family Caregiver Support program under Title III.

Increased funding during the 1970's allowed for the further development of AAAs and for the provision of other services, including access (transportation, outreach, and information and referral), in-home, and legal services. Expansion of OAA programs continued until the early 1980's when, in response to the Reagan Administration's policies to cut the size and scope of many Federal programs, the growth in OAA spending was slowed substantially, and for some programs was reversed.

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 until the end of the 106th Congress when Congress agreed on various amendments that had been in controversy for almost three Congresses (see discussion below).

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 (HHS), as the chief Federal agency advocate for older persons.

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, about 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 family caregiver support services.

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 and older persons residing in rural areas. 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 disease prevention and health promotion is allocated to States by AoA based on each State's relative share of the total population of persons aged 60 years and over. Funding for family caregiver support services is allocated to States based on each State's relative share of the total population aged 70 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 representing 40 percent of the Act's total funding and 59 percent of Title III funds. Data for FY1998 (the most recent data available on persons served) show that the program provided almost 244 million meals to 2.8 million older persons. Forty-seven percent of the meals were provided in congregate settings, such as senior centers, and 53 percent were provided to frail older persons in their own 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 evalua-
tion 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.

The supportive services and centers program provides funds to States for a wide array of social services, as well as the activities of approximately 6,400 multipurpose senior centers. Supportive services allow older adults to reside in their homes and communities and remain as independent as possible. The program serves nearly 7 million older persons of whom 36 percent had incomes below the poverty level, and almost 20 percent were minority older persons. There are three general categories of services provided: access services (such as information and referral, case management, outreach, and transportation), in-home services (such as homemaker and personal care), and community services (such as adult day care and health promotion). The most frequently provided services are transportation, information and assistance, home care, and recreation.

In FY1998, the program provided 46 million one-way trips, over 18 million hours of homemaking and personal care services to nearly 260,000 older persons, and over 6 million hours of adult day care to over 25,000 older persons.

The National Family Caregiver Support Program was added to Title III by P.L.106-501 in 2000. The legislation authorizes the following services: information and assistance to caregivers about available services; individual counseling, organization of support groups, and caregiver training; respite services to provide families temporary relief from caregiving responsibilities; and supplemental services (such as adult day care or home care services, for example), on a limited basis, that would complement care provided by family and other informal caregivers.

**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, supported over
61,500 jobs in program year (PY) 2000 (July 1, 2000-June 30, 2001).

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 Asociación 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.

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.

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 four separate vulnerable elder rights protection activities. States receive separate allotments of funds for the long-term care ombudsman program and elder abuse prevention activities. Two other authorized programs—legal assistance and the Native Americans elder rights program 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 FY2000, more than $57 million in Federal and non-Federal funding was devoted to support this program. About 56 percent of the program effort was supported by Older Americans Act sources ($22.2 million from the Title III supportive services and centers program, and $9.5 million from Title VII programs); non-Federal and other funds represented about 41 percent of the total program support. The remaining 3 percent came from other Federal sources.
B. SUMMARY OF MAJOR ISSUES IN THE 2000 REAUTHORIZATION

INTRODUCTION

After 6 years of congressional debate on reauthorization of the Older Americans Act, on November 13, 2000, President Clinton signed H.R. 782, the Older Americans Act Amendments of 2000, which became P.L. 106-501. The law extended the Act's programs through FY2005.

In summary, P.L. 106-501 contains the following major provisions:

- authorized $125 million for a new National Family Caregiver Support Program under Title III (Congress appropriated $125 million for the program for FY2001);
- reduced the number of separate authorizations of appropriations by eliminating authority for programs that were not funded;
- retained separate authorization of appropriations for the congregate and home-delivered nutrition programs, and expanded a State's authority to transfer funds between these programs;
- required the Secretary of the Department of Labor (DoL) to establish performance measures for the senior community service employment program, and retained the prior law division of funds for national organizations (78 percent) and States (22 percent) for FY2001. If funds increase above the FY2001 level ($440 million), State agencies are to receive proportionately more funding;
- retained authority for voluntary contributions by older persons toward the costs of services, and allowed States to impose mandatory cost-sharing for certain Title III services older persons receive;
- clarified that the Title III formula allocation is to be based on the most recent population data, while stipulating that no State will receive less than it received in FY2000;
- required the President to convene a White House Conference on Aging by December 2005.

BRIEF LEGISLATIVE BACKGROUND

Prior to passage of P.L. 106-501, authorizations of appropriations for programs under the Older Americans Act expired at the end of FY1995. For the expired period, FY1996-FY2000, programs continued to be funded through appropriations legislation for the Departments of Labor, Health and Human Services, and Agriculture, each of which administer portions of the Act.

In the past, the Act had received wide bipartisan congressional support. However, beginning with the 104th Congress, and continuing through the 106th Congress, Members of Congress differed about certain proposals that were under discussion as part of the reauthorization. These included proposals to change the formula for allocation of supportive services and congregate and home-delivered nutrition services to States; consolidate a number of separately authorized programs; change the way community service employment funds are allocated to national organizations and States;
and change minority targeting requirements, among other things. As a result of controversy around these issues, the 104th and 105th Congresses took no final action.

In the 104th Congress, legislation to reauthorize the Act was reported by both the House Economic and Educational Opportunities (EEO) \(^1\) Committee and the Senate Labor and Human Resources Committee, but not with bipartisan agreement.\(^2\) However, the bills were not acted upon by either chamber.

In the 105th Congress, legislation to reauthorize the Act was introduced by the Chairman of the Subcommittee on Early Childhood, Youth and Families of the House Education and the Workforce Committee (H.R. 4099), which had responsibility for the Act. However, no further action was taken on the bill. The Chairman of the Subcommittee on Aging of the Senate Labor and Human Resources Committee, which had responsibility for the Act, did not introduce legislation in the 105th Congress.

By early summer 1998, some Members of Congress were concerned that there was no action on reauthorization. In response to rising criticism from constituents and constituent organizations about the lack of action, two bills that would have reauthorized the Act through FY2001 were introduced. These bills would have simply reauthorized appropriations for programs in the Act, but would have made no substantive program changes (S. 2295, Senator McCain and H.R. 4344, Representative DeFazio). They received substantial congressional support S. 2295 had 67 co-sponsors, and H.R. 4344 had 188 co-sponsors. However, no further action was taken on these bills.

1. **106th Congress Activities**

Final congressional action was taken on the reauthorization in late October 2000. On October 25, the House passed H.R. 782, the Older Americans Act Amendments of 2000, by a vote of 405 to 2. The next day, the bill passed the Senate by a vote of 94–0. The President signed it on November 13, 2000 as P.L. 106–501.

Activities relating to the reauthorization spanned both sessions of the 106th Congress. On September 15, 1999, H.R. 782, the Older Americans Act of 1999, was approved by the House Committee on Education and the Workforce. H.R. 782 was scheduled to be considered by the House under “suspension of the rules” (which requires a two-thirds majority vote for passage) on October 4, 1999. However, the bill was not taken up due to controversy about provisions in the bill, including the proposal for changing the Title III funding formula to States and restructuring the Title V senior community service employment program (these issues are discussed below). In addition, there was concern that the bill was to be brought up under suspension of the House rules which would have meant that no floor amendments would have been allowed.

---

\(^1\) This House committee changed its name in the 105th Congress to the House Education and the Workforce Committee.

\(^2\) H.R. 2570 was reported by the House Economic and Educational Opportunities (EEO) Committee on April 25, 1996; S. 1643 was reported by the Senate Labor and Human Resources Committee on July 31, 1996. The Senate Committee’s name was changed to the Senate Committee on Health, Education, Labor and Pensions in the 106th Congress.
S. 1536, the Older Americans Act Amendments of 1999, was ordered reported by the Senate Committee on Health, Education, Labor and Pensions (HELP), on July 21, 2000. Both bills addressed the issues that had been in controversy during the 104th and 105th Congresses, in addition to some other topics that surfaced in the 106th Congress.

2. ISSUES IN REAUTHORIZATION

The following discusses proposals that were considered as part of the reauthorization and their resolution as part of P.L. 106-501.

National Family Caregiver Support Program

The Clinton Administration's Older Americans Act reauthorization proposal and the FY2000 and FY2001 budget proposals included a proposal for creation of the National Family Caregiver Support program that was to be part of Title III of the Act. The proposal was one part of a multipart Clinton Administration initiative on long-term care services for persons of all ages. Other parts of the Administration's initiative included a tax credit for functionally and/or cognitively impaired persons of all ages, and authority for the Office of Personnel Management (OPM) to offer group long-term care insurance for Federal employees, retirees, and their families.3

About 4 million persons age 65 and over living in the community are estimated to need long-term care assistance due to a functional disability. The need for long-term care is measured by need for assistance with activities of daily living (ADL), and/or instrumental activities of daily living (IADLs). Functional disability is defined as the inability to perform, without human and/or mechanical assistance, the following activities of daily living (ADLs): dressing, eating, bathing, moving around indoors, transferring from a bed to a chair, and toileting. It is also measured by the inability to perform certain instrumental activities of daily living (IADLs), including light housekeeping, meal preparation, shopping, taking medications, and managing money, among others. Of the 4 million older persons with any functional disability, over half need assistance with one or more ADLs, and almost 40 percent need assistance with IADLs only.

Research on disability and long-term care has documented the enormous responsibilities that families face in caring for relatives who are living in the community and who have significant impairments. Data from the 1994 National Long-Term Care Survey sponsored by the Department of Health and Human Services (DHHS) indicate that over 7 million persons provide 120 million hours of informal, that is, unpaid, care to about 4.2 million functionally disabled older persons each week. These data conclude that if the work of these caregivers were to be replaced by paid home care, costs would range from $45 billion to $94 billion annually. Moreover, research has shown that the informal, or unpaid, care pro-

3For further information on the Clinton Administration's proposal, see CRS Report RL 30254, Long-Term Care: The President's FY2000 Initiative and Related Legislation, by Carol O' Shaughnessy, Bob Lyke and Carolyn Merck.
vided by family members can prevent or delay entry into long-term care facilities.\footnote{Doty, Pam. Informal Caregiving, Compassion in Action. U.S. Department of Health and Human Services. Office of Assistant Secretary for Planning and Evaluation, 1998. Data are from the 1994 National Long-Term Care Survey, a nationally representative sample of functionally impaired Medicare beneficiaries living in the community.}

Data from the 1994 survey and previous surveys indicate that most persons who need long-term care receive no formal, or paid, assistance. Most assistance they receive is provided by family members. Almost 60 percent of impaired elderly rely exclusively on informal care provided by family members. Typically, elderly persons rely on their spouses and adult children for assistance.

The National Family Caregiver support program, authorized by P.L. 106–501, is intended to meet some of the needs of family caregivers. It authorizes $125 million in grants to State agencies on aging to establish the family caregiver support program. For FY2001, Congress appropriated $125 million for the program.

The legislation authorizes the following services: information to caregivers about available services; assistance to caregivers in gaining access to services; individual counseling, organization of support groups, and caregiver training; respite services to provide families temporary relief from caregiving responsibilities; and supplemental services (adult day care or home care services, for example), on a limited basis, that would complement care provided by family and other informal caregivers.

