108TH CONGRESS
2nd Session

SENATE

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Volume 1

DEVELOPMENTS IN AGING: 2001 and 2002
VOLUME 1

REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 66, SEC. 17(c), FEBRUARY 26, 2003

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

MAY 14, 2004.—Ordered to be printed

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(II)

LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, 2004.

Hon. DICK CHENEY,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 66, agreed to February 26, 2003, I am submitting to you the annual report of the U.S. Senate Special Committee on Aging, Developments in Aging: 2001 and 2002, 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 2001 and 2002 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,

LARRY CRAIG, *Chairman.*

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DEVELOPMENTS IN AGING: 2001 and 2002—VOLUME 1

MAY 14, 2004.—Ordered to be printed

Mr. CRAIG, 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 was 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 issued its final report in December 2001 and presented three alternative plans for reforming Social Security. Under all three plans, workers could choose to invest in personal retirement accounts, and their traditional Social Security benefit would be reduced by some amount. The first plan would make no other changes to the program. The second plan would slow the growth of Social Security through one major provision that would index initial benefits to prices rather than wages. The third plan would slow future program growth through a variety of measures. To mitigate the effects of benefit reductions, the latter two plans

would guarantee a minimum benefit and enhance benefits for widow(er)s.

Elements of the Commission's recommendations were reflected in a number of bills introduced in the 107th 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. None of these measures were acted upon during the 107th Congress.

Lawmakers, however, took up a number of other Social Security measures during the 107th Congress. On February 8, 2001, Representative Herger introduced H.R. 2, which attempted to create points of order against measures that would cause the budget surpluses to be less than Social Security and Medicare HI surpluses. H.R. 2 was passed by the House of Representatives on February 13, 2001.

On March 20, 2002, Representative Shaw introduced H.R. 4069, the Social Security Benefit Enhancements for Women Act of 2002. This bill was designed to enhance benefits for certain divorced spouses and disabled and elderly widow(er)s. The cost of H.R. 4069, approximately $3.3 billion over 10 years, would have been partially offset by three tax provisions expected to increase revenue by $694 million over 10 years. On May 14, 2002, the House passed H.R. 4069 as amended, by a vote of 418–0. The Senate did not take up the bill before the close of the 107th Congress.

In recent years, Congress has put an emphasis on reducing waste, fraud, and abuse in the Social Security program. On March 20, 2002, Representative Shaw introduced H.R. 4070, the Social Security Program Protection Act of 2002. This bipartisan bill would have imposed stricter standards on individuals and organizations that serve as representative payees for Social Security and Supplemental Security Income (SSI) recipients; made non-governmental representative payees liable for "misused" funds and subjected them to civil monetary penalties; tightened restrictions on attorneys who represent Social Security and SSI disability claimants and limited assessments on attorney fee payments; prohibited fugitive felons from receiving Social Security benefits; and made other changes designed to reduce program fraud and abuse. According to the Congressional Budget Office, the House version of H.R. 4070 would have resulted in net savings of $541 million over 10 years. On June 26, 2002, the House of Representatives passed H.R. 4070, as amended, by a vote of 425–0. The Senate passed a modified version of the bill on November 18, 2002 by unanimous consent. The House did not take up the Senate-passed version of the bill before the 107th Congress adjourned sine die.

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 that 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 2002, $454 billion in monthly benefits were paid to more than 50 million Social Security recipients, with payments to retired workers averaging $895 and those to disabled workers averaging $834. In 2002, administrative expenses were $4.1 billion, representing less than 1 percent of total revenues.

The Social Security program touches the lives of nearly every American. In December 2002, there were 46.5 million Social Security recipients: 29.2 million retired workers (62.8 percent of total recipients); 5.5 million disabled workers (11.8 percent); 4.9 million dependent family members of retired and disabled workers (10.5 percent); and 6.9 million surviving family members of deceased workers (14.8 percent). In 2002, there were an estimated 153 million workers in Social Security-covered employment, representing more than 95 percent of the total American work force.

In 2003, Social Security contributions are paid on earnings up to $87,000, 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 to cover both the employee and employer share, 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 2002, the Social Security trust funds held assets totaling $1.38 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 implemented strategies to protect the citizenry from hardship, with a deep concern for future Americans. Social Security succeeded and endured because of this effort.

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

While Social Security is generally regarded as a program to benefit the elderly, the program was designed within a larger generational context. According to the program's founders, by meeting the financial concerns of the elderly, some of the needs of 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 establishment, Social Security has been expanded and changed substantially. Disability insurance was pioneered in the 1950's. Nevertheless, the underlying principle of the program as a mutually beneficial compact between younger and older generations remains unaltered and accounts for the program's lasting popularity.

Social Security benefits, like those provided separately by employers, are related to each worker's 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 workers and their families with a floor of protection against sudden loss of their earnings due to retirement, disability, or death. By design, Social Security only replaces a portion of the income needed to preserve the 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 expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

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

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5

billion, an amount sufficient to pay benefits for only 1.5 months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

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

(B) THE SOCIAL SECURITY ACT AMENDMENTS OF 1983

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

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden of restoring solvency to Social Security equitably among 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 "full benefit" retirement age from 65 to 67 was scheduled to be gradually phased in from 2003 to 2027.

(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, the 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 one 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 payments.

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 2003 is estimated to be 288 percent.

(D) OASDI NEAR-TERM FINANCING

Combined Social Security trust fund assets are expected to increase over the next 5 years. According to the 2003 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 $7.5 trillion in 2027.

(E) OASDI LONG-TERM FINANCING

In the long run, the Social Security trust funds will experience just more than one decade of rapid growth, followed by declining fund balances thereafter. Beginning in 2018, Social Security's expenditures are projected to exceed tax income (i.e., income excluding interest). Beginning in 2028, 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 2003 and 2077 varies considerably. In the first 25-year period (2003 to 2027) income is expected to exceed costs on average by approximately 4.5 percent. Annual balances are projected to remain positive through 2027, with negative balances occurring thereafter. The contingency fund ratio is projected to peak at 471 percent at the beginning of 2016. In the second 25-year period (2028 to 2052) the financial condition of OASDI deteriorates and the trust funds are projected to become insolvent late in the period (2042) under intermediate projections. On

average, program costs are expected to exceed income by 33 percent. The third 25-year period (2053 to 2077) is expected to be one of continuous deficits. As annual deficits persist, program costs are expected to exceed income on average by 44 percent.

(1) Midterm Reserves

It is projected that, from 2001 to 2027, 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 2018). 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, decrease publicly held debt, or reduce taxes. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing an increase in taxes, a decline in government expenditure, or increased publicly held debt 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, spending will have to be drastically cut, or publicly held debt will have to rise when the debt to Social Security has to be repaid.

(2) Long-Term Deficits

The long-run financial strain on Social Security results 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 4.38 percent of GDP. Under intermediate assumptions, Social Security expenditures are expected to rise to 6.94 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 budget 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 a 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 George H.W. Bush Administration's interpretation of the new law. This interpretation was 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 trans-

ferred 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 107th Congress, 12 bills were introduced to liberalize the taxation provision. Seven bills (H.R. 122, H.R. 192, H.R. 1018, H.R. 2548, H.R. 4789, H.R. 5568, and S. 237) would have repealed 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. One bill, H.R. 2106, would have raised the thresholds at which 85 percent of Social Security benefits are subject to income tax from $34,000 to $80,000 for individuals and from $44,000 to $100,000 for married couples filing jointly. Three bills (H.R. 1532, H.R. 4790, and S. 181) would also have repealed the 1983 provision, and thus restore the original tax-free status of Social Security benefits. One bill, H.R. 209, would have excluded tax-exempt interest income from the computation of how much of the Social Security benefit is taxable. None of these bills was legislatively active.

(B) SOCIAL SECURITY EARNINGS TEST

The earnings test is a provision in the law that reduces the Social Security benefits of recipients below the full retirement age 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.

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 $30,720 in 2003.) 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 ($30,720 in 2003) 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. In 2003, recipients below the full retirement age may earn up to $11,520 with no reduction in benefits. If they earn more than $11,520, their benefits are reduced $1 for every $2 of earnings above that amount. This benefit reduction is widely viewed as a disincentive to continued work efforts by workers who retire before the full retirement age and 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 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 the test would increase poverty as most everyone would take early retirement.

In the 107th Congress, two bills (H.R. 1731 and H.R. 3497) would have repealed the earnings test for workers who attained age 62 and over. Neither bill was legislatively active.

(C) THE SOCIAL SECURITY "NOTCH"

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

ference 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 a 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. In the 107th Congress, five bills were introduced that would have provided additional cash benefits to workers born in the notch years (and their dependents and survivors). However, there was no legislative action on these measures.

(D) BENEFIT EXPANSIONS FOR WOMEN

The Social Security program provides benefits to retired and disabled workers, to their dependents, and to the survivors of deceased workers. In 2002, there were 46 million Social Security recipients (not including new awards). Of those, 57 percent were women, compared to 43 percent men. Benefit amounts varied by gender as well. The average benefit was $983 for men and $740 for women. For spouses of retired workers, the average benefit was $256 for men and $454 for women. For nondisabled widow(er)s the average benefit was $663 for men and $863 for women.

Social Security prevents many of the elderly from falling into poverty. For example, in 2000, 8.5 percent of elderly Social Security recipients were poor. Without Social Security, 48.1 percent would have been poor. Poverty rates for elderly Social Security recipients vary by gender and marital status. In 2000, the poverty rate for married Social Security recipients was 2.8 percent, compared to13.8 percent for nonmarried men and 16.2 percent for nonmarried women. For widowed recipients, the rate was 12.3 percent for men and 15.0 percent for women. For never-married recipients, the rate was 25.9 percent for men and 19.5 percent for women. For divorced recipients, the rate was 9.7 percent for men and 18.5 percent for women. These statistics illustrate the importance of Social Security

for women in particular. On average, women earn lower benefits than men because they earn less and spend more time outside the labor force. In addition, women are likely to live longer than men, are less likely to have other sources of retirement income, and are more likely to be poor.

On March 20, 2002, Representative Shaw introduced H.R. 4069, the Social Security Benefit Enhancements for Women Act of 2002. This bill was designed to enhance benefits for certain divorced spouses and disabled and elderly widow(er)s. Although the benefit changes in H.R. 4069 were gender neutral, the bill targeted benefits most often paid to women. H.R. 4069 would have eliminated the requirement that surviving spouses must become disabled within 7 years of the worker's death in order to qualify for widow(er)s benefits from ages 50–59 (i.e., it would have allowed disabled surviving spouses to qualify for widow(er)s benefits from ages 50–59 regardless of when the disability occurred). The bill would also have allowed a divorced spouse to claim Social Security benefits on their former spouse's work record immediately rather than 2 years after the divorce if their former spouse marries another individual within that 2-year period. Finally, in the case of a worker who retires and subsequently dies prior to the full retirement age (FRA), H.R. 4069 would have raised the limit on the widow(er)'s benefit payable on the worker's record by treating months following a deceased worker's death that occur prior to the FRA as nonpayment months under the earnings test. The cost of H.R. 4069, approximately $3.3 billion over 10 years, would have been partially offset by three tax provisions expected to increase revenue by $694 million over 10 years. On May 14, 2002, the House passed H.R. 4069 as amended, by a vote of 418–0. The Senate did not take up the bill before the close of the 107th Congress.