All caregivers eligible to receive services could receive information and assistance, and individual counseling, access to support groups, and caregiver training. Services that tend to be more individualized, such as in-home respite, home care, and adult day care, would be directed to persons who have specific care needs. These are defined in the law as persons who are unable to perform at least two activities of daily living (ADL) without substantial human assistance, including verbal reminding, or supervision; or due to a cognitive or other mental impairment, require substantial supervision because of behavior that poses a serious health or safety hazard to the individual or other individuals. ADLs include bathing, dressing, toileting, transferring from a bed or a chair, eating, and getting around inside the home.

Priority is to be given to older persons and their families who have the greatest social and economic need, with particular attention to low income minority individuals, and to older persons who provide care and support to persons with mental retardation and developmental disabilities. In addition, under certain circumstances, grandparents and certain other caregivers of children may receive services.

The law allows States to establish cost-sharing policies for individuals who would receive respite and supplemental services provided under the program, that is, persons could be required to contribute toward the cost of services received.

Funds are to be allotted to States based on a State's share of the total population aged 70 and over. However, persons under age 70 would be eligible for caregiver services. The Federal matching share for the specified caregiver services is 75 percent, with the remainder to be paid by States. This is a lower Federal matching
rate than is applied to other Title III services (such as congregate and home-delivered nutrition services, and other supportive services) where the Federal matching rate is 85 percent.

In its proposal, the Clinton Administration projected that the $125 million level would provide one or more of the caregiver support services to about 250,000 families each year. The number of persons served would be affected by several factors, including the number of persons who meet the specified eligibility requirements and actually apply for services, capabilities and readiness of service providers, and relative spending by States on specific services.

Consolidation of Older Americans Act Programs

The law that existed prior to P.L. 106–501 authorized 20 programs (although some had never been funded). A major issue in the 106th Congress, but especially in the two prior Congresses was a congressional initiative to streamline the Act, in part, by consolidating separately authorized programs. Some Members of Congress wanted to simplify certain requirements of law, and consolidate smaller programs. The House bill as originally approved by the House Committee on Education and Labor in 1999 would have reduced the number of authorized programs to 11; among other things, it would have eliminated a separate title (but not authorization) for training, research and demonstration activities in the field of aging. S. 1536 as approved by the Senate Committee on Health, Education, Labor and Pensions in 2000 would have reduced the number of programs to 15.5 Both bills would have eliminated authority for some programs that had not been funded.

P.L. 106–501 did not consolidate major programs, but eliminated authority for programs that had not received funding in FY2000 and prior years as well as authority for a number of demonstration projects. Table 1 presents authorization of appropriations for each program as contained in the law.

C. OLDER AMERICANS ACT APPROPRIATIONS

Table 1. Authorizations of Appropriations for Older Americans Act Programs in P.L. 106–501

<table>
<thead>
<tr>
<th>Older Americans Act Programs</th>
<th>Authorization of Appropriations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title I, Administration on Aging</td>
<td></td>
</tr>
<tr>
<td>Administration on Aging</td>
<td>FY2001–FY2005, such sums as may be necessary</td>
</tr>
<tr>
<td>ElderCare Locator</td>
<td>FY2001–FY2005, such sums as may be necessary</td>
</tr>
<tr>
<td>Pension counseling and information program</td>
<td>FY2001–FY2005, such sums as may be necessary</td>
</tr>
<tr>
<td>Title III, State and Community Programs on Aging</td>
<td></td>
</tr>
<tr>
<td>Supportive services and centers</td>
<td>FY2001–FY2005, such sums as may be necessary</td>
</tr>
<tr>
<td>Congregate nutrition services</td>
<td>FY2001–FY2005, such sums as may be necessary</td>
</tr>
<tr>
<td>Home-delivered nutrition services</td>
<td>FY2001–FY2005, such sums as may be necessary</td>
</tr>
<tr>
<td>Disease prevention and health promotion</td>
<td>FY2001–FY2005, such sums as may be necessary</td>
</tr>
</tbody>
</table>

For example, H.R. 782 would have eliminated a separate title authorizing appropriations for research, training, and demonstration activities that are the responsibility of the Assistant Secretary for Aging. Instead, H.R. 782 would have authorized these activities under Title I. S. 1536 would have retained the separate title. H.R. 782 would have consolidated authorizations of appropriations for the long-term care ombudsman and elder abuse prevention programs. On the other hand, S. 1536 would have retained separate authorization of appropriations for ombudsman, elder abuse prevention programs.
Table 1. Authorizations of Appropriations for Older Americans Act Programs in P.L. 106–501—Continued

| Family caregiver support               | FY2001, $125 million if the aggregate amount for supportive services and centers, congregate and home-delivered nutrition services, and disease prevention and health promotion is not less than the amount appropriated for FY2000. For FY2002–05, such sums as may be necessary. |
| Nutrition services incentive program (formerly named the USDA commodity program) | FY2001–FY2005, such sums as may be necessary |
| Title IV, Training, Research, and Discretionary Programs | |
| Title V, Community Service Employment Program |
| Title VI, Grants for Native Americans |
| Indian and Native Hawaiian Programs | FY2001–FY2005, such sums as may be necessary |
| Native American Caregiver Support Program | FY2001, $475 million and for FY2002–2005, such sums as may be necessary, and such additional sums for each fiscal year to support 70,000 part-time employment positions |
| Title VII, Vulnerable Elder Rights Protection Activities |
| Long-term care ombudsman program | FY2001–FY2005, such sums as may be necessary |
| Elder abuse, neglect, and exploitation prevention program | FY2001–FY2005, such sums as may be necessary |
| Legal assistance development program | FY2001–FY2005, such sums as may be necessary |

Restructuring the Senior 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 was funded at $440.2 million in FY2001, representing 26 percent Older Americans Act funds. It is administered by DoL, which awards funds directly to national sponsoring organizations and to States. The grantees and their FY2000 funding levels are shown in Table 2.

Table 2. FY2000 Funding to National Organizations and State Sponsors

<table>
<thead>
<tr>
<th>Sponsor</th>
<th>FY2000 amount (millions)</th>
<th>Percent of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Association of Retired Persons</td>
<td>$50.6</td>
<td>11.6</td>
</tr>
<tr>
<td>Asociacion Nacional Par Personas Mayores</td>
<td>13.2</td>
<td>3.0</td>
</tr>
<tr>
<td>Green Thumb</td>
<td>105.5</td>
<td>24.3</td>
</tr>
<tr>
<td>National Caucus and Center on the Black Aged</td>
<td>13.0</td>
<td>3.0</td>
</tr>
<tr>
<td>National Council on the Aging</td>
<td>38.0</td>
<td>8.7</td>
</tr>
<tr>
<td>National Council of Senior Citizens</td>
<td>64.3</td>
<td>14.7</td>
</tr>
<tr>
<td>National Urban League</td>
<td>15.3</td>
<td>3.5</td>
</tr>
<tr>
<td>National Indian Council on Aging</td>
<td>6.1</td>
<td>1.4</td>
</tr>
<tr>
<td>National Asian Pacific Center on Aging</td>
<td>6.0</td>
<td>1.4</td>
</tr>
<tr>
<td>U.S. Forest Service</td>
<td>28.5</td>
<td>6.5</td>
</tr>
<tr>
<td>National organization sponsors, total</td>
<td>$341.5</td>
<td>78.0</td>
</tr>
<tr>
<td>State agencies, total</td>
<td>$96.3</td>
<td>22.0</td>
</tr>
<tr>
<td>Total</td>
<td>$437.8</td>
<td>100.0</td>
</tr>
</tbody>
</table>

1This amount includes funds allocated to the territories.
2This 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.

Beginning in the 104th Congress and continuing through the 106th Congress, some Members of Congress were concerned about how the program was administered. Some Members wanted more
funds to be distributed to States, rather than having the majority of funds distributed to the same national organizations every year, as had been required by Appropriation Committee directives for many years. Other issues included concerns that funding to the 10 national organizations was awarded by DoL on a noncompetitive basis and about how much funding was used by the organizations for administration. A General Accounting Office (GAO) report completed in 1995 focused attention on these issues. GAO reviewed DoL's method of awarding funds, the allocation of funds to States, and grantee use of funds. It concluded that the program could be improved by assuring more equitable distribution of funds nationally, by enforcing statutory limits on use of funds for administration, and by applying procedures for competition for funds by sponsors, among other things.6

Like the 104th and 105th Congress reauthorization proposals, H.R. 782 and S. 1536 would have restructured the program, in part, to respond to the GAO findings although they differed in approach. Both proposals gave States more control of the administration of the program and introduced competition for funds among prospective grantee organizations. The bills 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 administration and other enrollee costs. These and other issues, and their resolution in P.L. 106-501, are discussed below.

**Distribution of Community Service Employment Funds by the Federal Government.**—For many years, Appropriations Committee directives stipulated that national organizations were to receive 78 percent of the total Title V funds, and States, 22 percent.7 The Committee directives differed from the authorizing statute that was in force. The statute stipulated that funds be awarded to national public and non-profit private organizations at the level they received funds in 1978; 55 percent of any funds in excess of the 1978 funding level was to be distributed to State agencies, and 45 percent to national organizations. However, for most years since 1978, the Appropriations Committee directives stipulated the 78 percent/22 percent split of funds.

In its 1995 report, GAO noted that there was inequitable distribution of funding within some States, as well as duplication of effort among national and State sponsors. Some State agencies have had long-standing concerns about the duplication of national organizations' activities that is caused by the distribution of funds to multiple organizations within a State. In addition, States maintained that because they administer only 22 percent of total funds in a State, their ability to coordinate operations of the program is very limited. In many States, multiple national organizations administer programs in addition to a designated State agency (usually the State agency on aging). For example, in six States, each with Title V FY2000 funding of $15 million or more, eight or nine

---


7 This has been a long-standing issue. For example, 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.
national sponsors administer the program in addition to the State agency (California, Florida, New York, Ohio, Pennsylvania, and Texas). In most States, at least three or four national organizations administer the program in addition to the State agency.

These concerns led to various proposals during the 104th, 105th, and 106th Congress to restructure the program, primarily by giving States more authority over the program, and by increasing their share of total funding and decreasing the national organizations' share. Proponents of shifting funds to States indicated that costs of program administration and duplication of effort would decrease since there would be fewer organizations to administer the program within a State. Proponents also said 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 the 104th and 105th Congresses, and the controversy continued during the 106th Congress. Some national organization grantees expressed concern that their continued existence would be threatened if more program funding were to be shifted to States. They were also concerned that restructuring could result in disruption of jobs for some existing enrollees. A number of organizations and some Members of Congress indicated that the program operated well under the national organizations' administration, and that because of their longstanding association, they had the needed expertise to continue administering the majority of funds.

Both H.R. 782 and S. 1536 would have changed the 78 percent/22 percent split of funds between national organizations and States, and transferred more funds to States; however, they took different approaches. H.R. 782 would have gradually transferred funds to States so that by FY2004, national organizations would have received 55 percent of total funds and State agencies would have received 45 percent. S. 1536 would have applied a different division of funds to national organizations and State agencies only when total funding exceeded the FY2000 appropriations level.

P.L. 106–501 ultimately retains the 78 percent/22 percent split by requiring that State agencies and national organizations be “held harmless” at their FY2000 level of activities that is, they are to receive no less than the amount they received in FY2000 to maintain the FY2000 level of activity. But when appropriations exceed the FY2000 level, proportionately more funds are to be distributed to State grantees. Specifically, any excess in appropriations over the FY2000 level up to the first $35 million is to be allocated so that 75 percent will be provided to States, and 25 percent to national organizations. Funds appropriated above the first $35

---

8For purposes of allocation of funds and determining the FY2000 hold harmless amount, “level of activities” is defined as “the number of authorized positions multiplied by the cost per authorized position.” “Cost per authorized position” is defined as the sum of:

the hourly minimum wage specified in the Fair Labor Standards Act of 1938, multiplied by 1,092 hours (21 hours times 52 weeks);

an amount equal to 11 percent of the above amount to cover Federal payments for fringe benefits; and

an amount determined by the Secretary to cover Federal payments for all other remaining program and administrative costs.
million in excess of the FY2000 level are to be divided equally between State agencies and national organizations.

When appropriations are in excess of the amount needed to maintain the FY2000 hold harmless level, the excess is to be allotted according to a State's relative population aged 55 and over and its relative per capita income. (The relative population and per capita income factors were contained in prior law.) But, in order for all States to share in any increased appropriations, the law requires that all States receive a portion of the increase (30 percent of the percentage increase) with the balance distributed according to the population and per capita income factors.

Use of Funds for Enrollee Wages/Fringe Benefits, Administration, and Other Enrollee Costs.—Title V funds are used for (1) enrollee wages and fringe benefits; (2) administration; and (3) other enrollee costs. For many years, DoL regulations required that at least 75 percent of funds be used for enrollee wages and fringe benefits, but this was never specified by law. By law, grantees are allowed to use up to 13.5 percent of Federal funds for administration (and up to 15 percent of Federal funds under a waiver approved by Secretary of DoL). Any remaining funds may be used for “other enrollee costs,” including, for example, recruitment and orientation of enrollees and supportive services for enrollees, among other things.

In its review of the program, 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,” thus increasing the total amount for administration above the statutory limits. During consideration of the reauthorization, some Members of Congress asserted that there should be legislative language clarifying the classification of these activities in order to avoid use of program funds for administration in excess of the statutory limit, as GAO found in the past.

In response to this concern and to clarify the various cost categories, P.L. 106-501 defines administrative costs, and programmatic costs as follows:

**Definition of administrative costs.**—Costs of administration are personnel and non-personnel, and direct and indirect costs, associated with the following:

- accounting, budgeting, financial, and cash management;
- procurement and purchasing;
- property management;
- personnel management;
- payroll;
- coordinating the resolution of audits, reviews, investigations, and incident reports;
- audits;
- general legal services;
- development of systems and procedures, including information systems, required for administration; and
- oversight and monitoring.

Administration also includes goods and services used for administration; travel; and information systems related to administration.

P.L. 106-501 retains the prior law limit on administrative costs, that is, a grantee may use up to 13.5 percent of its funds (with a
waiver up to 15 percent) for administration. The law also requires that, to the maximum extent practicable, Title V grantees provide for payment of administrative expenses from non-Federal sources.

"Programmatic activities."—Funds not used for administration are to be used for programmatic activities. These include primarily enrollee wages and fringe benefits (including physical exams) the law stipulates that no less than 75 percent of grant funds be used to pay wages and fringe benefits. The remainder of funds may be used for:

- enrollee training;
- job placement assistance, including job development and search assistance;
- enrollee supportive services, including transportation, health and medical services, special job-related or personal counseling, incidentals (work shoes, badges, uniforms, eyeglasses and tools); child and adult care, temporary shelter, and follow-up services; and
- outreach, recruitment and selection, intake, orientation, and assessments.

Performance Standards.—One of the areas that was under discussion during the 104th and 105th Congresses was the need to establish performance standards for Title V grantees. This discussion continued during the 106th Congress, and ultimately P.L. 106–501 added new provisions requiring the Secretary of Labor to establish standards and performance indicators, addressing the following areas:

- number of persons served, with particular consideration to individuals with greatest economic or social need, poor employment history or prospects, and those over the age of 60;
- community services provided;
- placement and retention into unsubsidized public or private employment;
- satisfaction of enrollees, employers, and their host agencies with the experiences and services provided; and
- any additional indicators determined appropriation by the Secretary.

The law set up procedures for corrective action if a grantee or a subgrantee of the State does not achieve specified levels of performance. These may include transferring funds from the grantee/subgrantee, under certain circumstances, when a grantee or subgrantee does not meet specified levels of performance.

Negligent or Fraudulent Activities of Project Grantees.—In the past, GAO performed audits of national organizations and found that Title V funds allotted to certain national organizations were used inappropriately. During the 106th Congress, there was concern among some Members of Congress about the findings of an audit of the National Council of Senior Citizens (NCSC) Title V grant by the Inspector General (IG) of DoL. The NCSC is the second largest of the national organization recipients; in FY2000, it received $64.3 million, representing 15 percent of the total Title V appropriation. In February 1999, the IG issued a final audit of NCSC (and its successor grantee, the National Senior Citizens Education and Research Center NSCERC). The audit covered oper-
ations of the grantee for 1992–1994. It questioned more than $6 million of a total of more than $180 million audited.

Partially in response to these audit findings, P.L. 106–501 adds provisions designed to assure that Title V applicants are capable of administering Federal funds. The law adds a set of responsibility tests that applicants must meet in order to receive funds. The following two tests would establish that the applicant is not responsible to administer Federal funds: unsuccessful efforts by the organization to recover debts established by DoL and failure to comply with requirements for debt repayment; and established fraud or criminal activity. Other responsibility tests include the presence of serious administrative deficiencies, willful obstruction of the audit process, and failure to correct deficiencies, among other things.

Coordination of State and National Organization Grantee Operations.—A recurring issue during the review of the program has been concern by some observers about the lack of coordination among project grantees within States, including the distribution of employment positions within States. As mentioned earlier, in some States, seven or eight grantees administer the program along with State agencies.

P.L. 106–501 contains provisions designed to address coordination among the various grantees. It adds new requirements for a State Senior Employment Services Plan. Each Governor is required to submit to the Secretary of DoL an annual plan that will identify the number of persons eligible for the program, and their characteristics and distribution within the State. The plan must also include a description of the planning process used to ensure the participation of relevant agencies and organizations with an interest in employment of older persons, including State and area agencies on aging, national organizations administering the Title V program, and State and local workforce investment boards, among others. The Secretary of DoL is required to monitor State implementation of these requirements to assure that the Statewide planning and coordination of Title V activities are taking place.

Placement of Participants in the Private Sector and in Other Unsubsidized Employment.—The stated purpose of Title V is to place low-income older individuals with poor employment prospects in subsidized employment so that they may increase their income and provide a source of labor to expand community services. While this goal substantially defines the program, in the past legislative provisions have given some attention to placement of participants in unsubsidized employment. For example, amendments to the Act in 1981 required DoL to use some Title V funds for experimental projects designed to place participants in second career training and in private business (Section 502(e) of the Act). In addition, DoL regulations have required that grantees attempt to achieve placement of enrollees in unsubsidized employment. The regulations require that each grantee strive to place at least 20 percent of their authorized positions in unsubsidized employment. Generally, projects have been successful at meeting or exceeding this goal.

P.L. 106–501 further emphasizes the role of the program regarding unsubsidized private placement of enrollees in a number of ways. First, it States that the purpose of Title V includes not only placement of participants in community service activities, but also
placement of participants in the private sector. Second, it increases the amount of funds to be spent by the Secretary on projects to place participants in unsubsidized employment to 1.5 percent of total funds (rather than 1 percent to 3 percent of the amount above the 1978 hold harmless amount required by prior law). Had this been in effect in FY2000, it would have meant for example, that the Secretary would have had to reserve $6.6 million of FY2000 funds ($440.2 million) for Section 502(e) projects, rather than the $2.4 million that was set aside in FY2000.

Third, the law codifies the regulation regarding placement of enrollees into unsubsidized employment. The Secretary is required to establish, as part of the performance measures, a requirement that grantees place at least 20 percent of enrollees into unsubsidized employment. The law defines “placement into public or private unsubsidized employment” as full- or part-time employment in the public or private sector by an enrollee for 30 days within a 90-day period without using a Federal or State subsidy program.

Coordination with the Workforce Investment System.—The Workforce Investment Act (WIA) was enacted in 1998 with the aim of consolidating and coordinating employment and training programs across the Nation. P.L. 106-501 establishes a number of requirements aimed at coordinating the Title V program with the workforce investment system established by WIA. Among other things, it requires that Title V projects participate in one-stop delivery systems in the local workforce investment area established under WIA. It also allows assessments of older individuals for participation in either Title V projects or under WIA (Subtitle B of Title I) to be used for the other program, and deems Title V participants to be eligible under Title I of WIA.

Interstate Funding Formula for Supportive and Nutrition Services

The way in which the Administration on Aging (AoA) distributes nutrition and supportive funds to States continued to be of concern in the 106th Congress, as it was in the 104th and 105th Congresses. In general, prior law required 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 contained a “hold harmless” provision requiring that no State receive less than it received in FY1987. P.L.106-501 changed the requirements regarding the formula distribution.

By way of background, prior to the recent law change, AoA distributed funds for supportive and nutrition services in the following way. First, States were allotted funds in an amount equal to their FY1987 allocations, which were based on estimates of each State’s relative share of the total population age 60 and older in 1985. Second, the balance of the appropriation was 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 were adjusted to assure that the minimum grant requirements are met. The effect of this meth-

---

9There is usually a 2-year time lag in availability of estimates of State population from the U.S. Census Bureau.
odology was that the majority of funds was distributed according to population estimates that do not reflect the most recent population trends. For example, for FY1999, 85 percent of total Title III funds was distributed according to the FY1987 "hold harmless." The remainder of funds appropriated was distributed according to 1997 population data.

The method that AoA used to meet the 1987 "hold harmless" provision has been criticized. In a 1994 report, GAO concluded that Title III funds were not distributed according to the requirements of the statute.\(^{10}\) GAO concluded that the method employed by AoA did not distribute funds proportionately according to States' relative share of the older population, based on the most recent population data and, therefore, negatively affected 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.

P.L. 106–501 followed the GAO recommendation by requiring that funds be distributed according to the most recent data on States' relative share of persons 60 years and older. The law then stipulates that no State would receive less than it received in FY2000, thereby creating a 2000 "hold harmless" requirement. The intent of this approach is to have funding distributed, first, according to the most recent population data (as compared to the prior methodology which distributed the majority of funds to States, first, based on State population data 13 years old), but at the same time assuring that individual State allotments would not go below their FY2000 levels.

If appropriations for Title III services increase over the FY2000 level, the effect of the law will be that States which are gaining a larger share of the total U.S. population over 60 years compared to other States will receive a proportionately larger share of the increased appropriation. However, the 1987 hold harmless would still affect the distribution of funds since the FY2000 hold harmless amount is partially based on the 1987 amount.

Congress also wanted to assure that if there were an increase in appropriations over the FY2000 level, all States will receive a share of the increase. Therefore, the law requires that all States receive a portion of the increase (20 percent of the percentage increase) with the balance distributed according to the population factors.

**Targeting of Services to Low-Income Minority Older Persons**

*Low Income Minority Older Persons.—*Targeting of services to low-income minority older persons continued to be a subject of review during the 106th Congress, as it has during past reauthorizations of the Act. Bills in the 104th and 105th Congresses would have deleted either some or most of current law provisions regarding targeting services to minority older individuals. The deletion of these provisions became quite controversial with some Members of

---

Congress as well as with national aging organizations. Some Members wanted deletion of the targeting provisions to create a level playing field for services among all elderly, but still wanted to keep references to those in greatest social and economic need. Others held that since minority elderly are most disadvantaged with respect to certain need characteristics, such as income, the special targeting provisions should have been maintained.