(E) PROGRAM PROTECTIONS

In recent years, Congress has put an emphasis on reducing waste, fraud, and abuse in the Social Security program. On March 20, 2002, Representative Shaw introduced H.R. 4070, the Social Security Program Protection Act of 2002. This bipartisan bill would have imposed stricter standards on individuals and organizations that serve as representative payees for Social Security and Supplemental Security Income (SSI) recipients; made non-governmental representative payees liable for "misused" funds and subjected them to civil monetary penalties; tightened restrictions on attorneys who represent Social Security and SSI disability claimants and limited assessments on attorney fee payments; prohibited fugitive felons from receiving Social Security benefits; and made other changes designed to reduce program fraud and abuse. According to the Congressional Budget Office, the House version of H.R. 4070 would have resulted in net savings of $541 million over 10 years. On June 26, 2002, the House of Representatives passed H.R. 4070, as amended, by a vote of 425–0. The Senate passed the bill on November 18, 2002 by unanimous consent. The Senate-passed version of H.R. 4070 closely resembled the House-passed version, however, it contained several additional provisions. The Senate version would have made ineligible for benefits in any trial work period month individuals who are convicted of fraudulently concealing work activity during the trial work period for disability and would

have made such individuals liable for repayment of those benefits as well as any other applicable penalties, fines or assessments; amended the "last day rule" under which an individual is exempt from the Government Pension Offset (GPO) if he or she worked in a Social Security-covered position on his or her last day of employment by requiring an individual to work in a Social Security-covered position for the last 5 years of employment to be exempt from the GPO; and, made several technical changes to the Railroad Retirement program. The Social Security Administration estimated that the Senate-passed version of H.R. 4070 would have had a negligible effect on the long-range actuarial status of the trust funds. The House did not take up the Senate-passed version of the bill before the 107th Congress adjourned sine die.

(F) FINANCING OF SOCIAL SECURITY TRUST FUNDS

Focus on the long-term solvency of the Social Security trust funds has limited proposals to increase benefits or cut payroll taxes. With the return of Federal budget deficits, 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 have primarily focused on protecting Social Security surpluses or wholesale restructuring of the system.

(1) 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 105th Congress. In his State of the Union message in 1998 President Clinton 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 reemerged, 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 was ultimately passed.

In the 107th Congress, nine bills (H.R. 2, H.R. 120, H.R. 373, H.R. 560, H.R. 816, H.R. 1065, H.R. 1204, H.R. 1207, and S. 21) were introduced that attempted to alter Social Security's budget treatment. Some of these measures attempted to keep Social Security surpluses from being used to offset increased spending or tax cuts by establishing points of order against any budget resolution or legislation that would create or increase an on-budget deficit or that would cause unified budget surpluses to be smaller than the surpluses in the Trust Funds. Others attempted to preserve all budget surpluses until legislation is enacted to extend OASDI and HI solvency by making it out of order in the House or Senate to consider any budget resolution, legislation or amendment that uses any part of the on- or off-budget surpluses. Still others attempted to make Social Security truly off-budget by prohibiting the receipts and disbursements from the OASDI or HI Trust Funds from being counted in the budget and requiring official statements from the Office of Management and Budget and the Congressional Budget Office to use only on-budget numbers. One bill, H.R. 2, saw legislative action and was passed by the House of Representatives on February 13, 2001. H.R. 2 again attempted to create points of 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.

(2) Privatization

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 was 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 Secu-

rity 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 December 21, 2001, the Commission issued a final report that included three alternative plans for reforming Social Security. Under all three plans, workers could choose to invest in personal retirement accounts and their traditional Social Security benefit would be reduced upon retirement(the amount of the offset would vary under the three plans). The first plan would make no other changes to the program. The second plan would slow the growth of Social Security through one major provision that would index initial benefits to prices (rather than wages). The third plan would slow future program growth through a variety of measures. To mitigate the effects of benefit reductions, the latter two plans would guarantee a minimum benefit and enhance benefits for widow(er)s.

Under Plans One and Two, a portion of existing payroll tax contributions would be used to fund the accounts (a "carve-out" funding approach). Under Plan Three, workers could make additional payroll tax contributions to fund their accounts (an "add-on" funding approach) and receive matching contributions "carved out" of existing payroll taxes. These additional contributions would be subsidized for lower-wage workers.

According to the Commission's report, Plan One would not restore solvency to the Social Security system. Plans Two and Three were reported to restore solvency on average over the next 75 years, but cash-flow deficits would occur at points during the projection period, requiring the use of general revenues to close the system's financing gap.

Representative Matsui introduced three bills (H.R. 4022, H.R. 4023, and H.R. 4024) that would have enacted into law the three reform plans put forth by the President's Commission to Strengthen Social Security. Six other bills introduced in the 107th Congress (H.R. 849, H.R. 2771, H.R. 3497, H.R. 3535, H.R. 5734, and S. 5) would have created voluntary or mandatory personal accounts as part of Social Security reform. However, none of these measures was legislatively active.

B. SOCIAL SECURITY DISABILITY INSURANCE

1. BACKGROUND

Generally, the goal of disability insurance is to replace a portion of a worker's income should illness or disability prevent him or her from working. Individuals may receive disability benefits from either Federal or state governments, or from private insurers. The Social Security Disability Insurance (SSDI) program was enacted in 1956 and provides benefits to insured disabled workers under the full retirement age (and to their spouses, surviving disabled spouses, and children) in amounts related to the disabled worker's previous earnings in covered employment. Individuals receiving Disability Insurance benefits have their benefits converted to Re-

tirement Insurance benefits when they reach the full retirement age.

In recent years, Congress has raised concern over SSA's administration of SSDI, the largest national disability program. In particular, there was concern over the backlog of cases in the disability determination process. However, no bills were introduced in the 107th Congress to address the backlog of disability cases.

2. Issues and Legislative Response

(A) 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 did 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 planned 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. Over the last 7 years, SSA has spent more than $39 million to test and implement various initiatives designed to improve the timeliness, accuracy, and consistency of its disability decisions and to make the process more efficient and understandable for claimants. 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 "proto-

type 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. According to GAO, those state DDSs operating under the prototype awarded a higher percentage of claims at the initial decision level, while the overall accuracy of their decisions remained comparable to those made under the traditional process. Furthermore, because the prototype eliminated the reconsideration step, appeals reached a hearing office about 70 days faster than under the traditional process. However, SSA indicated that more denied claimants would appeal to administrative law judges (ALJs) under the prototype than under the traditional process, resulting in longer waiting times for other claimants, increased workloads for hearings offices, higher backlogs in the hearings offices, higher administrative costs, more awards from the ALJs and higher benefit costs under the prototype. As a result, SSA decided in December 2001 to not extend the prototype to other states.[1]

The Disability Claim Manager initiative attempted to make the initial part of the claims process easier for claimants by creating a new position to explain the disability process and program requirements and serve as the claimant's main point of contact on their claims. The initiative was completed in June 2001. According to GAO, the results of the pilot test were mixed; claims were processed faster and customer and employee satisfaction improved, but administrative costs were substantially higher. SSA concluded that the overall improvements were not worth additional implementation of the initiative.[2]

In addition, SSA implemented a third initiative, a Hearings Process Improvement Plan, nationwide in 2000, 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. However, according to GAO, this initiative has actually slowed the processing time in hearings offices from 318 days to 336 days, leading to increased backlogs.[3] SSA is studying the situation to determine what changes are needed.

A fourth SSA initiative, the Appeals Council Process Improvement initiative, sought to alter the processes for handling appeals of claims denied by the state DDSs. Under current law, if the DDS denies a claim, the claimant can request a hearing before an ALJ. If the claim is denied at the ALJ level, the claimant can make a final appeal to an Appeals Council. This initiative was implemented in FY2000 and, according to GAO, has reduced the time required to process a case in the Appeals Council by 11 days and subsequently reduced the backlog of cases.[4]

A fifth SSA initiative, the Quality Assurance initiative, sought to improve the process that SSA uses to ensure accuracy in its disability decisions. This process would evaluate accuracy throughout the disability determination process. However, because of disagree-

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GAO, "Disappointing Results from SSA's Efforts to Improve the Disability Claims Process Warrant Immediate Attention," February 2002.

[2] Ibid.

[3] Ibid.

[4] Ibid.

ments on how to achieve this goal, this initiative has been put on hold.[5]

At a September 25, 2003 Ways and Means hearing before the Subcommittee on Social Security, the Commissioner of Social Security laid out her plans to improve the disability determination process. Among the proposed changes are implementing an electronic disability folder system and changing the number and types of reviews/appeals. In addition, the SSA requested additional funding for FY2004 to help eliminate the backlog of cases within 5 years.

According to the Commissioner's testimony, the Accelerated Electronic Disability System (AeDIB), an electronic disability claims system, is a prerequisite for all of SSA's plans for other long-term changes in the process. When fully implemented, this system would allow Social Security field offices, state DDS offices, hearings offices, and others to access and manage all aspects of a claimant's file electronically. The agency plans to roll out AeDIB nationwide over an 18-month period beginning January 2004.

The proposed new disability determination process would be comprised of seven steps, compared to the six steps of the current process. The biggest change in the process would be to provide a "quick decision" granting benefits to certain "obviously disabled" claimants before their cases reach the state DDS. Some examples of cases that would be approved at this level would be those with end-stage renal disease, aggressive cancers, and ALS (Lou Gehrig's Disease). This review of cases would occur in a Regional Expert Review Unit before a case would even reach the state DDS. In addition to speeding the delivery of benefits to these categories of claimants, this new step would reduce the number of cases that would reach the DDS, allowing them to focus their attention on the more complicated and time-consuming cases. The other changes would eliminate reconsideration at the DDS level and replace it with an independent review by a Federal Reviewing Official, and eliminate the Appeals Council review and replace it with an Oversight Panel review.[6]

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[5] Ibid.

[6] For more information about the SSA's proposed changes to the disability determination process, see the Sept. 25, 2003 testimony of the Commissioner of Social Security before the House Committee on Ways and Means Social Security Subcommittee at [http://waysandmeans.house.gov/hearing.asp?formmode=view&id=761].

CHAPTER 2

EMPLOYEE PENSIONS

BACKGROUND

Many workers participate in retirement plans other than Social Security. In 2002, 49 percent of all workers in the United States between the ages of 21 and 64 participated in an employer-sponsored retirement plan. Forty-four percent of all wage and salary workers in the private sector and 75.4 percent of employees in the public sector participated in an employer-sponsored retirement plan in 2002.[1] Because employer-sponsored pension plans play a significant role in providing a secure source of income for retired Americans, Congress has over the years passed many laws intended to expand access to these plans and strengthen their financing.

The *Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001* (P.L. 107–16) increased the maximum annual contribution to employer-sponsored retirement § 401(k) plans, to § 403(b) annuity plans of nonprofit employers, and § 457 deferred compensation plans sponsored by state and local governments. Other measures in this law are intended to encourage employers to offer pensions, and to increase participation by eligible employees. The law raised limits on benefits under traditional defined benefit plans, improved asset portability between jobs, strengthened legal protections for plan participants, and reduced regulatory burdens on plan sponsors. Due to budgetary constraints, provisions of the law that reduce Federal tax revenue are scheduled to sunset after 10 years.

A. PRIVATE PENSIONS

1. BACKGROUND

Income from employer-sponsored retirement plans is the third most common and the third-largest source of income among Americans age 65 and older. In 2001, 91 percent of people 65 and older received income from Social Security, 58 percent received income from assets that they owned, and 40 percent received income from an employer-sponsored retirement plan. Also in 2001, Social Security provided 39 percent of total income received by the elderly, earnings provided 24 percent of their income, and pensions provided 18 percent of total income among the elderly.[2]

[1] CRS analysis of the March 2003 Current Population Survey.

[2] Social Security Administration, Office of Policy, *Income of the Aged Chartbook, 2001,* April 2003.