P.L. 106–501 retained all prior law provisions regarding targeting to low income minority individuals. These include requirements that State and area agencies on aging target services to persons in greatest social and economic need, with particular attention on low-income minority older persons. It requires that States, in developing their intraState funding formulas, take into account the distribution within the State of persons with the greatest economic and social 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.

Older Persons Residing in Rural Areas.—Many advocates maintain that service needs of older persons in rural area are often overlooked. Delivery of social services in rural areas may be particularly difficult due to the lack of service personnel and high transportation costs, among other things. During the 106th Congress some Members of Congress were concerned that the Act did not place enough focus on the needs of older persons living in rural and sparsely populated areas.

In order to respond to this concern, P.L. 106–501 contains a number of new provisions that are designed to recognize the special problems of older persons in rural areas. Among other things, the law requires that in providing services and in developing planning objectives, State and area agencies take into consideration the needs of persons in rural areas. In addition, State agencies are required to consider the needs of rural older persons when developing their intraState funding formulas.

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 long-standing Federal policy, mandatory fees for Older Americans Act services have been prohibited, but nutrition and supportive services providers have always been encouraged solicit voluntary contributions from older persons toward the costs of services. Congress has intended that older persons 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. Prior to the 104th and 105th Congresses, Members resisted proposals to allow Older Americans Act programs to conduct cost-sharing for services.
Since the late 1980's, 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, such as home care and adult day care services. They also have argued that cost-sharing would improve targeting of services if cost-sharing policies were to be applied to persons who have higher incomes while exempting low income persons.

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. They have also argued that cost-sharing would create a welfare stigma for Older Americans Act programs which has not existed because of the absence of "means testing" or cost-sharing policies.

The Clinton Administration's proposed that State agencies be allowed to conduct cost-sharing for certain services, with limitations. It specified that certain services be exempted from cost-sharing policies. The Senate and House proposals differed on cost-sharing. H.R. 782 would have retained the voluntary nature of contributions, but S. 1536 contained elements of the Administration's proposal and added other requirements.

P.L. 106--501 ultimately made a distinction between cost-sharing for certain services and voluntary contributions by older persons. The law contains the following provisions.

**Cost-Sharing.**—The law allows States to implement cost-sharing by recipients for certain services. There are exceptions, however. Cost-sharing is not permitted for the following services: information and assistance, outreach, benefits counseling, case management, ombudsman, elder abuse prevention, legal assistance, consumer protection services, congregate and home-delivered nutrition services, and services delivered through tribal organizations.

States may not apply cost-sharing for services to persons who have low income (defined as income at or below the Federal poverty level) and may not consider assets, savings, or other property owned by individuals when creating a sliding scale for cost sharing, or when seeking contributions. In addition, States may exclude from their cost-sharing policies other low income persons who have income above the poverty level.

Cost-sharing must be applied on a sliding scale, based on income, and the cost of services. Income is to be established by individuals on a confidential self-declaration basis, with no requirement for verification. Service providers and area agencies on aging would be prohibited from denying services to older individuals due to their income or failure to make cost-sharing payments.

The law requires the Secretary to conduct an evaluation of cost-sharing practices that are conducted by States in order to determine the impact of these practices on participation under the Act. The evaluation is to be conducted at least 1 year after enactment, and annually thereafter.

**Voluntary Contributions.**—The law provides that each recipient of services have an opportunity to voluntarily contribute toward the
cost of all services. It stipulates that voluntary contributions must be allowed, and may be solicited, for all services provided under the Act, as long as the method of solicitation is non-coercive. Among other things, older persons may not be denied services if they do not contribute toward the costs of services.

The law requires that both the cost-sharing and the voluntary contributions policies protect the privacy of each recipient of services. State and area agencies must establish appropriate procedures to safeguard and account for cost share payments, and use funds collected through cost sharing to expand services for which payment was made.
## D. OLDER AMERICANS ACT FUNDING - FY 1998- FY 2001

The following table shows funding for Older Americans Act programs for FY1998 through FY2001. The chart shows FY2001 funding.

**Table 1. Older Americans Act and Alzheimer’s Demonstration Program, FY1998-FY2001 Funding, and FY 2002 Request**  
($ in millions)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE II: Administration on Aging</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TITLE III: Grants for State and Community</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programs on Aging</td>
<td>$961.798</td>
<td>952.339</td>
<td>987.617</td>
<td>1,151.285</td>
</tr>
<tr>
<td>Supportive services and centers</td>
<td>309.500</td>
<td>300.192</td>
<td>310.082</td>
<td>325.082</td>
</tr>
<tr>
<td>Family caregivers</td>
<td></td>
<td></td>
<td></td>
<td>125.300</td>
</tr>
<tr>
<td>Nutrition services</td>
<td>626.412</td>
<td>626.261</td>
<td>661.412</td>
<td>680.085</td>
</tr>
<tr>
<td>Congregate meals</td>
<td>(374.412)</td>
<td>(374.261)</td>
<td>(374.336)</td>
<td>(378.412)</td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td>(112.000)</td>
<td>(112.000)</td>
<td>(146.970)</td>
<td>(152.000)</td>
</tr>
<tr>
<td>USDA nutrition services incentive</td>
<td>(140.000)</td>
<td>(140.000)</td>
<td>(140.000)</td>
<td>(149.668)</td>
</tr>
<tr>
<td>In-home services for the frail elderly</td>
<td>9.763</td>
<td>9.763</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>TITLE IV: Training, Research, and Discretionary Projects and Programs</strong></td>
<td>10.000</td>
<td>18.090</td>
<td>31.162</td>
<td>37.678</td>
</tr>
<tr>
<td><strong>TITLE V: Community Service Employment</strong></td>
<td>440.200</td>
<td>440.200</td>
<td>440.200</td>
<td>440.200</td>
</tr>
<tr>
<td><strong>TITLE VI: Grants to Native Americans</strong></td>
<td>18.457</td>
<td>18.457</td>
<td>18.457</td>
<td>23.457</td>
</tr>
<tr>
<td>Long-term care ombudsman program</td>
<td>none</td>
<td>(7.449)</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Elder abuse prevention</td>
<td>none</td>
<td>(4.732)</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Legal assistance a/</td>
<td>none</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>Native Americans elder rights program</td>
<td>none</td>
<td>none</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td><strong>Total - Older Americans Act Programs</strong></td>
<td>$1,445.250</td>
<td>$1,456.569</td>
<td>$1,507.078</td>
<td>$1,684.033</td>
</tr>
<tr>
<td><strong>Alzheimer’s Demonstration Grants b/</strong></td>
<td>5.970</td>
<td>5.970</td>
<td>5.970</td>
<td>8.962</td>
</tr>
</tbody>
</table>

*a/ Formerly elder rights and legal assistance.

b/ 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 authorized under Section 398 of the Public Health Service Act.
Older Americans Act Funding, FY2001

- Community service employment $440.2 mil. (26.1%)
- State & community programs on aging $1.152 bil. (68.4%)
- Ombudsman & elder abuse prevention $14.2 mil. (8.1%)
- Native Americans $23.5 mil.
- ACA $17.2 mil.
- Research, demonstration, & training $37.7 mil. (Total=$1.7 billion)

Total=$1.7 billion
ROLE OF THE OLDER AMERICANS IN LONG-TERM CARE

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 greater than the number provided in community settings under the congregate nutrition program. Congress recognized the growing need for assistance to families caring for older persons in the 2000 amendments when it authorized the National Family Caregiver Support Program.

Another important role the OAA plays in long-term care is through the administration of the long-term care ombudsman program. 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 FY2000, there were 591 local ombudsman programs with 970 paid staff (full-time equivalent). The program relies heavily on volunteers to carry out ombudsman responsibilities about 14,000 volunteers assisted paid staff in FY2000.

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

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 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. Under provisions of the Transportation Equity Act (P.L. 105–178) the amount that States could transfer into the SSBG was to be reduced to 4.25 percent of their annual TANF allotments, beginning in FY2001. However, this provision was superceded in FY2001 by the FY2001 Consolidated Appropriations Act, which maintains the transfer authority at the 10 level. Under current law, the transfer authority is scheduled to decrease to 4.25 percent in FY2002. Legislation proposing to maintain the 10 percent transfer level has been introduced in the 107th Congress. Any of 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 payments to individuals, these transferred funds may be used for vouchers for families who are denied cash assistance because of time limits under TANF; or for children who are denied cash assistance because they were born into families already receiving benefits for another child.

Some of the diverse activities that block grant funds are used for are: child and adult day-care, home-based services for the elderly, protective and emergency services for children and adults, family planning, transportation, staff training, employment services, meal preparation and delivery, and program planning.

(B) COMMUNITY SERVICES BLOCK GRANT

The Community Services Block Grant (CSBG) is the current version of the Community Action Program (CAP), which was the centerpiece of the war on poverty of the 1960's. This program originally was administered by the Office of Economic Opportunity within the Executive Office of the President. In 1975, the Office of Economic Opportunity was renamed the Community Services Administration (CSA) and reestablished as an independent agency of the executive branch.

As the cornerstone of the agency's antipoverty activities, the Community Action Program gave seed grants to local, private non-
profit or public organizations designated as the official antipoverty agency for a community. These community action agencies were directed to provide services and activities “having a measurable and potentially major” impact on the causes of poverty. During the agency’s 17-year history, numerous antipoverty programs were initiated and spun off to other Federal agencies, including Head Start, legal services, low-income energy assistance and weatherization.

Under a mandate to assure greater self-sufficiency for the elderly poor, the CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. Programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at both the State level and the point of delivery.

In 1981, the Reagan Administration proposed elimination of the CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs’ combined spending levels in fiscal year 1981. Although the General Accounting Office and a congressional oversight committee had criticized the agency as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) abolished the CSA as a separate agency, but replaced it with the CSBG to be administered by the newly created Office of Community Services within the Administration for Children and Families, under the Department of Health and Human Services (HHS). Most recently the Coats Human Services Reauthorization Act of 1998 (P.L. 105-285) reauthorized CSBG through FY2003.

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 (including the elderly), to address the needs of youth in low-income neighborhood programs that will support the primary role of the family through after-school child care programs and establishing violence free zones for youth development, 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. States also must provide an assurance that the State and all eligible entities in the State will participate in the Results Oriented Management and Accountability System (ROMA) or another performance measure system. 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. In the 1998 fifty State survey released by the National Association for State Community Services Programs (NASCSP) and funded by HHS, it was reported that the States distributed the CSBG funds to their low-income communities through more than 1,100 local “eligible entities.” Although several types of local entities are eligible to deliver CSBG-funded services, e.g., limited purpose agencies, migrant or seasonal farm worker organizations, local governments or councils of government, and Indian tribes or councils, 85 percent of all local CSBG agencies were Community Action Agencies (CAAs). By statute, CAAs are governed by a tri-partite board consisting of one-third elected public officials and at least one-third representatives of the low-income community, with the balance drawn from private sector leaders, including business, faith-based groups, charities, and civic organizations.

The 1998 fifty State survey also found that in FY1998, the total resources spent by the CSBG network in 49 States were about $6 billion. Of that total, approximately 66 percent came from Federal programs other than CSBG; approximately 13 percent came from the State; 6 percent came from local sources; 8 percent came from private sources; and 7 percent came from CSBG.

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 (18 percent), linkages between and among programs (21 percent), nutrition programs (10 percent), education (10 percent), employment programs (9 percent), income management programs (5 percent), housing initiatives (8 percent), self-sufficiency (12 percent), health (3 percent), and other (4 percent).

2. ISSUES

(A) NEED FOR A PERFORMANCE MEASUREMENT SYSTEM

In the 1998 reauthorization of the CSBG, Congress required that the Department of Health and Human Services work with the States and local entities to facilitate (not establish) a performance measurement system to be used by States and local eligible entities to measure their performance in programs funded through CSBG. This requirement was built on a voluntary performance measurement system called the Results-Oriented Management and Accountability System (ROMA), which was initiated by States and local entities with HHS assistance several years before. ROMA is intended to allow States and local communities to determine their
own priorities and establish performance objectives accordingly. Full participation in such a performance measurement system (either ROMA or an alternative acceptable system) is required not later than FY2001.

To encourage full participation in ROMA the HHS Office of Community Services (OCS) reiterated six national goals for community action that were identified by a CSBG Monitoring and Assessment Task Force (MATF), composed of Federal, State and local network representatives. These goals are intended to respect the diversity of the Community Services Network and provide clear expectations of results: (1) low-income people become more self-sufficient; (2) the conditions in which low-income people live are improved; (3) low-income people own a stake in their community; (4) partnerships among supporters and providers of service to low-income people are achieved; (5) agencies increase their capacity to achieve results; and (6) low-income people, especially vulnerable populations, achieve their potential by strengthening family and other supportive systems. The OCS said that ROMA implementation has been steady, although uneven across the network (In the 1998 National Association for State Community Services Programs survey, it was reported that over 60 percent of the States and more than half of CAAs were actively engaged in ROMA implementation). ROMA data for fiscal year 1997 were reported for the first time last year (2000) as States moved from a service categorization to an outcome orientation. OCS believes that the six national ROMA goals reflect a number of important concepts that transcend CSBG as a standalone program. According to HHS, the goals convey the following unique strengths that the broader concept of community action brings to the Nation's anti-poverty efforts: (1) Focusing our efforts on client/community/organizational change, not particular programs or services. As such, the goals provide a basis for results-oriented, not process-based or program-specific plans, activities and reports; (2) Understanding the interdependence of programs, clients and community. The goals recognize that client improvements aggregate to and reinforce, community improvements, and that strong and well-administered programs underpin both; and (3) Recognizing that CSBG does not succeed as an individual program. The goals presume that community action is most successful when activities supported by a number of funding sources are organized around client and community outcomes, both within an agency and with other service providers.

(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.

In July of 2001, HHS released the annual report on SSBG expenditures and recipients for 1999. This report is based on information submitted by the States to HHS. According to that report, 36 States used SSBG funds to support home-based services (delivered to, but not restricted to, elderly adult recipients), and their combined expenditures for these services reflected approximately 7 percent of all SSBG expenditures made by all 50 States and the District of Columbia. Likewise, 28 States made SSBG expenditures for providing special services for the disabled (which again include, but are not limited to, elderly disabled adults), amounting to 8 percent of all SSBG expenditures made by all States on all services. The HHS analysis highlights four particular services as being a cluster of “Services to Elderly in the Community”: adult day care, adult protective services, congregate meals, and home-delivered meals.
According to the report, in 1999, approximately 752,000 individuals were recipients of at least four of those services.

It seems clear that there is a strong potential for fierce competition among competing recipient groups for SSBG dollars. The service categories receiving the greatest amount of SSBG funds in 1999 were child day care and child foster care. 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. Although some argue that the decrease in SSBG federally appropriated funds has been accompanied by TANF fund transfers into SSBG, advocates of maintaining, if not increasing, SSBG funds emphasize that in the case of an economic downturn, the transfers from TANF may decline, leaving SSBG with the inability to support and provide services at the level States have come to depend. Others contend that regardless of transfers, States can use unspent TANF funds to replace funding used for social services. Title XX advocates counter that many of the services that the SSBG funds or supports are not eligible activities under TANF, particularly adult protection and in-home services for the elderly. Legislation to restore the SSBG authorized ceiling to its 1996 level of $2.38 billion has been introduced in the 107th Congress, but has not been approved. Likewise, bills proposing to maintain the transfer authority from TANF to SSBG at 10 percent have been introduced, but not as yet acted upon, for FY2002.

(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. Although 31 States provided information concerning outcome measures and/or ROMA implementation, detailed information concerning support services for the elderly is not readily available at this stage of reporting and assessing results.

The report by NASCSP on State use of fiscal year 1998 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 21 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 18 percent of CSBG expenditures in fiscal year 1998; 8 percent of CSBG clients in FY1998 were older than 70. The same 50 State survey reported
that the number of families who were still active in the labor force at the time they came to CAA for support, was nearly the same as those who were retired.

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 FY2000, the appropriation dropped further, to $1.775 billion, and in FY2001, the year in which transportation legislation enacted in 1998 (P.L. 105–178) scheduled a reduction in the entitlement ceiling to $1.7 billion, Congress actually exceeded the ceiling by funding the SSBG at $1.725 billion.

(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 facilities, community food and nutrition programs and the national youth sports program. Two additional programs, although not authorized by the CSBG Act, are administered by OCS together with these CSBG related discretionary programs. They are job opportunities for low-income individuals (JOLI) and the assets for independence program which will enable low-income individuals to accumulate assets in individual development accounts.

In fiscal year 2001, appropriations are as follows: $600 million for the CSBG; $24.5 million for community economic development; $5.5 million for job opportunities for low-income individuals (JOLI); $5.3 million for rural community facilities; $16 million for national youth sports; $6.3 million for community food and nutrition and $25 million for 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 the quality of programs, and to address selected national education priorities.

While several 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 education have been directed primarily at the establishment and maintenance of programs for children and college age students. This is due largely to the perception that education is a foundation constructed in the early stages of human development.

Although learning continues throughout one's life in experiences with work, family, and friends, formal education has traditionally been viewed as a finite activity extending only through early adulthood. Thus, it is a relatively new notion that the elderly have a need for formal education extending beyond the informal, experiential environment. This need for structured learning may appeal to "returning students" who have not completed their formal education, workers of any age 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 literacy have proliferated. These definitions have become more complex as the technological information needs of the economy and society have increased. For example, the National Literacy Act of 1991 defined literacy as "an individ-
ual’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, defined 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 survey tested adults in three different literacy skill areas: prose, document, and quantitative. It found that adults performing at the lowest literacy levels in these areas 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 underscored the strong connection between low literacy skills and low economic status. The U.S. Department of Education will undertake another national literacy survey in 2002 to determine what changes have occurred in the Nation’s literacy ability level during the past 10 years.

Statistics on educational attainment reveal cause for concern. According to the Statistical Abstract of the U.S., 2000, 174 million American adults were 25 years old and over in 1999; of these, 16.6 percent (29 million) never graduated from high school (Statistical Abstract of the U.S., 2000, Table 251). As might be expected, there is a concentration of older persons among this group of adults. According to the Statistical Abstract, in contrast to the 16.6 percent rate of non-completion of high school for all adults 25 years old and over, almost twice that proportion, 32.0 percent, of those 65 years old and over did not graduate from high school, and among those 75 years old and over, 37.3 percent did not graduate. The use of these data to estimate functional literacy rates has the drawback, however, that the number of grades completed does not necessarily correspond to the actual level of skills of adult individuals.

2. PROGRAM DESCRIPTION

The Adult Education and Family Literacy Act (AEFLA) is the primary Federal adult education program. The AEFLA was authorized as Title II of the Workforce Investment Act of 1998 (WIA), P.L. 105-220. Under the AEFLA, the U.S. Department of Education makes grants to assist states and localities provide adult education and family literacy programs. Approximately 5 million adults currently participate in these programs on an annual basis. The FY2001 appropriation for AEFLA programs is $561 million, representing a substantial increase above the FY2000 amount of $470 million.

Compared to previous Federal adult education programs, the AEFLA significantly augmented requirements for the implementation of a performance accountability system. This system is being implemented 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.

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 literacy and basic education skills, adult secondary education and high school equivalency; English-as-a-second-language; educational skills needed to obtain or retain employment; 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 under the AEFLA State Grants program. Most states spend more than the minimum, and many spend significantly more. For FY1998, the total of Federal, state, and local expenditures related to adult education was an estimated $1.3 billion. Of this amount, states and localities contributed an estimated $958 million, or 74 percent of adult education expenditures from all sources.

In the latest year for which detailed 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 Education and Literacy at the U.S. Department of Education has estimated the target population for AEFLA programs to be more than 44 million adults, or nearly 27 percent of the adult population. 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 106TH CONGRESS

The Workforce Investment Act of 1998 (P.L. 105–220), including the AEFLA under Title II, was enacted by the 105th Congress. In comparison, the 106th Congress enacted relatively little with regard to adult education and literacy. The AEFLA is authorized through FY2003, so congressional attention may not give a comprehensive look in that direction for another year or more.

As already noted, the 106th Congress funded adult education and literacy programs at a level of $561 million for FY2001 under the provisions of P.L. 106–554, the Consolidated Appropriations Act, 2001, which is an increase over the FY2000 appropriation of $470 million. The FY2001 appropriation continues a practice begun in FY2000 by reserving adult education funds for English literacy and civics education services for new immigrants and other limited English speaking populations. The FY2001 reserve of $70 million will assist communities with concentrations of recent immigrants by helping such persons learn English literacy skills, obtain knowledge about the rights and responsibilities of citizenship, and acquire key skills necessary to deal with the government, public schools, health services, the workplace, and other institutions of American life.
C. DOMESTIC VOLUNTEER SERVICE ACT

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 is 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), and 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 on 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 non-profit 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 they do under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses, such as transportation costs.
In FY1999, 485,000 volunteers served in 764 projects. Roughly 89 percent were white, 8 percent were African American, and 3 percent were Asian/Pacific Islanders or American Indian/Alaskan Natives. Persons of Hispanic ethnicity of any racial group accounted for 4 percent of the volunteers. Persons under the age of 65 accounted for 15 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 FY2001 $48.9 million was appropriated.

(2) Foster Grandparent Program (FGP)

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 foster grandparents who served in the 12 months ending June 30, 1999 was 28,700, of which roughly 56 percent were white, 38 percent were African American, and 6 percent were Asian/Pacific Islanders or American Indian/Alaskan Natives. Persons of Hispanic ethnicity of any racial group accounted for 9 percent of the volunteers. Persons under the age of 65 accounted for 15 percent of the volunteers, those between 65 and 84 accounted for 79 percent, and those 85 and older accounted for 5 percent. Women made up 90 percent of the volunteers. For FY2001, $98.9 million was appropriated.

Of the over 230,000 children served by the foster grandparents for FY1999, 40 percent were 5 years of age or under, 45 percent were between 6 and 12 years of age, and 14 percent were 13 and older. Of the children served, 63 percent had one of five special needs. The special needs areas were learning disabilities (25 per-
cent), abused/neglected (12 percent), developmentally delayed/disabled (10 percent), emotionally impaired/autistic (8 percent), and significantly medically impaired (8 percent).

(3) Senior Companion Program (SCP)

The Senior Companion Program (SCP) was authorized in 1973 by P.L. 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.