Over the past 25 years, there has been a shift in the distribution of retirement plans and of plan participants from defined benefit plans to defined contribution plans. According to the U.S. Department of Labor, only 22 percent of full-time workers in the private sector participated in defined benefit pension plans in 2000, while 42 percent participated in defined contribution plans.[3] In a defined benefit or "DB" plan, the retirement benefit is usually paid as a lifelong annuity based on the employee's length of service and average salary in the years immediately preceding retirement. In the private sector, DB plans usually are funded entirely by the employer. The employer's contributions and their investment earnings are held in a trust fund that is protected from the claims of creditors in the event that the employer becomes insolvent. In the public sector, defined benefit plans are typically funded by contributions from both the employer and the participating employees. A defined contribution or "DC" plan is much like a savings account maintained by the employer on behalf of each participating employee. The employer contributes a specific dollar amount or percentage of pay, which is invested in stocks, bonds, or other assets. The employee usually contributes to the plan, too. In a defined contribution plan, it is the employee who bears the investment risk. At retirement, the balance in the account is the sum of all contributions plus interest, dividends, and capital gains—or losses. The account balance is usually distributed as a single lump sum. Many large employers recently have converted their traditional DB pensions to hybrid plans that have characteristics of both DB and DC plans, the most popular of which has been the cash balance plan. In a cash balance plan, the accrued benefit is defined in terms of an account balance. The employer makes contributions to the plan and pays interest on the accumulated balance. However, these account balances are merely bookkeeping devices. They are not individual accounts owned by the participants. Legally, therefore, a cash balance plan is a defined benefit plan.

Private pensions are provided voluntarily by employers. Federal law has long required, however, that in exchange for favorable tax treatment, employer-sponsored retirement plans must benefit a broad class of workers without discriminating in favor of highly paid employees. Pension trusts receive favorable tax treatment in three ways: (1) Employers can deduct their current contributions to the plan from their taxable income; (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 and the likelihood that income will be subject to a lower marginal tax rate in retirement. The preferential tax treatment of retirement plans provides a strong financial incentive for employers to establish such plans. The *Employee Retirement Income Security Act (ERISA) of 1974,* (P. L. 93–406), established minimum eligibility standards for pension plans to ensure a broad distribution of benefits among employees and to limit the use of pension plans as tax shelters for company owners and officers. ERISA

[3] Nine percent participated in both types of plan. *National Compensation Survey,* U.S. Department of Labor.

also established pension funding standards, defined rules for administering pension trusts, and added an employer-financed insurance program to secure the pension benefits of workers whose employers become financially insolvent.

Title XI of the *Tax Reform Act of 1986* (P.L. 99–514) made major changes in pension and deferred compensation plans in four general areas. The Act:

(1) limited an employer's ability to "integrate" pension benefits with Social Security to reduce the benefits of lower-paid workers;

(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-qualified plans.

In 1987, Congress strengthened pension plan funding rules and limited employer contributions to fully funded plans. These rules were tightened further by the *Retirement Protection Act of 1994* (P.L. 103–465), 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 of 1996* (P.L. 104–188). Legislative and regulatory actions over the last 20 years had improved the security of pensions, but the complexity of the new rules was blamed for the decline in the number of employers that sponsored a plan. More complex rules resulted in higher administrative costs to the plans, and failure to comply could result in a plan losing its preferred tax status. The *Small Business Job Protection Act of 1996* was intended to begin reducing some of the perceived over-regulation of pension plans. While the number of defined benefit pension plans has continued to decline in recent years, the number of defined contribution plans has risen steadily. Small businesses, especially, are more likely to sponsor a defined contribution plan than a defined benefit plan, and while the percentage of workers in firms with 100 or more employees who participate in a retirement plan fell from 71.0 percent in 1994 to 66.6 percent in 2002, the percentage of workers in firms with fewer than 100 employees who participate in a plan rose from 31.5 percent to 35.0 percent during this period.

2. Issues and Legislative Responses

(A) COVERAGE

Employers who offer pension plans do not have to cover every employee. ERISA requires that employees be eligible for the employer's retirement plan if they are 21 or older, have worked for the employer for a year or more, and work 1,000 hours or more during the year. An employer also may not tailor a plan to benefit only highly compensated employees. The *Tax Reform Act of 1986* increased the proportion of an employer's work force that must be covered under an employer-sponsored plan. While Congress and the IRS have sought to restrict the practice of designing plans to provide disproportionately large benefits to company owners and officers, the regulations are complex and difficult to administer. Some 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 reduce some of the regulatory obstacles that small employers face when establishing a retirement plan. Since 1999, salary deferral plans have been exempt from these rules if the plan adopts a "safe-harbor" design authorized under the law. In addition, the coverage rules apply only to DB plans. Another important change was the repeal of the family aggregation rules. Under prior law, related employees were 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).

Participating in a pension plan does not ensure that a worker will receive retirement benefits. To receive retirement benefits, a worker must "vest" under the company plan. Vesting entails remaining with a firm for a requisite number of years and thereby earning the right to receive a pension. To enable more employees to vest either partially or fully in a pension plan, the *Tax Reform Act of 1986* required more rapid vesting. Employees must now be fully vested after 5 years of service if vesting occurs all at once or after 7 years if vesting is gradual. Employees are always fully vested in their own contributions to a defined contribution plan, and they must be fully vested in employer matching contributions to such plans in no more than 5 years if vesting occurs all at once and in no more than 7 years if vesting is gradual. Under the EGTRRA of 2001, vesting schedules have been accelerated. Employees must be fully vested in employer matching contributions in a maximum of 3 years under "cliff" vesting and in no more than 6 years under gradual vesting.

(1) Access

Workers at large firms are substantially more likely than employees of small businesses to work for an employer that sponsors a retirement plan. In 2002, 31.7 percent of full-time workers in businesses with fewer than 25 employees were employed at firms that sponsored a retirement plan. Among workers in firms with 25 to 99 employees, 56.3 percent were employed at firms that sponsored a retirement plan in 2002, compared to 59.0 percent in 1999 and 53.4 percent in 1994. Among employees at businesses with 100 or more workers, 76.8 percent worked at firms that sponsored a retirement plan in 2002.

Not all employees whose employer sponsors a retirement plan are eligible to participate. For example, employees under age 21, or who have been employed for less than 1 year, or who work fewer than 1,000 hours per year can be excluded. In firms with fewer than 25 employees, 27.3 percent of full-time employees between the ages of 25 and 64 participated in a retirement plan in 2002. In firms with 25 to 99 employees, 47.8 percent of workers participated in a retirement plan in 2002. Participation in retirement plans among workers in firms with 100 or more employees was much higher, at 66.6 percent.

One of the goals of the *Small Business Job Protection Act of 1996* 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. The Act increased access to DC plans by restoring to nonprofit organizations the right to sponsor 401(k) plans, which had been taken away by The *Tax Reform Act of 1986.* State and local government entities are still prohibited from offering 401(k) plans, but they can sponsor plans under I.R.C. section 403(b) and section 457. The SBJPA 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. Originally, an employee could contribute up to $6,000 annually to a SIMPLE plan, indexed yearly for inflation in $500 increments. The EGTRRA of 2001 increased this limit to $7,000 in 2002 and by $1,000 annual increments thereafter until it reaches $10,000 in 2005. The $10,000 dollar limit will be indexed to inflation in $500 increments. The employer must meet a matching requirement and vest all contributions at once.

(2) Benefit Distribution and Deferrals

Vested workers who leave an employer before retirement age generally have the right to receive deferred benefits from the plan when they reach retirement age. Benefits that can be paid only at retirement 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. Employers may make distributions without the consent of the employee on amounts of $5,000 or less. The participant's written consent is required for such distributions if the value of the distribution exceeds this amount. Some workers that receive lump-sum distributions spend them rather than save them. Thus, distributions could reduce future retirement income.

Formerly, the primary incentive to save lump-sum distributions was to continue the deferral of income taxes until retirement. 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. The EGTRRA of 2001 allows a plan sponsor to disregard benefits attributable to rollover contributions for purposes of determining whether a lump-sum distribution will be greater than $5,000. In the case of involuntary distributions of $1,000 or more, the law makes direct rollover to an IRA the required method of distribution unless the participant directs otherwise.

(B) TAX EQUITY

Private pensions are encouraged through tax deductions and deferrals. In return, Congress regulates private plans to prevent them from being used to provide benefits solely to highly paid employees. Efforts to prevent the discriminatory provision of benefits

have focused on tests that reveal the proportion of total benefits or contributions that accrue to highly compensated employees.

(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. 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 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 EGTRRA of 2001 increased the allowable contribution to an IRA—either traditional or Roth—to $3,000 in 2002, 2003, and 2004; to $4,000 in 2005, 2006, and 2007; and to $5,000 in 2008, after which it will be indexed to inflation. For individuals age 50 and older, the maximum allowable contribution to an IRA will increase by an additional $500 in 2002 through 2005 and by $1,000 in each year thereafter.

EGTRRA increased the limit on annual elective deferrals under Section 401(k) plans, Section 403(b) annuities, and salary-reduction Simplified Employee Pensions (SEPs) from $10,500 in 2001 to $11,000 in 2002 and by $1,000 each year thereafter until it reaches $15,000 in 2006. In years after 2006, the annual limit on salary deferrals will be indexed to inflation in $500 increments. Beginning in 2006, a Section 401(k) plan or a Section 403(b) annuity will be permitted to allow participants to elect to have all or a portion of their elective deferrals under the plan treated as after-tax contributions, called "designated Roth contributions." These contributions will be included in current income, but qualified distributions from designated Roth contributions will not be included in the participant's gross income. Such contributions will otherwise generally be treated the same as elective deferrals for purposes of the qualified plan rules.

The maximum deferral under a Section 457 plan for employees of state and local governments was $8,500 in 2001. EGTRRA raised this limit to $11,000 in 2002, $12,000 in 2003, $13,000 in 2004, $14,000 in 2005, and $15,000 in 2006. The limit will be indexed in $500 increments thereafter. For the 3 years immediately preceding retirement, the limit on deferrals under a Section 457 plan will be twice the otherwise applicable dollar limit. The law also repealed the rules coordinating the dollar limit on Section 457 plans with contributions under other types of plans.

Also as a result of the EGTRRA of 2001, the maximum annual benefit payable by a tax-qualified defined benefit pension was increased from $140,000 to $160,000 beginning in 2002. Thereafter, it is indexed to inflation in $5,000 increments. The annual limit on benefits is reduced if benefits begin before age 62 and increases if benefits begin after age 65. The limit on compensation that may be taken into account under a plan was increased from $170,000 in 2001 to $200,000 in 2002. It is indexed in $5,000 increments. The limit on annual additions to defined contribution plans—comprising the sum of employer and employee contributions—was increased from $35,000 in 2001 to $40,000 in 2002, and it is indexed in $1,000 increments.

EGTRRA permits individuals who are age 50 or older to make additional contributions to a retirement plan authorized under section 401(k), 403(b), or 457 of the tax code. The maximum permitted additional contribution is $2,000 in 2003, $3,000 in 2004, $4,000 in 2005, and $5,000 in 2006. This amount will be indexed to inflation in years after 2006. Catch-up contributions to a Section 401(k) plan or similar plan will not be subject to any other contribution limits and will not be taken into account in applying other contribution limits; however, they will be subject to the nondiscrimination rules.

(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, 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. ERISA also requires pension plans to diversify their assets. Plans are prohibited from buying, selling, exchanging, or leasing property with a "party-in-interest," (e.g., a company officer), and they are prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Before 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 pension insurance to guarantee the vested benefits of participants in single-employer defined-benefit plans. This program guaranteed benefits up to $44,386 in 2004 (adjusted annually). The single-employer program is funded through annual premiums paid by employers to the Pension Benefit Guaranty Corporation (PBGC)—a Federal 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. The current (2004) premium is $19 per participant per year. 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, companies terminated plans 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 30 percent of the company's net worth. The PBGC was unable to collect much from the financially troubled companies because they were likely to have little or no net worth.

The OBRA of 1987 established a "full funding limit" for tax-qualified defined benefit plans equal to 150 percent of the plan's accrued liability. EGTRRA raised this limit to 165 percent of current liability for plan years beginning in 2002 and to 170 percent for plan years beginning in 2003. The current-liability full-funding limit was repealed for plan years beginning in 2004 and thereafter. A special rule allowing a deduction for unfunded current liability generally has been extended to all defined benefit pension plans covered by the Pension Benefit Guaranty Corporation (PBGC). In determining the amount of pension contributions that are not deductible, an employer is permitted to disregard contributions to a defined benefit plan except to the extent that they exceed the accrued-liability full-funding limit. If an employer so elects, contributions in excess of the current-liability full-funding limit are not subject to the excise tax on nondeductible contributions.