In FY1999, the number of individuals who served as senior companions was 14,700. Roughly 60 percent were white, 33 percent were African American, 5 percent were Asian/Hawaiian/Pacific Islander, and 2 percent were American Indian/Alaskan Natives. Hispanic of any race made up 11 percent of the senior companions. Persons between the age of 60 and 74 accounted for 67 percent of the volunteers, those between 75 and 84 accounted for 28 percent, and those 85 and older accounted for 5 percent. Women made up 85 percent of the volunteers. For FY2001 $40.4 million was appropriated.

Of the nearly 62,000 adults served by the senior companions in FY1999, 13 percent were between 22 and 64 years of age, 22 percent were between 65 and 74, 36 percent were between 75 and 84, and 30 percent were 85 and older. Nearly half of the clients were frail elderly and nearly 10 percent had Alzheimer's disease.

(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 of approximately $8,730, and either a lump sum stipend that accrues at the rate of $100 for each month of service, or the educational award under the National Service Trust. In FY1999, 55 percent of participants completing their VISTA service chose the educational award. Participants 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 participants serving somewhere other than in their own community.

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 of at least 900 hours. An individual can earn 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.

In program year 1998–1999, 4,563 participants completed VISTA service. Based on a random sample of program year 1998–1999 participants, 60 percent were white, 26 percent were African-American, 11 percent were Hispanic, 2 percent were Asian, and 1 percent were American Indian. Women made up 80 percent of the volunteers. By statute, the Corporation is required to encourage participation of those 18 through 27 years of age and those 55 and older. In program year 1998–1999, approximately 39 percent were 18 through 25 years of age; 22 percent of the participants were 55 and older. For FY2001, $83.1 million was appropriated.

D. TRANSPORTATION

1. BACKGROUND

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. It is a vital connecting link between home and community. For the elderly and non-elderly alike, adequate transportation is essential 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 they are accessible to those who need them.
Three strategies have shaped 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 Transportation Act (UMTA 1964) 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 declared 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 stated 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 1964 to provide block grants for mass transit funding in urban and nonurban areas nationwide. Under this program, block grant money could be used for capital or operating expenses at the localities' discretion. The Act also required 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 1964 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. Elderly people 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 appropriations have increased significantly over time, from approximately $65 to $75 million in the period 1979–1991, to an average of around $120 million for 1992–1998, to an average of almost $200 million for 1999–2001. The STAA of 1982 (P.L. 97–424) established Section 5307 in its amendments to the UMTA Act. Section 5307 provides general as-
sistance to urbanized areas, 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, States 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 nationwide 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 year 2000, $22.4 million of flexible highway funds was transferred to Section 5311.

The Rural Transit Assistance Program (RTAP), created in 1987 by Congress (P.L. 100–17), provides 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 transportation systems to meet their individual needs. In the future, the increasing need for specialized services for the growing population of elderly persons will challenge State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

The reauthorization of the STAA (the Intermodal Surface Transportation Efficiency Act of 1991 [ISTEA]; P.L. 102–240) in 1991 provided a number of important changes for the elderly and disabled. Key provisions of ISTEA (which renamed UMTA to the Federal Transit Administration [FTA]) included: (1) Allowing para-transit agencies to apply for Section 3 (the Capital Funding Program, 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 and purchase of buses and related equipment, and construction of bus-related facilities; and (3) allowing transit service providers receiving assistance under Section 5310 (Elderly and Persons with Disabilities Program) or Section 5311 (Non-Urbanized Area Program) to use vehicles for meal delivery service for homebound persons if meal delivery services did not conflict with the provision of transit services or result in the reduction of services to transit passengers.

ISTEA also 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, TCRP has resulted in the publication of over 150 reports on a variety of topics, including Americans with Disabilities Act transit service, delivery systems for rural transit, and demand forecasting for rural transit.

ISTEA also provided a substantial increase in funding for programs benefiting elderly and disabled persons. Section 5310 funding rose from $35 million in FY1991 to $56 million in FY1997; Section 5311 funding rose from $70 million in FY1991 to $120 million in FY1997.

The Omnibus Transportation Employee Testing Act of 1991 gave the Federal Transit Administration (FTA) the statutory authority to impose testing as a condition of financial assistance. FTA can also require 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 to develop a national data base of experience with drug and alcohol testing.

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. Annual appropriations for Section 5310 have risen from $56 million in FY1997 to $77 million in FY2001; for Section 5311, appropriations have risen from $120 million in FY1997 to $210 million in FY2001. 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, transportation is considered a priority service and is among the most frequently provided services funded through the supportive services and centers program. In Fy1998, the program provided 46 million one-way trips.
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 incomes of the rural elderly generally are insufficient to afford the high fares necessary to support a rural transit system. Third, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of operators willing to transport the rural elderly. Fourth, the physical design and service 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 transporting seniors to other 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 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 an 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 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 populations make transit systems practical, the sprawling low-density geography of suburbs makes developing and operating mass transportation systems prohibitively expensive. Private taxi companies, if they operate in the outlying suburban areas at all, are often very expensive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has significantly affected 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 to support suburb-wide services, and are generally viewed as penalizing the low-income elderly most in need of transportation services in the community.

The aging of the suburbs, therefore, 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, should be designed with supportive transportation services in mind. In addition, service providers should assist in coordinating transportation services for their elderly clients. Primary transportation systems, or mass transit, should ensure accessibility from all perimeters of the suburban community to adequately serve the dispersed elderly population. All too often, public transit primarily serves the needs of working-age commuters. If accessibility for the entire community is not possible, then service route models should be considered. Service routes use smaller buses and follow fixed-routes that connect concentrations of elderly residents to the services that they need to access to maintain their independence.

Challenges Associated With Some Older Drivers.—Americans like to drive, and our automobiles have become much more than a means of transportation they have become a reflection of our personalities and a status symbol. Moreover, either the shortage of, distance to, or costs of other transportation services frequently means that not being able to drive greatly limits one’s access to the community. Particularly for older persons, the automobile is often a symbol of independence and dignity. Thus, many older Americans will continue depending on the automobile for their basic means of transportation because of their need for mobility, the availability and ease of using the modern highway system, or the lack of other acceptable choices.

In the United States, there were 18.5 million older drivers (70 years and above) in 1999. These drivers constitute about 10 percent of all drivers. In 1999 there were 56,352 drivers involved in fatal crashes of which 8.8 percent were age 70 or older, and there were 25,210 drivers killed in crashes, of which 13.1 percent were in the same age category. Because older persons constitute an ever growing segment of the driving public, risks to highway safety could likewise increase as U.S. population demographics change. DOT reports that currently there are 35 million Americans 65 years old or older, by 2020 there could be 53 million such older persons, and by 2030, one in five Americans could be 65 years old or older. The largest increase in this population group could come around the year 2010, when large numbers of baby boomers reach retirement age. Based on these statistics and projected population break-
downs, the number of older persons killed in auto crashes could increase threefold by 2030.

There is substantial controversy regarding the safety of older drivers. Some claim that older drivers are unsafe and for that reason, more of them die in auto accidents. They cite newspaper stories about older drivers getting lost on the highways, driving on sidewalks, striking pedestrians at intersections, and driving in oncoming traffic lanes. In fact, some statistics suggest that older drivers have higher rates of fatal crashes than any other age group other than young drivers. Data indicate that:

- Drivers aged 70 and older have more motor vehicle deaths per 100,000 people than other groups except people younger than 25;
- Drivers 75 years and older have higher rates of fatal motor vehicle crashes per mile driven than drivers in other age groups except teenagers; and
- Per licensed driver, fatal crash rates rise sharply at age 70 and older.

It does not follow, however, that because a higher percentage of elderly die in traffic crashes, that the elderly actually cause a greater number of such crashes. Some statistics suggest that the elderly, as a group, are safe drivers. They have fewer crashes per 100,000 licensed drivers, have the lowest rate of alcohol involvement, and have the highest level of restraint use among various age groups. According to DOT's Traffic Safety Facts: 1999, "Older drivers involved in fatal crashes had the lowest proportion of intoxication with blood alcohol concentrations (BAC) of 0.10 grams per deciliter (g/dl) or greater of all adult drivers. Fatally injured older pedestrians also had the lowest intoxication rate of all adult pedestrian fatalities." Older drivers may also travel at times other than peak traffic hours and opt for less hazardous routes in running their errands. Because older people, be they drivers, occupants, or pedestrians, are more physically fragile than younger people, they often die in traffic accidents that younger people survive, in spite of their positive driving habits. For example, when they are involved in crashes, occupants over 80 years old are more than four times more likely to die than persons under 60 years old. Over the past 10 years, traffic fatalities among the elderly have grown. In 1999 (according to the Department of Transportation's Traffic Safety Facts: 1999), the fatality rate for drivers 85 and over rose to over 9 times the rate for drivers 25 through 69.

Many of the crashes involving the elderly may be due to their inability to make quick decisions, or to react to rapidly changing traffic conditions. The driving instincts and experience of some older drivers may be compromised by declining motor skills or cognitive ability. Crash causation factors involve reduced eye, hand, and foot coordination, the reflexes most likely to be impaired with aging. Furthermore, mixing older, drivers with younger, more impetuous drivers, could trigger incidents of road rage, a further risk to the elderly. While medical problems may affect drivers in any age category, there appear to be certain maladies associated with aging that could, in turn, potentially compromise the ability of the elderly to drive safely. Included among these are a decline in peripheral vision and nighttime acuity, difficulties with glare, and problems
when focusing on close objects. Also, advanced age brings increased incidence of cataracts, dementia, cardiovascular disease, diabetes, stroke, episodes of loss of consciousness, Parkinson's disease, glaucoma, arthritis, and bursitis. Any, or a combination of these, could reduce or impair driving ability. Although the literature suggests that these factors show little relationship to crash involvement, these impairments are predictive of the discontinuing of driving and decreased mobility. Ironically, some of the medicines prescribed to alleviate these maladies could also negatively impact the ability of the elderly to drive or react to traffic situations.

On the other hand, there are medical, technological, and social factors that are increasing the ability of some older Americans to continue to drive, and societal factors that decrease the need for the elderly to drive. These include:

• longer life spans with associated better health, improved medical technologies reducing the incidence of age-related disabilities;
• 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 onsite services; and
• a willingness of many elder drivers to recognize their risks and medical limitations, and voluntarily "turn in" their keys, or to engage in safer driving habits, such as driving at other than peak traffic hours or only in the daytime.

Numerous programs to identify and address the problems of elderly drivers have been initiated by both the Federal and state governments. For example, during the last 5 years or so, the National Highway Traffic Safety Administration (NHTSA) of the U.S. Department of Transportation (DOT) has invested roughly $500,000 to $600,000 per year into a research program pertaining to the older driver. The agency has studied some of the medical problems associated with older drivers and expects to use its National Driving Simulator to replicate the most hazardous situations for elders. NHTSA has sponsored studies that characterize or assess the older driver problem, supported pilot tests involving state licensing agents and other professionals seeking innovative ways to deal with the older driver challenge, and worked with the medical and licensing community to improve licensing standards. The Federal Highway Administration of DOT has also sponsored research to improve highway signage, specifically with the older driver in mind. There is also a diversity of state activities pertaining to the older driver. Some states require more frequent testing of the skills and abilities of elders behind the wheel; some provide refresher courses for any drivers receiving citations; while some require re-examination every 2 years and 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 analyzed crash 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. The
American Association for Retired Persons (AARP) has addressed problems experienced by some older drivers. Since 1979, AARP has sponsored a course entitled “55 Alive: A Mature Driving Program.” The course provides 8-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.