Because pension benefits under multi-employer plans are generally based on factors other than compensation—such as a flat benefit per month of service—the limits on benefits provided for under § 415 of the tax code can result in significant benefit reductions for workers who are covered by these plans and whose compensation varies from year to year. The EGTRRA of 2001 eliminates the cap on benefits (equal to 100 percent of compensation) for multi-employer plans and provides that multi-employer plans are not to be aggregated with single employer plans for purposes of applying the 100 percent-of-compensation cap to those plans. The law also clarifies the method of determining the tax year to which an employer contribution to a multi-employer plan is attributable.

(D) ISSUES FOR THE 108TH CONGRESS

About half of all workers in the United States participate in an employer-sponsored retirement plans, a rate that has not changed much since 1980. Workers in small firms are only about half as likely as those in firms with 100 or more workers to have access to an employer-sponsored retirement plan. Another trend in pension coverage has been the shift away from traditional defined benefit plans toward retirement savings arrangements, in which the employee bears much of the responsibility for choosing to participate, how much to contribute to the plan, and how to invest those contributions. Defined benefit plans have changed, too, as about

one-fourth of all participants in these plans are now covered under "cash balance" arrangements in which the accrued benefit is defined in terms of an account balance rather than as an annuity. Conversions of traditional defined benefit plans to cash balance plans have been controversial because they can cause some older workers to experience significant decreases in the rate at which future benefits will be earned. The legal status of cash balance plans is uncertain as Federal courts have not agreed on whether the design of these plans complies with ERISA and the Age Discrimination in Employment Act. So far, Congress has not amended these statutes to clarify how they apply to cash balance plans.

The financial status of the Pension Benefit Guaranty Corporation once again became a serious concern in 2003. As the result of three consecutive years of declines in the major stock market indices and a prolonged period of low interest rates, the value of pension plan assets fell as the present value of the plans' liabilities increased. (The value of a defined benefit plan's obligations moves in the opposite direction in which interest rates move.) The Federal pension agency covers about 33,000 pension plans for a total of 44 million workers. The number of plans is down from more than 100,000 in the mid–1980's. As of August 2003, the amount owed by the Pension Benefit Guaranty Corporation to participants in plans it had taken over exceeded the PBGC's assets by $8.8 billion. The Director of the PBGC told the Senate Special Aging Committee on October 14, 2003 that the PBGC "has sufficient assets on hand to pay benefits for a number of years in the future," but that "there are serious structural issues that require fundamental reform to the defined benefit system now." The PBGC Director said that several reforms might reduce the risks to the program's long term financial viability. These include replacing the 30-year Treasury bond interest rate—which is used to calculate pension plan liabilities—with an interest rate based on investment-grade long-term corporate bonds. Changes in pension funding rules could set stronger funding targets, foster more consistent contributions, mitigate volatility, and increase flexibility for companies to fund up their plans in good economic times, according to PBGC officials.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. Background

Ninety-eight percent of full-time employees of state and local governments participated in an employer-sponsored retirement plan in 1998, according to the U.S. Department of Labor. Defined benefit plans are much more common in the public sector than in the private sector, covering 90 percent of full-time state and local government employees. State and local governments are not subject to the requirements of ERISA, being governed instead by the laws passed by state legislatures. Although some public plans are not adequately funded, most state plans and local 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.

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, state and local officials thus far have successfully counteracted these efforts, arguing that the extension of such standards would be unwarranted and unconstitutional interference with the right of state and local governments to set the terms and conditions of employment for their workers. In the *Taxpayer Relief Act of 1997* (P.L. 105–34), Congress permanently exempted public plans from Federal tax code rules regarding nondiscrimination among participants and minimum participation standards.

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. 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 amount that workers have paid is not directly related to the size of their retirement benefits. Civil service retirement is classi-

fied in the Federal budget as an entitlement, and, in terms of budget outlays, represents the fourth largest Federal entitlement program.

(A) FINANCING CSRS AND FERS

The Federal retirement systems are employer-provided pension plans similar to plans provided by private employers for their employees. Like other employer-provided defined benefit plans, the Federal civil service plans are financed mostly by the employer. 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 7.0 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. So long as the "balance" of the securities in the fund exceeds the annual cost of benefit payments, the Treasury has the authority to write annuity checks without congressional action. Because interest and other payments are credited to the fund annually, the fund continues to grow, and the system faces no shortfall of authority to pay benefits well into the future. Nevertheless, the balance in the fund does not cover every dollar of future pension benefits to which everyone who is, or ever was, a vested Federal worker will have a right from now until they die. Because benefits under the old Civil Service Retirement System were not fully funded by employer and employee contributions, general revenues will be needed to pay some CSRS pension obligations.

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

eral service and who will not be eligible for benefits for another 30 years or so.

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

Nevertheless, the special securities held in the fund represent money the Government owes for current and future benefits. The securities represent an indebtedness of the U.S. Government and constitute part of the national debt. However, this is a debt the Government owes itself. Thus, it will never have to be paid off by the Treasury, as must other U.S. Government securities such as bonds or Treasury bills, which must be paid, with interest, to the private individuals who purchased them. In summary, the trust fund is an accounting ledger used to keep track of revenues earmarked for the retirement programs, benefits paid under those programs, and money that is owed by the Government for estimated future benefit costs. The concept of unfunded liability, while indicative of future costs that must be financed by government over a long time period, is not particularly relevant as a measure of a sum that might have to be paid at a point in time.

(B) CIVIL SERVICE RETIREMENT SYSTEM

CSRS Retirement Eligibility and Benefit Criteria.—Workers enrolled in CSRS may retire and receive an immediate, unreduced annuity at the following minimum ages: age 55 with 30 years of service; age 60 with 20 years of service; age 62 with 5 years of service. Workers who separate from service before reaching these age and service thresholds may leave their contributions in the system and draw a "deferred annuity" at age 62. CSRS benefits are determined according to a formula that pays retirees a certain percentage of their pre-retirement Federal salary. The pre-retirement 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 7.0 percent of their gross Federal pay. This amount is automatically withheld from workers' paychecks but is included in an employee's taxable income. Employees who separate

before retirement may withdraw their contributions (no interest is paid if the worker completed more than 1 year of service), but by doing so the individual relinquishes all rights to retirement benefits. If the individual returns to Federal service, the withdrawn sums may be redeposited with interest, and retirement credit is restored for service preceding the separation. Alternatively, workers may accept a reduced annuity 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 pay part of 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 also may receive an annuity. Certain unmarried, incapacitated children may receive a survivor annuity for life.

CSRS Disability Retirement.—The only long-term disability program for Federal workers is disability retirement. Eligibility for CSRS disability retirement requires that the individual be (a) a Federal employee for at least 5 years, and (b) unable, because of disease or injury, to render useful and efficient service in the employee's position and not qualified for reassignment to a vacant position in the agency at the same grade or pay level and in the same commuting area. Thus, the worker need not be totally disabled for any employment. This determination is made by the Office of Personnel Management (OPM). Unless OPM determines that the disability is permanent, a disability annuitant must undergo periodic medical reevaluation until reaching age 60. A disability retiree is considered restored to earning capacity and benefits cease if, in any calender year, the income of the annuitant from wages or self-employment, or both, equal at least 80 percent of the current rate of pay of the position occupied immediately before retirement.

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

Cost-of-Living Adjustments.—Federal law provides annual retiree cost-of-living adjustments (COLAs) payable in the month of January. COLAs are based on the Consumer Price Index for Urban

Wage Earners and Clerical Workers (CPI-W). The adjustment is made by computing the average monthly CPI-W for the third quarter of the current calender year (July, August, and September) and comparing it with that of the previous year.

(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 ($87,900 in 2004). The wage base is indexed to the annual growth of wages in the national economy. Employees enrolled in FERS contribute 0.8 percent of their full base pay to the civil service retirement and disability fund.

(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 as a 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 waived the survivor benefit or elected a lesser amount. FERS retiree annuities are reduced by 10 percent to pay part of 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. In 2004, employees can contribute up to 14 percent of their salaries to the TSP, not to exceed $13,000. The employing agency matches the first 3 percent of pay contributed on a dollar-for-dollar basis and the next 2 percent of pay contributed at the rate of 50 cents per dollar. The maximum matching contribution to the TSP by the Federal agency equals 4 percent of pay plus the 1 percent automatic contribution. Therefore, employees contributing 5 percent or more of pay will receive the maximum employer match. An open season is held every 6 months to permit employees to change levels of contributions and direction of investments. Employees are allowed to borrow from their TSP accounts. Originally, loans were restricted to those for the purchase of a primary residence, educational or medical expenses, or financial hardship. However, P.L. 104–208 removed this restriction effective October 1, 1996.

The TSP allows investment in one or more of five funds: a stock index fund based on the Standard & Poor's 500, a stock index fund of small and mid-size company stocks, a stock index fund of international companies, a bond index fund that tracks corporate bonds, and a fund that pays interest based on the yields on certain Treasury securities.

2. Issues and Legislative Response

(A) 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. 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 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. 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 1960 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.

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).

However, the Congress began taking notice publicly of potential problems related to Redux in 1997. Subsequently, during the fall of 1998, the Clinton Administration announced that it supported congressional calls for repeal of Redux and restoration of the option to retire with unreduced benefits with 20 years of service. Eventually, the FY2000 National Defense Authorization Act (Secs 641–644, P.L. 106–65, October 5, 1999; 113 Stat. 512 at 662) 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 2003, 2.0 million retirees and survivors received military retirement benefits, with total Federal military retirement outlays of an estimated $36.2 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 FY2002 was 43 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 considerably 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 total military compensation being received by active duty personnel at the time they retire(the remaining parts of RMC and other cash components comprising the rest).

Retirement benefits are computed using a percentage of the retired pay computation base. Because each military member has 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 1 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. Until enactment of legislation in November 2003 (see below), an1891 law had required that military retired pay be reduced by the amount of any VA disability compensation received. Since the late 1980's, some military retirees had sought a change in law to permit receipt of all or some of both, and legislation to allow this had been introduced in the past several Congresses. The issue is usually referred to as "con-

current receipt," because it involves the simultaneous receipt of two different benefits.

Concurrent receipt's proponents had 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 alleged 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 argued against concurrent receipt usually cite its cost estimated by the Congressional Budget Office as, for full concurrent receipt, $3 billion in FY2004 and, if implemented, almost $41 billion for the FY2004-FY2013 timeframe. They also were concerned that eliminating this offset would be the "camel's nose in the tent," leading to pressure to eliminate other offsets which would cost the Federal Government tens of billions of dollars yearly. Interestingly, some analysts also asserted that the reason there was no analogous offset for VA disability compensation and civilian benefits was that, in fact, the military retiree situation was unique. They noted that the combinations of benefits other than the simultaneous receipt of military retirement and VA disability compensation involved receiving two separate benefits from the same Federal agency, unlike the military retirement-VA compensation situation, where benefits from two separate Federal agencies were involved.

After over a decade of failed attempts, legislation authorizing concurrent receipt for a substantial number (the largest estimates are approximately 300,000) of military retirees was enacted as part of the FY2004 National Defense Authorization Act (Sections 641–642, Act of November 24, 2003). This legislation:

- Authorizes the progressive implementation, over a 10-year period, of full concurrent receipt for those military retirees with at least a 50 percent disability. This is the first time since 1891 that the statutory prohibition of concurrent receipt has been modified.
- Greatly expands the scope of so called "Combat-Related Special Compensation" (CRSC), first enacted in 2002, to provide the financial equivalent of full concurrent receipt to military retirees who have (1) been awarded a Purple Heart for wounds incurred in combat, regardless of the degree of disability; or (2) possess at least a 60 percent disability resulting from involvement in "armed conflict," "hazardous service," "duty simulating war," or "through an instrumentality of war." This appears, in lay terms, to encompass combat with any kind of hostile force; hazardous duty such as diving, parachuting, using dangerous materials such as explosives, and the like; individual and unit military training and exercises in the field; and "instrumentalities of war" such as accidents in military vehicles, naval vessels, or aircraft, and accidental injuries due to occurrences such as munitions explosions, injuries from gases and vapors related to combat training, and the like.
- Opens CRSC to reserve retirees, who had, when it was first enacted in 2002, been almost universally excluded.

(B) CHANGING THE 20-YEAR RETIREMENT NORM

For more than 30 years, the military retirement system, in particular its central feature of allowing career personnel to retire at any age with an immediate annuity upon completing 20 years of service, has been the object of intense criticism and equally intense support among military personnel, politicians, and defense manpower analysts. Critics of the system have 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 by inducing too many personnel to stay until the 20-year mark and too few to stay beyond the 20-year mark. Others have strongly defended the existing system as essential to recruiting and maintaining sufficient high-quality career military personnel who could withstand the rigors of arduous peacetime training and deployments as well as war. They tend to agree with the statement that "20-year retirement makes up with power what it lacks in subtlety," by providing a 20-year "pot of gold at the end of the rainbow."

Secretary of Defense Rumsfeld and other senior defense officials have suggested on several occasions that the existing 20-year retirement paradigm should be modified. Legislative proposals sent to Congress by DOD in late April 2003, included provisions to extend or eliminate a variety of age and years-of-service limits for general officers. The net effects of these provisions would be to prevent the mandatory retirement of skilled high-level officers who might otherwise want to stay on active duty; give DOD and the military services more flexibility in managing the senior uniformed leadership of the services; allow generals and admirals to serve longer tours of duty and minimize too-frequent rotation of assignments; and provide greater compensation incentives related to the greater lengths of service. However, some opposed to them are concerned about longer terms for generals and admirals resulting in excessive stultification and stodginess in the senior uniformed leadership; an excessive slowing of promotions, as more people stay on active duty in the same grade for longer periods of time; and, combined with other measures in the proposed bill, a greater alignment of the senior generals and admirals with the senior appointed political leadership of DOD, and, hence, the Administration and political party in power. Only one of these proposals arguably one of the less significant ones was adopted in the FY2004 National Defense Authorization Act specifically, the reduction in years in grade before an officer is allowed to retire in that grade.

E. RAILROAD RETIREMENT

1. BACKGROUND

The Railroad Retirement program is a federally managed retirement system that covers employees in the rail industry, with benefits and financing coordinated with Social Security. The system was first established during the 1934–37 period, 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 primarily through a combination of employee and employer payments to a trust fund, with the exception of vested dual (or "windfall") benefits, which are paid with annually appropriated Federal general revenue funds through a special account.

In fiscal year 2002, $8.6 billion in total benefits were paid to 684,000 beneficiaries of the Railroad Retirement program. In January 2003, the Railroad Retirement equivalent of Social Security benefits (Tier I benefits) increased by 1.4 percent as a result of the annual Cost-of-Living Adjustment (COLA) applied to Social Security benefits. The industry pension component of Railroad Retirement (Tier II benefits) increased by 0.5 percent because of an annual adjustment equal to 32.5 percent of the Tier I COLA. As of February 2003, average monthly benefits were $1,509 for retired workers and $595 for spouses. The average monthly benefit for aged widow(er)s was $968.

2. Issues and Legislative Response

(A) 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 *Railroad Retirement Act of 1974* (hereafter cited as the 1974 Act) fundamentally altered the Railroad Retirement program by creating a two-tier benefit structure, with Tier I benefits intended as an equivalent to Social Security benefits and Tier II benefits intended as a private pension. More recently, the *Railroad Retirement and Survivors' Improvement Act of 2001* (hereafter cited as the 2001 Act) made a number of benefit and financing changes to the Railroad Retirement system. Specifically, the 2001 Act expanded benefits for the widow(er)s of rail employees; lowered the minimum retirement age at which employees with 30 years of experience are eligible for full retirement benefits; reduced the number of years required to be fully vested for Tier II benefits; eliminated the limit on total monthly Railroad Retirement benefits payable to an employee and spouse; expanded the system's investment authority; phased in changes to the Tier II tax structure; and repealed the supplemental annuity work-hour tax paid by employers. These changes were negotiated by rail labor organizations and rail freight carriers.

Workers are eligible for benefits from the Railroad Retirement program if they have at least 10 years of railroad service, or in some cases at least 5 years of railroad service after 1995. Tier I benefits are based on combined earnings credits from rail and nonrail employment. Tier II benefits are based solely on railroad employment. The 1974 Act continued the 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 rail and nonrail employment.

A special study group created in the early days of the Clinton Administration the National Performance Review (NPR) 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, because program costs are borne by the industry through payroll taxes, 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 RAILROAD UNEMPLOYMENT/SICKNESS INSURANCE BENEFITS

The railroad industry finances: (1) Tier I benefits paid under criteria that differ from Social Security (i.e., unrecompensed benefits); (2) Tier II benefits; (3) supplemental annuities for long-time employees; and (4) benefits payable under the Unemployment/Sickness Insurance program.

Railroad retirement and survivor benefits are financed by: (1) payroll taxes paid by employees and employers on covered railroad earnings; (2) income from the Social Security financial interchange; (3) appropriations from general revenues (including transfers of income taxes collected on benefits); and (4) investment income. In an effort to increase the Railroad Retirement System's return on investments, the 2001 Act established the National Railroad Retirement Investment Trust (NRRIT), a nongovernmental entity administered by a Board of Trustees authorized to invest Railroad Retirement program funds in nongovernmental securities, such as equities and debt securities. Previously, the RRB was authorized to invest Railroad Retirement funds only in U.S. Government or U.S. government-guaranteed securities. With the assistance of independent advisors and investment managers, the Board of Trustees of the NRRIT invests assets, pays administrative expenses and transfers funds to a private disbursing agent responsible for the payment of benefits (the U.S. Treasury serves as the interim disbursing agent).

The Federal Government finances vested dual (or "windfall") benefits under an arrangement established by the 1974 Act. Prior to the 1974 Act, individuals could qualify for Railroad Retirement and Social Security benefits concurrently. The 1974 Act coordinated Railroad Retirement and Social Security benefit payments to eliminate certain dual benefits considered to be a "windfall" for persons

receiving benefits under both systems. Vested dual benefits were preserved for employees who qualified for both Railroad Retirement and Social Security benefits prior to the 1974 Act. 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, current and former rail employees, and Federal taxpayers. Congress then 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 through employment in the rail industry, paid by the rail 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 by Congress. The Tier I payroll tax is the same as that for Social Security (Old-Age, Survivors, and Disability Insurance) and Medicare Hospital Insurance (Medicare Part A)—6.2 percent of earnings up to a maximum ($87,000 in 2003) and 1.45 percent of total earnings, paid by employers and employees.

Tier II benefits are also financed by payroll taxes. In 2003, the Tier II payroll tax is 14.2 percent for employers and 4.9 percent for employees on the first $64,500 of a worker's covered railroad wages. Under the 2001 Act, the Tier II tax rate paid by employers was lowered from 16.1 percent to 15.6 percent in 2002 and 14.2 percent in 2003. The Tier II tax rate paid by employees remained unchanged at 4.9 percent in 2002 and 2003. Beginning in 2004, tax rates will be adjusted annually based on the 10-year average ratio of certain asset balances to the sum of benefits and administrative expenses (the "average account benefits ratio"). Depending on the average account benefits ratio, Tier II tax rates for employers will be between 8.2 percent and 22.1 percent. Tier II tax rates for employees will be between 0 percent and 4.9 percent.

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 purpose of the financial interchange is to place Social Security in the same financial position as if railroad employment

had been covered at the beginning of Social Security. Every year since 1957, the net interchange has been in the direction of Railroad Retirement, primarily due to a steady decline in the number of rail industry jobs.

When Congress, with the support of rail labor and rail management, 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 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 FY2002, Congress appropriated $146 million, which includes the estimated amount of income taxes paid on dual benefits. For FY2003, Congress appropriated $131 million, including income tax transfers. If, for any given year, the appropriation is not sufficient to pay dual benefits in full, benefits are subject to reduction. Currently, dual benefits are paid to about 12 percent of railroad retirement beneficiaries and average $147 per month.

Supplemental annuities are paid to employees beginning at age 60 with at least 30 years of railroad service, or at age 65 with 25–29 years of railroad service, and a current connection with the rail industry. The supplemental annuity equals $23 for 25 years of service, plus $4 for each additional year of service, up to a maximum of $43 per month. Employees first hired after October 1, 1981, are not eligible for supplemental annuities.

(2) Unemployment and Sickness Benefits

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

(C) TAXATION OF RAILROAD RETIREMENT BENEFITS

Tier I benefits are subject to the same Federal income tax treatment as Social Security benefits. Under those rules, up to 50 percent of the Tier I benefit is taxable if modified adjusted gross income (i.e., adjusted gross income plus tax-exempt interest income plus one-half of the Tier I benefit) exceeds $25,000 for an individual or $32,000 for a married couple, with proceeds credited to the Social Security trust funds to help finance Social Security and Railroad Retirement Tier I benefits. Up to 85 percent of the Tier I benefit is taxable if modified adjusted gross income exceeds $34,000 for an individual or $44,000 for a married couple, with proceeds credited to the Medicare Hospital Insurance trust fund.

Unrecompensed Tier I benefits (Tier I benefits paid in excess of Social Security benefit levels) and Tier II benefits are taxed as ordinary income, on the same basis as all other private pensions.

Under 1983 legislation to strengthen Railroad Retirement financing, 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.

(D) FINANCIAL OUTLOOK FOR THE RAILROAD RETIREMENT SYSTEM

The Railroad Retirement Board, the Federal agency that administers the Railroad Retirement and Unemployment/Sickness Insurance programs, is required to submit annual reports to Congress on the financial status of the programs, including any financing recommendations. The Board's 2003 report to Congress on the Railroad Retirement program indicated no cash-flow problems over the 75-year projection period under the optimistic and moderate employment assumptions. Only the most pessimistic assumptions resulted in cash-flow problems, starting in 2022. Overall, the report concluded that "barring a sudden, unanticipated, large drop in railroad employment, the railroad retirement system will experience no cash-flow problems during the next 19 years. The long-term stability of the system, however, is not assured. Under the current financing structure, actual levels of railroad employment and investment return over the coming years will determine whether additional corrective action is necessary." The Board's 2003 report to Congress on the status of the Unemployment Insurance System stated that, under all three sets of employment assumptions (optimistic, moderate and pessimistic), experience-based contribution rates are projected to respond to fluctuating employment and unemployment levels maintaining fund solvency over the 11-year projection period. The report recommended no financing changes at this time.

The combinations of RUIA and retirement taxes projected by the Board 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.

3. Outlook in the 108th Congress

The benefit and financing changes enacted in 2001 are being implemented. Congress is not expected to consider major program changes during the 108th Congress.

CHAPTER 3

TAXES AND SAVINGS

A. TAXES

1. Overview of Important Provisions

While the general rules of the Federal income tax apply to older Americans, the Internal Revenue Code recognizes their special needs in various ways. Social Security the single most important source of income for older Americans is not taxed in the case of a majority of beneficiaries. Medicare the most important form of health insurance for older Americans provides tax-exempt coverage and payments for all beneficiaries. The exclusion of gains from the sale of one's principal residence, while not aimed at or restricted to older Americans, benefits those who want to move to less expensive or rental housing. The additional standard deduction for the elderly allows many to reduce their tax liability and frees some from having to file a tax return. These and other provisions are described below, followed by a brief summary of recent tax legislation.

The Federal income tax also recognizes the special needs of older Americans before they become 65. So they will have money in retirement, the Code has significant incentives for employers to offer pension and other qualified retirement plans and for employees to participate in these plans across their working lives. It encourages individuals to save additional sums through individual retirement accounts (IRAs). These policies are described in other sections of this report.