Additional information on these research and educational activities can be obtained at following Internet Web sites, maintained by:
American Association of Retired Persons <http://www.aarp.org/>
Insurance Institute for Highway Safety <http://www.iihs.org/>

Concerns associated with some elder drivers are actually components of a larger issue: promoting mobility for an aging population. Addressing this challenge may require the development of both short-term and long-term strategies. A short-term approach could identify those changes that can be made quickly and without extensive disruption to existing transportation infrastructure. These strategies might include:

- assessing key medical problems and conducting rehabilitation of older drivers;
- providing relevant medical information to licensing bureaus;
- requiring that driver licensing include tests for hand, foot, and visual capabilities (including useful field of view);
- developing graduated licensing programs that often reduce risks by limiting driving (similar to those now applied to new drivers);
- offering insurance incentives (similar to those provided in the AARP program) to encourage elders to self assess their driving habits, capabilities, and difficulties, and to refresh their knowledge of traffic laws and improve their driving skills;
- changing the characteristics of traffic lights and road signs (longer caution lights at intersections and larger letters on traffic signs); and
- promoting the deployment of tested automotive technologies such as “night vision” to increase the time available to react to rapidly changing traffic situations in poor light.

Over the long-term, Federal and state transportation authorities as well as the automobile industry may need to refocus their activities to better meet the needs of older drivers. Approaches could include:

- tightening medical standards for driver licensing;
- developing and testing of model license renewal processes that would assist many state agencies facing difficult decisions regarding the renewal, suspension, or revocation of licenses of older drivers. Such processes could include the development of improved screening, diagnostic or assessment capabilities as well as driver rehabilitation programs;
- developing and deploying vehicles equipped with intelligent transportation systems (ITS) designed to reduce the specific medical challenges facing many older drivers;
• accelerating construction of more mass transit systems throughout the United States;
• advancing research to find better ways to protect vehicle occupants and to compensate for the fragility of older populations;
• redesigning or improving the design of intersections, where older drivers have a higher percentage of their crashes, to reduce crash frequency; and
• providing financial incentives (such as tax credits or lower fares) for using mass transit and improving the accessibility and reliability of transit systems to reduce the need for many older Americans to drive.

E. LEGAL SERVICES

1. BACKGROUND

(A) THE LEGAL SERVICES CORPORATION

Legislation establishing the Legal Services Corporation (LSC) was enacted in 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. Because litigation initiated by legal services attorneys often involves local and State governments or controversial social issues, legal services programs can be subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, the Nixon Administration developed legislation creating a separate, independently housed corporation.

The LSC was then established as a private, nonprofit corporation headed by an 11 member board of directors, nominated by the President and confirmed by the Senate. No more than 6 of the 11 board members, as directed in the Corporation's incorporating legislation, may be members of the same political party as the President. The Corporation does not provide legal services directly. Rather, it funds local legal aid programs which are referred to by LSC as “grantees.” Each local legal service program is headed by a board of directors, of whom about 60 percent are lawyers admitted to a State bar. In 2000, LSC funded 207 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.
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 2001 (P.L. 106-553), 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 non federal funds may be used to represent aliens who have been victims of domestic violence or child abuse; conduct advocacy training 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 efforts to reform a Federal or state welfare system; 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.

With respect to restrictions related to welfare reform, the reader should note that on February 28, 2001, the Supreme Court held in the case of Legal Services Corporation v. Velazquez, 121 S. Ct. 1043 (2001), that an LSC funding restriction related to welfare reform violates the First Amendment (i.e., freedom of speech) rights of LSC grantees and their clients and is thereby unconstitutional. The Supreme Court agreed with the Second Circuit Court's ruling that, by prohibiting LSC-funded attorneys from litigating cases that challenge existing welfare statutes or regulations, Congress had improperly prohibited lawyers from presenting certain arguments to the courts, which had the effect of distorting the legal system and altering the traditional role of lawyers as advocates for their clients.

Grantees also are required to maintain timekeeping records and account for any non federal funds received. The appropriations law contains extensive audit provisions. The Corporation is prohibited from receiving non federal 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 serv-
Ice 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 FY1999, a very small amount (0.4 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 example, many elderly persons rely on the Social Security program for income security and on the Medicare and Medicaid programs to meet their health care needs. These benefit programs are extremely complicated and often difficult to understand.

In addition to problems with government benefits, older persons' legal problems typically include consumer fraud, property tax exemptions, special property tax assessments, evictions, foreclosures, custody of grandchildren, 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.

In 2000, legal services attorneys closed about one million cases. 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 10 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 one 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. President Bush's nominations for the 11 members to succeed the longest-serving Board of Directors in LCS history are not expected for several months.

(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.

In FY1996, Congress funded the LSC at $278 million, a reduction of almost 31 percent from the previous year. In its FY1996 budget resolution, the House assumed a 3-year phase-out of the LSC, recommending appropriations of $278 million in FY1996, $141 million in FY1997, and elimination by FY1998. The House Budget Committee stated in its report (H.Rept. 104-120), "Too often, . . . lawyers funded through Federal LSC grants have focused on political causes and class action lawsuits rather than helping poor Americans solve their legal problems. . . . A phaseout of Federal funding for the LSC will not eliminate free legal aid to the poor. State and local governments, bar associations, and other organizations already provide substantial legal aid to the poor." The $278 million appropriation for the LSC in FY1996 provided funding for basic field programs and audits, the LSC inspector general, and administration and management. However, funding was eliminated entirely for supplemental legal assistance programs, including Native American and migrant farmworker support, national and state support centers, regional training centers, and other national activi-
ties. The 1996 appropriation also added more restrictions on the activities of LSC attorneys.

For FY2001, the Clinton Administration requested $340 million for the LSC. The Clinton Administration had requested $340 million every year since FY1997, in an effort to partially restore cutbacks in funding. The proposal would have continued all existing restrictions on LSC-funded activities. The conference report on H.R. 4942 (H.Rept. 106–1005), the FY2001 District of Columbia appropriations, which includes the FY2001 Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies appropriations, provided $330 million for LSC for FY2001. This is $25 million higher than the FY2000 LSC appropriation and $10 million lower than the Clinton Administration’s request. The $330 million appropriation for LSC includes $310 million for basic field programs and independent audits, $10.8 million for management and administration, $2.2 million for the inspector general, and $7 million for client self-help and information technology. H.R. 4942 was signed by President Clinton on December 21, 2000 as P.L. 106–553. The reader should note that P.L. 106–554 mandated a 0.22 percent governmentwide rescission of discretionary budget authority for FY2001 for almost all government agencies. Thus, the $330 million appropriation for LSC for FY2001 has been reduced to $329.3 million. Current funding still remains below the Corporation’s highest level of $400 million in FY1994 and FY1995.

The language accompanying the President Bush’s FY2002 budget affirms the President Bush’s support for the LSC. It states: “The Federal Government, through LSC, ensures equal access to our Nation’s legal system by providing funding for civil legal assistance to low-income persons. For millions of Americans, LSC-funded legal services is the only resource available to access the justice system. LSC provides direct grants to independent local legal services programs chosen through a system of competition. LSC programs serve clients in every State and county in the Nation. Last year, LSC-funded programs provided legal assistance and information to almost one million clients.” For FY2002, the Bush Administration has requested the current level funding of $329.3 million for the LSC.

(B) ACTIVITIES OF THE PRIVATE BAR

To counter the effects of cuts in Federal legal services and to ease the pressure on overburdened legal services agencies, some law firms and corporate legal departments began to devote more of their time to the poor on a pro bono basis. Such programs are in conformity with the lawyer’s code of professional responsibility which requires every lawyer to support the provisions of legal services to the disadvantaged. Although pro bono programs are gaining momentum, there is no precise way to determine the number of lawyers actually involved in the volunteer work, the number of hours donated, and the number of clients served. Most lawyers for the poor say that these efforts are not yet enough to fill the gap and that a more intensive organized effort is needed to motivate and find volunteer attorneys.

A relatively recent development in the delivery of legal services by the private bar has been the introduction of the Interest on
Lawyers’ Trust Accounts (IOLTA) program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts is then channeled to federally funded, bar affiliated, and private and nonprofit legal services providers. IOLTA programs have grown rapidly. There was one operational program in 1983. Today all 50 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 $69 million in 1999, 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; simplification of administrative procedures affecting the elderly; long-term care; Social Security; and housing. In addition, since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The Commission on Legal Problems of the Elderly has undertaken many activities to promote the development of legal resources for older persons and to involve the private bar in responding to the needs of the aged. One such activity was a national bar activation project, which provided technical assistance to State and
local bar associations, law firms, corporate counsel, legal service projects, the aging network, and others in developing projects for older persons.

The private bar has also responded to the needs of elderly persons in new ways on the State and local levels. A number of State and local bar association committees on the elderly have been formed. Their activities range from legislative advocacy on behalf of seniors and sponsoring pro bono legal services for elderly people to providing community legal education for seniors. Other State and local projects utilize private attorneys to represent elderly clients on a reduced fee or pro bono basis. In more than 38 States, handbooks that detail seniors' legal rights have been produced either by State and area agencies on aging, legal services offices, or bar committees. In addition, some bar associations sponsor telephone legal advice lines. Since 1982, attorneys in more than half the States have had an opportunity to attend continuing legal education seminars regarding issues affecting elderly people. The emergence of training options for attorneys that focus on financial planning for disability and long-term care are particularly noteworthy.

In 1987, the Academy of Elder Law Attorneys was formed. The purpose of this organization is to assist attorneys advising elderly clients, to promote high technical and ethical standards, and to develop awareness of issues affecting the elderly.

A few corporate law departments also have begun to provide legal assistance to the elderly. For example, Aetna Life and Casualty developed a pro bono legal assistance to the elderly program in 1981 through which its attorneys are granted up to 4 hours a week of time to provide legal help for eligible older persons. The Ford Motor Company Office of the General Counsel also began a project in 1986 to provide pro bono representation to clients referred by the Detroit Senior Citizens Legal Aid Project.

As recognized by the American Bar Association, private bar efforts alone fall far short in providing for the legal needs of older Americans. The ABA has consistently maintained that the most effective approach for providing adequate legal representation and advice to needy older persons is through the combined efforts of a continuing Legal Services Corporation, an effective Older Americans Act program, and the private bar. With increased emphasis on private bar involvement, and with the necessity of leveraging resources, the opportunity to design more comprehensive legal services programs for the elderly exists.
CHAPTER 16
CRIME AND THE ELDERLY

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 1980's. According to the 1999 Uniform Crime Reports (UCR), in the United States there is one violent crime every 22 seconds, one murder every 34 minutes, one forcible rape every 6 minutes, one robbery every minute, and one aggravated assault every 34 seconds.