In enacting these special rules, Congress recognized that older Americans often are confronted with rising costs and fixed or shrinking resources; as most are not employed, they cannot bring in additional income or increase their savings by working more. In addition, many older Americans face significant involuntary expenditures for health care, sometimes for prolonged periods. Some older Americans also have long-term care needs that are expensive to meet, even if they remain in their homes.

At the same, time, older Americans are not a homogenous group. Some are employed, many have pension income and assets, and many enjoy good health, at least for a number of years. Special treatment for their income thus may seem unfair to younger taxpayers. Striking the right balance between helping a population that generally has special needs and treating all taxpayers equitably will continue to be a challenge as the Nation's population ages.

(A) SOCIAL SECURITY BENEFITS

For more than four decades, Social Security benefits were completely exempt from the Federal income tax. Their tax-free status arose from a series of administrative rulings in 1938 and 1941 by 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.

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, up to one-half of Social Security benefits became subject to taxation in the case of beneficiaries whose other income plus one-half their Social Security benefits exceeds a threshold of $25,000 ($32,000 for joint filers). (Similar tax treatment applies to equivalent tier I Railroad Retirement benefits, which railroad workers would have received had they been covered by Social Security.) Tax-exempt interest (such as from municipal bonds) is included in the other income used in this determination. While tax-exempt interest itself remains free from taxation, it can have the effect of subjecting some people's benefits to taxation.

The 1983 legislation reflects continuing congressional concern that the benefits of lower and moderate income taxpayers not be subject to taxation. Because the tax thresholds are not indexed for inflation, however, with time beneficiaries of more modest means will also be affected.

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, defined as those 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 up to one-half of their benefits.

In 2000, approximately 40 percent of Social Security beneficiaries had part of their benefits subject to taxation. Revenue attributable to the taxation of benefits due to the 1983 legislation (i.e., taxation of up to 50 percent of the benefit) is credited to the Social Security trust funds. Based on the intermediate assumptions in the 2003 Social Security trustees' report, an estimated $13.4 billion is to be credited to the Social Security trust funds in fiscal year 2003. Revenue attributable to the taxation of benefits due to the 1993 legislation (i.e., taxation of the additional part up to 85 percent of the benefit) is credited to the Medicare Part A trust fund; in fiscal year 2002, $8.3 billion was credited to it.

(B) MEDICARE COVERAGE AND BENEFITS

Medicare has two parts, Part A (insurance for hospitalization, skilled nursing facilities, hospice care, and some home health care) and Part B (supplemental insurance for doctors' fees, outpatient hospital services, some physical and occupational therapy, and some home health care). Part A is funded through an employment tax on both the employer and the employee; individuals age 65 and over generally are entitled to benefits if they or their spouse have at least 10 years of covered employment. (Individuals with disabilities who are under age 65 may also receive Part A benefits after they have Social Security benefits for 24 months.) The employment tax is not a deductible medical expense, though voluntary payments of premiums for Part A by those who do not otherwise qualify may be counted toward the itemized deduction for medical expenses, subject to a 7.5 percent adjusted gross income floor (described below). Medicare Part B premiums may also be considered for purposes of the deduction.

Coverage under either Part A or Part B of Medicare is not taxable income. Similarly, benefits paid under either part are not subject to taxation. The exemptions are based upon Internal Revenue Service revenue rulings in 1966 (Rev. Rul. 66–216) and 1970 (Rev. Rul. 70–341) that the benefits are in the nature of disbursements made in furtherance of the social welfare objectives of the Federal Government.

The Balanced Budget Act of 1997 authorized a limited number of Medicare beneficiaries to elect Medicare+Choice medical savings accounts (MSAs) instead of traditional Medicare. Contributions to these accounts, to be made only by the Secretary of Health and Human Services, are exempt from taxes, as are account earnings. Withdrawals are likewise not taxed nor subject to penalties if used to pay unreimbursed medical expenses, with some exceptions. As no insurer has yet offered a Medicare+Choice MSA plan, no beneficiary has been able to take advantage of this provision.

(C) SALE OF PRINCIPAL RESIDENCE

Gains from the sale of a principal residence are exempt from income, subject to certain limits. For married couples filing a joint return, gains of up to $500,000 may be excluded; for other tax filers, gains of up to $250,000 may be excluded. The residence must have been owned and used by the taxpayer as the principal residence for at least 2 years of the 5-year period that ends on the date of the sale. Exceptions to the 2-year rule are allowed for changes in the place of employment, health problems, and certain other unforeseen circumstances.

Though the provision is neither aimed nor restricted to older taxpayers, it helps many who want to move to less-expensive or rental housing. The exclusion helps both by eliminating (or at least reducing) the tax liability at the time of sale and by freeing many taxpayers from having to maintain detailed records of expenditures that affect their home's tax basis.

The exclusion was included in the Taxpayer Relief Act of 1997. It replaced a once-in-a-lifetime exclusion of gains (limited to certain amounts, at that time $125,000) that had been available to older

taxpayers since 1964. Taxpayers not qualifying for this earlier exclusion could defer gains from the sale of their principal residence only if they purchased a new residence for equal or greater value. The 1997 legislation repealed this deferral.

(D) BELOW-MARKET INTEREST LOANS TO CONTINUING CARE FACILITIES

With some exceptions, taxpayers are required to recognize imputed interest income on loans they make that have little or no interest (such as 1 percent when the market rate is 5 percent) or for which interest is received in the form of noncash benefits (such as future services). Special rules exempt loans made by elderly taxpayers to qualified continuing care facilities. (The loan in this instance is usually an up-front payment at the time of admission.) For this exception to apply, either the taxpayer or the taxpayer's spouse must be 65 years of age or older before the end of the year in which the loan is made. The loan must be made to a facility that is designed to provide services under continuing care contracts, and substantially all of the residents must be covered by those contracts. Substantially all of the facilities which provide the required services must be owned or operated by the borrower. Nursing homes per se are excluded.

Under a continuing care contract, the individual or spouse must be entitled to use the facility for the remainder of their life. 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 is no longer able to live independently. Further, the facility must provide personal care services and long-term nursing care services without substantial additional cost.

The exclusion of imputed interest is based upon loan amounts that are adjusted annually for inflation. In 2004, a taxpayer may lend up to $154,500 before being subject to the imputed interest rules.

(E) DEDUCTION OF MEDICAL AND DENTAL EXPENSES

Taxpayers who itemize their deductions instead of taking the standard deduction may deduct unreimbursed medical and dental expenses to the extent they exceed 7.5 percent of adjusted gross income (AGI). Medical expenses include payments made by the taxpayer for health insurance premiums (including premiums for Medicare Part B and for Medigap policies), qualified long-term care insurance premiums (as discussed below), nursing home and other long-term care services, and deductibles and copayments. Some capital expenditures on one's home can also be taken into account, such as the cost of constructing wheelchair ramps.

This itemized deduction is not widely used. In 2000, about one-third of all returns filed had itemized deductions, and of these about 15 percent (i.e., about 5 percent of all returns) claimed the deduction for medical and dental expenses. While older taxpayers have higher than average medical expenses, their Medicare and supplemental private insurance reimbursements often preclude their meeting the 7.5 percent AGI floor. However, the deduction may be of use to elderly taxpayers who have high prescription drug charges (which Medicare with some exceptions currently does not

cover) or nursing home fees (which may be considered in their entirety, notwithstanding they partly cover what might be considered ordinary living expenses.)

The deduction for health care expenses was first allowed in 1942. It has been modified many times, sometimes to exempt individuals age 65 and over from the floor, sometimes to impose a ceiling on expenses, and sometimes to have different treatment for health insurance and for prescription drugs. The present form of the deduction with the 7.5 percent AGI floor was established by the Tax Reform Act of 1986.

(F) LONG-TERM CARE INSURANCE

Qualified long-term care insurance is treated as accident and health insurance, and its benefits are treated as amounts received for personal injuries and sickness and for reimbursement of medical expenses actually incurred. As a consequence, long-term care insurance benefits are exempt from taxation. In 2004, the exemption for insurance benefits paid on a per diem or other periodic basis is limited to the greater of $230 a day or the cost of long-term care services.

As discussed above, unreimbursed long-term care expenses are allowed as an itemized deduction to the extent they and other unreimbursed medical expenses exceed 7.5 percent of adjusted gross income. Long-term care insurance premiums can be counted among these expenses subject to age-based limits. In 2004, these limits range from $260 for persons age 40 or less to $3,250 for persons over age 70.

Self-employed individuals are allowed to include long-term care insurance premiums in determining their above-the-line deduction (a deduction not limited to itemizers) for health insurance expenses. Only amounts not exceeding the age-based limits can be counted.

Employer contributions to the cost of qualified long-term care insurance premiums are exempt from both income and employment taxes. Age-based limits do not apply. The exemption does not cover insurance provided through employer-sponsored cafeteria plans or flexible spending accounts.

Qualified long-term care insurance is a contract that covers only qualified long-term care services; does not pay or reimburse expenses covered under Medicare; is guaranteed renewable; does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policy holder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Policies issued before January 1, 1997, and meeting a state's long-term care insurance requirements at the time the policy was issued are considered qualified.

Qualified long-term care services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a chronically ill individual, and are provided according to a plan of care prescribed by a licensed health care practitioner.

Services provided by a spouse or relative generally cannot be taken into account.

Chronically ill persons are individuals who are:

- unable to perform without substantial assistance from another individual at least two of the following six activities of daily living (ADLs)for a period of at least 90 days due to a loss of functional capacity: bathing, dressing, transferring, toileting, eating, and continence;
- have a level of disability similar to the level of disability specified for functional impairments (as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services); or
- require substantial supervision to protect them from threats to health and safety due to severe cognitive impairment.

A licensed health practitioner (such as a physician, registered professional nurse, or licensed social worker) must have certified within the past 12 months that the person for whom services are provided meets these criteria.

Provisions governing the tax treatment of long-term care insurance were added to the Code in 1996 by the Health Insurance Portability and Accountability Act of 1996. The provisions clarified a murky area of taxation and indicated congressional support for helping families insure against the catastrophic costs of caring for people who are frail or have disabilities.

(G) ADDITIONAL STANDARD DEDUCTION

Taxpayers may claim a standard deduction or itemized deductions, whichever is greater, in calculating their taxable income. The standard deduction is based upon one's filing status and is adjusted for inflation each year. For 2004, the standard deduction is $4,850 for single filers, $7,150 for heads-of-household filers, and $9,700 for married couples filing jointly (married individuals filing separately each have a standard deduction of $4,850).

Some taxpayers who claim the standard deduction may also claim an additional standard deduction for being blind or age 65 or older. Taxpayers who are both blind and 65 or older may claim two additional standard deductions; if married and filing a joint return, it is possible for the couple to claim up to four additional standard deductions. In 2004, each additional standard deduction is $950 for married individuals and $1,200 for unmarried individuals.

The additional standard deduction reduces taxpayers' taxable income and thus their tax liability. It could also free some taxpayers from having to file a tax return since the filing threshold is increased by the amount of the additional deduction. Taxpayers must file a return if their gross income is equal to or above their filing threshold. For most taxpayers, the threshold is equal to the sum of their personal exemption ($3,100 each in 2004), their standard deduction, and any additional standard deduction. Different thresholds apply if the taxpayer could be claimed as a dependent by another taxpayer, as sometimes occurs with the elderly.

The additional standard deduction for the blind or elderly was established by the Tax Reform Act of 1986; it replaced an additional personal exemption for people with these characteristics that had been in the Code since 1948. One reason for the change is that the additional standard deduction is less likely to benefit higher income taxpayers, who are more likely to itemize their deductions.

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

This credit was initially established to correct inequities in the taxation of different types of retirement income. Since Social Security benefits were originally tax-free, as described above, it was considered appropriate to shield other forms of retirement income from taxation as well.

The credit has changed over the years, with the current version enacted as part of the Social Security Amendments of 1983. Individuals age 65 or older are provided a tax credit of 15 percent of their taxable income up to an 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 investment income as well as retirement income. The initial amount for computing the credit is $5,000 for a single taxpayer age 65 or older. In the case of a married couple filing a joint return where both spouses are 65 or older the initial amount is $7,500. A married individual filing a separate return has an initial amount of $3,750. Not being adjusted for inflation, these amounts have remained the same since 1983.

Additional limitations apply. The initial amount is reduced by tax-exempt retirement income, such as Social Security, received by the taxpayer. It is also reduced by $1 for each $2 that 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. Due to these limitations and the absence of an inflation adjustment, the number of taxpayers claiming this credit has declined sharply: in 1980 the credit was claimed on 561,918 returns (for a total of $134,993,000) while in 2000 it was claimed on 155,796 returns (for a total of $32,608,000).

2. TAX LEGISLATION IN THE 107TH CONGRESS

(A) ECONOMIC GROWTH AND TAX RELIEF RECONCILIATION ACT OF 2001

The Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA, P.L. 107–16) made significant changes to Federal tax laws, some of which are important for older Americans. In order to comply with the Congressional Budget Act of 1974, EGTRRA provided that none of its changes would apply to tax years beginning after 2010; thus, barring subsequent congressional action, the changes discussed below will expire after 10 years.

For many individuals, the most notable change made by EGTRRA was the reduction in tax rates on ordinary (as opposed to capital) income. Before EGTRRA, statutory tax rates were 15 percent, 28 percent, 31 percent, 36 percent, and 39.6 percent, depending upon one's taxable income. EGTRRA added a new 10 percent bracket for the first band of taxable income and immediately reduced the statutory rates above 15 percent by 0.5 percent; it further reduced those rates to 25 percent, 28 percent, 33 percent and 35 percent starting in tax year 2006. The Act also provided some marriage-penalty relief, starting in 2005, by gradually increasing the standard deduction and the size of the 15 percent bracket for married couples filing jointly to twice the amounts for single filers. Alternative minimum tax (AMT) exemptions were increased by $4,000 for married couples and $2,000 for other filers; this change reduces the AMT increase that some middle income and higher income taxpayers will experience due to the rate reductions on ordinary income. In addition, individual retirement account (IRA) contribution limits were gradually increased from $2,000 to $5,000 by 2008, and additional contributions were permitted for individuals age 50 and over.

EGTRRA made numerous changes to pensions. For defined benefit plans, the Act increased the compensation limits taken into account in determining deductible employer contributions; it also increased the limit on allowable annual benefits. For defined contribution plans, the Act increased the limit for deductible employer contributions and no longer requires them to take account of certain elective deferrals. Limits on employees' elective deferrals were increased for 401(k) accounts, section 457 deferred compensation plans, and section 403(b) annuity plans among others, and additional contributions were permitted for individuals age 50 and over. Rules were repealed that reduced deferral amounts in section 457 plans by contributions to other qualified plans. Rollovers from one type of qualified plan to another were made easier.

EGTRRA allowed small employers a new tax credit for the start-up costs of establishing or maintaining a new employee retirement plan. In addition, low and middle income taxpayers were allowed a new nonrefundable tax credit for contributions to retirement savings plans; the maximum credit is 50 percent for married couples filing a joint return whose adjusted gross income does not exceed $30,000 ($22,500 for heads of household and $15,000 for single filers); the credit is reduced at higher incomes and then eliminated for joint filers with adjusted gross incomes over $50,000 ($37,500 for heads of household and $25,000 for single filers).

EGTRRA also made important changes to the estate, gift, and generation-skipping taxes. Estate and generation-skipping taxes were completely abolished after 2009. Since this change, like other EGTRRA changes, expires at the end of 2010 the abolition may be temporary. Prior to 2010, other changes become effective. The exclusion amount applicable to the gift tax was increased from $675,000 in 2001 to $1 million starting in 2002, while the exclusion amount for the estate tax was increased from $675,000 in 2001 to $1 million in 2002 and 2003, $1.5 million in 2004 and 2005, $2 million in 2006, 2007, and 2008, and $3.5 million in 2009. The max-

imum rates for all three taxes were gradually reduced across these years.

(B) THE JOB CREATION AND WORKER ASSISTANCE ACT OF 2002

The Job Creation and Worker Assistance Act of 2002 (P.L. 107–147) included a number of minor changes and technical corrections that may affect some older Americans. Amended provisions included the standard deduction for married individuals filing separately, Medicare+Choice medical savings accounts, pension plans, and the estate and gift taxes.

(C) TRADE ADJUSTMENT ASSISTANCE REFORM ACT OF 2002

The Trade Adjustment Assistance Reform Act of 2002, part of the Trade Act of 2002 (P.L. 107–210), authorized a new Federal income tax credit for health insurance starting in December, 2002. The credit, known by various names including the health coverage tax credit (HCTC) and the Trade Adjustment Assistance (TAA) credit, reimburses eligible taxpayers for 65 percent of the cost of their insurance. As the credit is refundable, taxpayers may claim it even if they have no Federal income tax liability. The credit is also advanceable, so taxpayers need not wait until they file their returns in order to benefit.

The credit is available to three groups of taxpayers: (1) individuals who are receiving an allowance under the Trade Adjustment Assistance (TAA) program (or who would be except their unemployment benefits are not yet exhausted); (2) individuals age 50 and over who are receiving the new alternative TAA benefit, and (3) individuals age 55 and over who are receiving a pension benefit from the Pension Benefit Guarantee Corporation or who took a lump sum payment from it after August 5, 2002. The credit applies to ten categories of insurance, including continuation coverage required by Federal or state law, state-based or state-arranged plans, and, in limited instances, individual market insurance.

The credit is not available once individuals become entitled to Medicare (normally at age 65) or are enrolled in various insurance plans, including a plan maintained by the individual's or spouse's employer or former employer that pays 50 percent or more of the cost, the Federal Employees Health Benefit Program, Medicaid; or the State Children's Health Insurance Program. The Medicare restriction precludes most older Americans from using the credit, but individuals in their 50's and early 60's (particularly those in the second and third eligibility groups above) may find it especially helpful since they often have high health insurance costs. Maintaining health insurance coverage for people in these age groups is important for helping them preserve assets they will need in retirement.

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 2002, the EEOC received 19,921 complaints and filed suits in just 29 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 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 was similar but not identical to H.R. 2554, "Firefighters and Police Retirement Security Act of 1993," introduced by Representative Murphy 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.[1] 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."[2] 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.[3] A violation can be shown even if the person was replaced by someone who also falls within the protected class. For example, replacing a 76-year-old with a 45-year-old may be a violation of the ADEA, if the person was replaced because of his age.

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

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

[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"' (quoting *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 *Trans-World 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*

Community Affairs v. *Burdine*, 450 U.S. 248 (1981). Burdine had regularly been applied to ADEA cases. See, e.g. *Williams* v. *Valentec Kisco, Inc.*, 964 F.2d 723 (8th Cir.), cert. denied, 506 U.S. 1014 (1992); *Williams* v. *Edward Apffels Coffee Co.*, 792 F.2d 1492 (9th Cir. (1992)). As a result of the holding in Hicks, an employee who discredits all of an employer's articulated legitimate nondiscriminatory reasons for an employment decision is not automatically entitled to judgment in an action under 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 discredits 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 Eight 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-

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.

In 2002, the Court considered whether a complaint in an employment discrimination lawsuit must contain specific facts that establish a prima facie case of discrimination under the McDonnell-Douglas framework. In *Swierkiewicz* v. *Sorema*, 534 U.S. 506 (2002), the petitioner alleged that he had been terminated on account of his national origin in violation of Title VII and on account of his age in violation of the ADEA. The petitioner's complaint had been dismissed by a U.S. district court because it was found to

have not adequately alleged a prima facie case. The court maintained that the complaint had not adequately alleged circumstances that supported an inference of discrimination. The Second Circuit affirmed the district court's decision.

The Court reversed the Second Circuit's decision. The Court noted that the imposition of a heightened pleading standard in employment discrimination cases conflicted with rule 8(a)(2) of the Federal Rules of Civil Procedure. Rule 8(a)(2) requires that a complaint include only "a short and plain statement of the claim showing that the pleader is entitled to relief." This statement must simply give the defendant fair notice of the plaintiff's claim and the grounds upon which it rests.

The Court also observed that it would be inappropriate to require a plaintiff to plead facts that establish a facie case because the McDonnell-Douglas framework does not apply in every employment discrimination case. An employee may prevail on an employment discrimination claim, and avoid the McDonnell-Douglas framework, by producing direct evidence of discrimination. Thus, the Court maintained that "[u]nder the Second Circuit's heightened pleading standard, a plaintiff without direct evidence of discrimination at the time of his complaint must plead a prima facie case of discrimination, even though discovery might uncover such direct evidence." The court found it "incongruous" to require a plaintiff to plead more facts than he may ultimately need to prove to succeed on the merits if direct evidence of discrimination is discovered.

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 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 Con-

gress' 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 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 second full year of WIA implementation ended June 30, 2002.

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 FY2002 appropriation for adult activities is $945.4 million, and for dislocated workers is approximately $1.5 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. For the pe-

riod between July 1, 2001 and June 30, 2002, over 10,000 adults who exited the WIA adult program were age 55 or older, representing 6 percent of total adult exiters.

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. For the period between July 1, 2001 and June 30, 2002. nearly 15,000 dislocated workers who exited the WIA dislocated worker program were age 55 or older, representing 11 percent of total dislocated worker exiters.

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 though 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.

THE LABOR MARKET EXPERIENCE OF OLDER WORKERS

Older workers, a group with varying definitions, tend to be less disadvantaged economically than some other groups (e.g., minorities and women). The older worker group, for example, has a lower unemployment rate and a higher wage than the typical labor force participant. According to data from the U.S. Bureau of Labor Statistics (BLS), the unemployment rate in 2002 of persons age 55 and older was below 4 percent compared to the rate for all workers of almost 6 percent. Similarly, among full-time wage and salary workers in 2002, median weekly earnings were $649 for persons at least 55 years old as opposed to $609 for all workers. For this reason, the labor market difficulties of older workers sometimes have been overlooked.

As members of the large baby-boom cohort (those born between 1946 and 1964) are now in the middle or nearing the end of their working lives, it is likely that size alone will bring more attention to the labor market problems of older persons. The age of baby-boomers will range from the mid–40's to the mid–60's by 2010. BLS projects that the number of workers age 45–64 will increase by 30 percent during the current decade, which is more than twice the growth rate of the labor force as a whole (12 percent). As a result, baby-boomers could account for almost 37 percent of the entire labor force in the last year of the 2000–2010 projection period (some 58 million out of 158 million workers). The addition of workers age 65 and older, who are projected to expand to the same degree as baby-boomers, could bring the number of workers age 45 and older in 2010 to over 63 million or 4 out of every 10 members of the labor force.[1]

Another demographic change could operate to the advantage of older workers in the coming years. Older workers will become more noticeable not just because of their absolute size, but also because of the comparatively small cohort (the baby bust) that immediately followed the baby-boom generation into the labor force. The comparatively small supply of 35–44 year olds projected to be available in 2010 to fill jobs older workers have held might make it more costly for employers to engage in what may be discriminatory behavior. That is to say, the impending scarcity of experienced mid-career workers[2] could prompt employers to cast aside stereotypical

[1] Howard N. Fullerton, Jr. and Mitra Toossi, Labor Force Projections to 2010: Steady Growth and Changing Composition, Monthly Labor Review, Nov. 2001.