According to research done by the American Association for Retired Persons (AARP), "one-third of persons age 50 and older avoid going out at night because they are concerned about crime." 1 A recent poll released on June 7, 2001, shows that older Americans continue to fear criminal victimization. According to an ABC News/Washington Post poll, the elderly (and women) continue to perceive crime as an important problem. 2

The Federal Bureau of Investigations preliminary 2000 UCR figures, released on May 30, 2000, suggest that the fears of many of these Americans may be exaggerated. According to the FBI's press release, "Crime Index Trends, 2000 Preliminary Figures," the crime index 3 did not yield a significant change from the 1999 figures. The 1999 Crime Index total saw its greatest decline since 1978, 6.8 percent. 4 The 2000 findings of the Bureau of Justice Statistics' National Crime Victimization Survey (NCVS) showed a decline in the violent crime rate by 15 percent and the property crime rate by 10 percent. In August 2000, the Bureau of Justice Statistics released a report, Criminal Victimization 1999, Changes 1998–99 with Trends 1993–99. According to the report, "in 1999, the rate of violent crime victimization of persons ages 65 or older was 4 per 1,000" and in 2000 the rate was 3.7 per 1,000. In addition to the continued decline in the crime rate, statistics show that the elderly, in comparison to younger Americans, are less likely to experience a violent crime. 5

---

3 The FBI's Uniform Crime Report's crime index is composed of violent crimes (murder, non-negligent manslaughter, forcible rape, robbery, and aggravated assault) as well as property crimes (burglary, larceny-theft, motor vehicle theft, and arson).
4 According to the FBI's Crime in the United States, 1999 Uniform Crime Reports, "This total (6.8 percent) represented the eighth consecutive annual decline in the Crime Index." See: [http://www.fbi.gov/pressrel/pressrel01/ucrprelim2000.htm], p. 6.
5 According to the Bureau of Justice Statistics, Victim Characteristics:

In 2000 persons age 12 to 24 sustained violent victimization at rates higher than individuals of all other ages.
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.

2. LEGISLATIVE RESPONSE

Congress has expressed concern regarding the criminal victimization of elderly citizens. On October 28, 2000, for example, the Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386) was signed into law. Section 1209 of the Act amends the Violence Against Women Act by adding a new Subtitle H (Elder Abuse, Neglect, and Exploitation, Including Domestic Violence and Sexual Assault Against Older or Disabled Individuals). The Act directs the Attorney General to award grants for training programs that would assist the law enforcement community in recognizing and addressing instances of elder abuse, neglect, exploitation, and violence against individuals with disabilities as well as instances of domestic violence and sexual assault against the elderly and individuals with disabilities. Although the Act authorized appropriations for the grants, Congress did not appropriate funding for FY2001. President Bush, however, requested $5 million for FY2002.

A. 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. A groundbreaking study, completed by the NCEA in 1998, assessed the incidence of elder abuse nationwide. The

Elderly persons (age 65 or older) were victims of an annual average 46,000 purse snatchings or pocket pickings, 166,000 nonlethal violent crimes (rape, sexual assault, robbery, aggravated and simple assault), and 1,000 murders between 1992–97. Robbery accounted for a quarter of the violent crimes against persons age 65 or older, but less than an eighth of the violent crimes experienced by those age 12–64 between 1992–97. For further information, see: [http://www.ojp.usdoj.gov/bjs/cvict-v.htm].
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).

This study found that over 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 fives 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.

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.

B. CONSUMER FRAUDS AND DECEPTIONS

1. BACKGROUND

An AARP report entitled “Beyond 50 A Report to the Nation on Economic Security” found that incomes and asset levels among retirees (over the age of 50) have steadily risen over the past 20 years. The same study reported that per capita net worth of the over-50 age category increased 36 percent between 1983 and
This fact contributes to making the elderly prime targets of consumer frauds and deceptions. 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.

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. According to an AARP fact sheet, “there are approximately 140,000 telemarketing firms in the country [and] up to 10 percent, or 14,000 may be fraudulent.”7 Telemarketers prey on the repeated victimization of the elderly. According to a 1999 survey done by AARP, “...older consumers are especially vulnerable to telemarketing fraud. Of the people identified by the survey who had suffered a telemarketing fraud, 56 percent were age fifty or older.”8 In one case, the FBI reported a fraudulent telemarketing scam wherein nearly 80 percent of the calls were directed to older consumers.9

One scheme frequently used by fraudulent marketers is the so-called “sweepstakes” or “free giveaways” scheme. According to the National Consumer League’s (NCC) National Fraud Information Center (NFIC), “sweepstakes were the No. 1 form of telemarketing consumer fraud reported in 1995, 1996 and 1997.”10 Senator Thad Cochran, in his opening remarks during a September 1998 hearing reported that 52 percent of the complaints received by the Federal Trade Commission are related to sweepstakes, and over $40 billion is lost to consumers annually as a result of telemarketing and sweepstakes scams.11

2. LEGISLATIVE RESPONSE

On August 10, 2000, Congress held a hearing that examined how seniors are victimized by fraudulent activities.12 Several senior citizens testified during the hearing on how they had been victimized by fraudulent acts. Law enforcement officials as well as service providers from several states provided testimony on their respective state laws and programs that attempt to address fraudulent activities directed to the elderly.

The Protecting Seniors From Fraud Act (P.L. 106–534) was enacted on November 22, 2000. The Act authorized appropriations for FY2001 through FY2005 for TRIAD programs. The Act requires the Secretary of Health and Human Services to disseminate information designed to educate senior citizens and raise awareness about the dangers of fraud. Additionally, the Act directs the Attorney General of the United States to provide programs and services to senior citizens and their families.13

---

7 See: [http://www.aarp.org/fraud/1fraud.htm].
9 See: [http://www.aarp.org/fraud/1fraud.htm].
General to conduct a study that would provide assistance in developing new crime prevention strategies (pertaining to crimes against seniors) and to include statistics in the National Crime Victimization Survey on crimes that impact seniors.

The Honesty in Sweepstakes Act of 1998 (P.L. 106-118) became law on December 12, 1999. Title I of the Act (Deceptive Mail Prevention and Enforcement) curtails the “you’re a winner” language found in many sweepstakes. The law imposes harsh fines on sweepstakes companies that violate the law and gives the U.S. Postal Inspection Service authority to stop illegal mailings. Additionally, Title I of the law amends Chapter 30 of Title 39, United States Code, by strengthening the current prohibition against mail solicitations by a nongovernmental entity for a product or service, for information, or for the contribution of funds or membership fees, which contain a seal, insignia, trade or brand name which could reasonably be construed as implying any Federal Government connection or endorsement.

The AARP, along with local law enforcement officials and citizens, continues to combat elderly victimization. In 1988 TRIAD was formed after the AARP, the International Association of Chiefs of Police, and the National Sheriff's Association signed a cooperative agreement to work together to reduce both criminal victimization and unwarranted fear of crime affecting older persons. The cornerstone of TRIAD is the exchange of information between law enforcement and senior citizens. Additionally, TRIAD programs sponsor various crime prevention activities such as involvement in neighborhood watch, victim assistance, and training for deputies and officers in communicating with and assisting older persons. TRIAD programs also provide social assistance to the elderly (i.e., buddy system and adopt-a-senior for shut-ins, senior walks at parks or malls, and senior safe shopping trips for groceries). TRIAD can be found in many communities throughout the Nation as well as the world. The Federal Government provides some funding for TRIAD programs through the Bureau of Justice Assistance and the Office of Victims of Crime.

Ironically, as older Americans increase in size as a cumulative market with growing 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. 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

---

13 The amended language specifies all possible federal connections (i.e., “Postmaster General, citation to a federal statute, name of a federal agency, department, commission ...”) that could reasonably be construed as implying any federal government connection or endorsement.

14 For additional information on TRIAD programs, visit AARP’s website at [http://www.aarp.org] and [http://www.vbe.com/~jonvon/triad-1.htm].
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 they 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 quick decisions to take advantage of a "today only" special price. Increasingly, con artists operate on a very sophisticated level. New technology provides a variety of clever ways to defraud consumers. Schemes now exist that victimize even the most cautious and skeptical among us, especially the elderly.
SUPPLEMENTAL MATERIAL

LIST OF HEARINGS AND FORUMS HELD IN 1999 AND 2000

The Senate Special Committee on Aging, convened 30 hearings, 5 field hearings, and 5 forums during the 106th Congress.

HEARINGS

February 22, 1999—Women and Social Security Reform: Are Individual Accounts the Answer?
March 1, 1999—Social Security Reform: Is More Money the Answer?
March 22, 1999—Residents At Risk? Weaknesses Persist in Nursing Home Complaint Investigation and Enforcement
March 23, 1999—Long-Term Care for the 21st Century: A Common Sense Proposal to Support Family Caregiver
April 13, 1999—Beneficiary Beware: Inadequate Review of Medicare Managed Care Plans Results in Incomplete Information for Consumers
April 26, 1999—Shopping for Assisted Living: What Customers Need to Make the Best Buy
May 24, 1999—Too Much Information? The Impact of OASIS on Access to Home Health Care
June 1, 1999—The Impact of Social Security Reform on Women
June 17, 1999—Learning to Save: Innovations in the Pursuit of Income Security
June 30, 1999—The Nursing Home Initiative: Results at Year One
July 20, 1999—Drugstore Surprise: The Impact of Drug Switching on Older Americans
September 14, 1999—Going the Distance: Senior Athletes and the Benefits of Exercise
November 4, 1999—HCFA Regional Offices: Inconsistent, Uneven, Unfair
November 8, 1999—The Boomers Are Coming: Challenges of Aging in the New Millennium
February 8, 2000—The Right Medicine? Examining the Breaux-Frist Prescription For Saving Medicare
March 6, 2000—Colon Cancer: Greater Use of Screenings Would Save Lives
March 27, 2000—Income Taxes: The Solution to the Social Security and Medicare Crisis?
April 3, 2000—Hearing on Now Hiring: The Rising Demand for Older Workers
April 10 and 11, 2000—Funerals and Burials: Protecting Consumers From Bad Practices
May 2, 2000—Inviting Fraud: Has the Social Security Administration Allowed Some Payees to Deceive the Elderly and Disabled?
June 5, 2000—The Cash Balance Condundrum: How to Promote Pensions Without Harming Participants
June 26, 2000—Kidney Dialysis Patients: A Population At Undue Risk?
July 11, 2000—Death Planning Made Difficult: The Danger of Living Trust Scams
July 17, 2000—The End of Life: Improving Care, Easing Pain and Helping Families
July 27, 2000—Nursing Home Residents: Shortchanged by Staff Shortages, Part II
September 5, 2000—Nursing Home Bankruptcies: What Caused Them?
September 13, 2000—Long Term Care Insurance: Protecting Consumers From Hidden Rate Hikes
September 18, 2000—Barriers to Hospice Care: Are We Shortchanging Dying Patients
September 21, 2000—Joint Hearing on Pension Tension: Does the Pension Benefit Guaranty Corporation Deliver For Retirees

FIELD HEARINGS
August 12, 1999—Making Long-Term Care Affordable, Indianapolis, IN
October 4, 1999—Long-Term Care and the Role of Family Caregivers: A Rhode Island Perspective, Cranston, RI
October 11, 1999—The Boomers Are Coming: The Challenge of Family Caregiving, Monroe, LA
March 15, 2000—Elder Fraud and Abuse: New Challenges in the Digital Economy
August 10, 2000—Protecting Seniors From Fraud, Indianapolis, IN

FORUMS
June 10, 1999—Passport to Independence: Battling the Leading Causes of Disability Among Seniors
September 23, 1999—Consumers Assess the Nursing Home Initiative
November 3, 1999—Nursing Home Residents: Short-Changed by Staff Shortages
December 14, 1999—Funerals, Burials and Consumers
November 21, 2000—Living Longer, Living Better: The Challenge to Policymakers