[2] Ibid. Note: Between 2000 and 2010, the number of 35–44 year olds in the labor force is projected to contract by 1.1 percent, bringing their total to almost 34 million or 22 percent of the 2010 labor force—down from 27 percent in 2000.

notions concerning the productivity of older workers and make firms less reluctant to hire them.[3] Without a large supply of individuals to replace older employees, firms also could become more interested in retaining them and less reluctant to provide them with any needed skill upgrading or retraining. (Companies more often provide training to younger employees, in part because they perhaps incorrectly assume a longer time horizon over which they can recoup training expenditures on younger compared to older workers.[4]) As of 2003, however, it appears that a majority of firms have not changed their employment practices in response to the aging of the labor force.[5] And, some members of the business community wonder whether employers will wait to make changes until they perceive a labor shortage has occurred rather than acting in advance to avoid its development.[6]

LONG SPELLS OF UNEMPLOYMENT AND DISCOURAGEMENT OVER JOB PROSPECTS

Despite the aforementioned positive experience of older persons in the labor market, some older workers who lose their jobs are likely to continue having above-average difficulty finding new ones. This is reflected by the group's comparatively lengthy spells of unemployment. In 2002, the average duration of unemployment was 16.6 weeks; workers age 55–64 were jobless 5 weeks longer and workers age 65 and over were jobless almost 6 weeks longer. While 18 percent of all unemployed persons went without jobs for 27 or more weeks, 26 percent of workers between 55 and 64 years old and 27 percent of those at least 65 years old were unable to find jobs for half the year.[7] Thus, older workers are more likely than other job losers to exhaust Unemployment Insurance benefits for which they may be eligible.

Unemployment data understate the labor market problems encountered by older workers because they are more likely than others to withdraw from the labor force. An individual must either have a job (employed) or have recently sought a job (unemployed) to be counted as a member of the labor force. As the unemployment rate is the number of unemployed persons divided by the number of labor force participants, an individual who has given up seeking work is not tabulated in this and other labor force statistics.

Older workers might be more prone to exit the labor force because they may have accumulated more wealth than younger workers and because they may be eligible for alternatives to employment that provide them income and health security (e.g., pension and Social Security benefits, and Medicare). In addition, society does not stigmatize older persons for leaving the labor force for re-

[3] Glenn M. McEvoy and Mary Jo Blahna, Engagement or Disengagement? Older Workers and the Looming Labor Shortage, Business Horizons, v. 44, issue 5, Sept. 2001.

[4] Older workers generally are less mobile than the typical employee. According to BLS data for 2002, the median tenure of all employees was 3.7 years. In contrast, half of 55–64 year olds have been with their current employers for more than 9.9 years and half less than 9.9 years. The median tenure of employed persons at least 65 years old in 2002 was similarly long (8.7 years).

[5] SHRM Survey Shows Organizations Slowly Preparing for Worker Shortage in 2010, US Newswire, June 22, 2003.

[6] Committee for Economic Development, New Opportunities for Older Workers, Washington, D.C.: 1999.

[7] BLS data.

tirement. Although retirement generally is characterized as a voluntary decision, it is argued that some older persons take the option because they think they really have no other choice. They may, for example, come to this conclusion after having engaged in a lengthy and fruitless job search, or after realizing they cannot get jobs with wages that compare favorably with their former pay levels or with their private/public pensions.

Two percent (884,000) of individuals at least 55 years old who were not in the labor force in 2002 indicated that they wanted a job. Somewhat over one-fifth (191,000) of them had both looked for jobs in the previous year and were currently available for work, that is, they were not ill or disabled for example. Some regard this group as a component of the hidden unemployed, whose joblessness reduces the rate of economic growth and the nation's standard of living below what they otherwise would be. Almost 27 percent of the 191,000 older persons available for work reported that they had not more recently sought employment because of discouragement over their prospect of success. In other words, they previously had been unable to find jobs, believed no work was available or that they lacked the necessary education or training for the available jobs, or they perceived their age to be a hiring barrier. Empirical studies typically have found that discouragement is more prevalent among older individuals than among persons in the prime work years.[8]

The Employment and Wage Consequences of Displacement

Long-tenured workers tend to be older workers and seniority often protects individuals from job loss. Thus, older workers are often sheltered from displacement associated with insufficient work and the abolition of a position or shift (e.g., caused by a national recession, changes in the nature of consumer demand, and corporate reorganization). However, seniority affords no protection from job loss linked to plant or company closures, or relocations. According to a nationally representative survey, plant/company shutdowns or moves caused the displacement of 51 percent of all workers at least 55 years old who lost long-held jobs between January 1999 and December 2001. In contrast, this was the cause of displacement for 46 percent of comparable younger workers.[9]

Older workers are more likely than the typical worker to suffer adverse consequences from displacement. As of January 2002, fewer workers age 55 and older displaced from jobs over the 1999–2001 period were able to find new positions: while the average reemployment rate was 64 percent, the share of 55–64 year olds in new jobs was 51 percent and of those age 65 and over, 20 percent. Many more older workers withdrew from the labor force as well. Only 15 percent of all displaced workers were not in the labor force in January 2002, compared to 29 percent of displaced workers age 55–64 and 60 percent of those at least 65 years old. The higher in-

[8] Suzanne Heller Clain, The Effect of Increases in the Level of Unemployment on Older Workers, Applied Economics, Oct. 1995 v. 27, n. 10.

[9] BLS, Worker Displacement, 1999–2001, USDL 02–483, Aug. 21, 2002. Note: BLS uses a tenure cutoff of 3 or more years to capture workers who have developed an attachment to their positions and are more likely to have difficulty adjusting to the loss of their jobs. All of the discussion above concerning displaced workers relates to persons who fulfilled the job tenure requirement.

cidence of labor force withdrawal among older displaced workers could partly reflect the much larger share of them who experienced lengthy joblessness. Among those who were employed in January 2002, 11 percent of all workers were jobless for 27 or more weeks during the 1999–2001 survey period in contrast to 21 percent of workers age 55 and older.[10]

The greater adversity encountered by older dislocated workers does not end upon their reemployment. An above-average share of workers 55 or more years old who lost full-time jobs between 1999 and 2001 were employed part-time in January 2002 (9 percent versus 6 percent), and fewer hours of employment yields smaller paychecks. Older displaced workers who found new full-time jobs more often earned less than they had on their lost jobs: 60 percent of displaced workers age 55 and older versus 52 percent across all displaced workers. Numerous empirical studies have shown that "older job losers, who are more likely to have lost a high-tenure job, suffer larger wage declines than do younger workers."[11] In addition, older workers have a shorter time horizon in which to try to recover from their displacement-induced wage declines.

2. Title V of the Older Americans Act

The Senior Community Service Employment Program (SCSEP) has as its purpose to promote useful part-time opportunities in community service activities for unemployed low income persons with poor employment prospects. Created during the 1960s as a demonstration program under the Economic Opportunities Act, and later authorized under the Title V of the Older Americans Act, it is the only federally subsidized jobs programs for older persons. 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 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

[10] Ibid.

[11] Henry S. Farber, Job Loss in the United States, 1981–2001, Working Paper 9707, National Bureau of Economic Research, Cambridge, Mass., May 2003, p. 25.

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.

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 October 2003, 6.9 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 2002, the elderly poverty rate was 10.4 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 the Social Security Administration 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 making benefit payments in

1974, providing a nationally uniform guaranteed minimum income for qualifying elderly, disabled, and blind individuals. 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, by paying an administrative fee, 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, $564 for an individual and $846 for a couple in 2004. Second, the value of assets must not exceed a variety of limits.

Under the program, income is defined as earnings, cash, checks, and items received "in kind," such as food and shelter. Not all income is counted in the SSI calculation. For example, the first $20 of monthly income from virtually any source and the first $65 of monthly earned income plus one-half of remaining earnings, are excluded and labeled as "cash income disregards." Also excluded are the value of social services provided by federally assisted or State or local government programs such as nutrition services, food

stamps, or housing, weatherization assistance; payments for medical care and services by a third party; and in-kind assistance provided by a nonprofit organization on the basis of need.

In determining eligibility based on assets, the calculation includes real estate, personal belongings, savings and checking accounts, cash, and stocks. Since 1989, the asset limit has been $2,000 for an individual and $3,000 for a married couple. The income of an ineligible spouse who lives with an SSI applicant or recipient is included in determining eligibility and amount of benefits. Assets that are not counted include the individual's home; household goods and personal effects with a limit of $2,000 in equity value; $4,500 of the current market value of a car (if it is used for medical treatment or employment it is completely excluded); burial plots for individuals and immediate family members; a maximum of $1,500 cash value of life insurance policies combined with the value of burial funds for an individual.

The Federal SSI benefit standard also factors in a recipient's living arrangements. If an SSI applicant or recipient is living in another person's household and receiving support and maintenance from that person, the value of such in- kind assistance is presumed to equal one-third of the regular SSI benefit standard. This means that the individual receives two-thirds of the benefit. In 2004, this totals $376 for a single person and $564 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 2002, 4.2 percent, or 284,369 recipients came under this "one-third reduction" standard. Sixty-seven percent of those recipients were receiving benefits on the basis of disability.

When an SSI beneficiary enters a hospital, or nursing home, or other medical institution in which a major portion of the bill is paid by Medicaid, the SSI 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 pro-

vision 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, P.L. 105–306, the Noncitizen Benefit Clarification and Other Technical Amendments Act of 1998, and P.L. 106–386, the Victims of Trafficking and Violence Protection Act of 2000. Provisions in these laws (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 2002, it was estimated that 5.4 million disabled adult SSI beneficiaries received benefits from SSA. The workload for initial disability claims was 1.7 million in fiscal year 2002. 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. In 2000, SSA introduced the Hearings Process Improvement Initiative. In these efforts, SSA has taken steps to reduce hearing processing times from the peak of 397 days in fiscal year 1997 to about 343 days as of June 2002, but the number of pending SSI cases has increased by 29,000 from December 2000 to December 2002.

In response to concerns raised by the General Accounting Office (GAO), Congress, and disability advocates, SSA has moved forward from these past inefficient efforts to new initiatives that utilize technology and collaboration. The solution presented by SSA fo-

cuses on streamlining the determination process and improving service to the public.

In 2003, SSA introduced the Accelerated Electronic Disability System (AeDIB) and the Electronic Disability Collect System (EDCS). These systems are intended to address near-term and longer-term operational policy and disability process issues in an effort 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, the replacement of many paper forms and evaluation materials, 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 processes will take advantage of the improvement of secure data bases and files, a major privacy and security concern of the past. SSA has selected areas as the sites of implementation trials, but once sufficient data has been gathered on these test sites, SSA will decide whether to extend the process to other areas.

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 99,276 in 1980 to 340,910 in December 2002, which represents 6.3 percent of the SSI benefit population.

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 work incentive provisions and SSA's administration of these provisions. GAO's report concluded that the work incentives are not effective in encouraging recipients with work potential to return to employment or pursue rehabilitation options. In addition, it concluded that SSA has not done enough to promote the work incentives to its field employees, who in turn do not promote the incentives to beneficiaries.

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

> To a large extent, the small incidence of return to work on the part of disabled beneficiaries reflects the fact that eligibility is restricted to those with impairments which have been found to make them unable to engage in any substantial work activity. By definition, therefore, the disability population is composed of those who appear least capable of employment. Moreover, since eligibility depends upon proving the inability to work, attempted work activity represents a risk of losing both cash and medical bene-

> fits. 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 ineligi-

bility 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.

In 2002, unveiled its Corrective Action Plan, a response to GAO's listing of SSI as a Federal program at "high risk" for abuse, mismanagement, and overpayment. The plan incorporates many of the hearing and appeals initiatives mentioned above, and also includes plans to conduct reviews of beneficiaries in current payment status to verify income, resources, and living arrangements to confirm SSI eligibility, as well as payment simplification, and increased punitive actions and debt collection efforts . Though the plan has yet to be fully implemented, its initiatives and scope impressed GAO enough that the agency did not list SSI a "high risk" program in January 2003, the first time the SSI program was absent from the list since 1996.

CHAPTER 6

FOOD ASSISTANCE PROGRAMS AND FOOD SECURITY AMONG THE ELDERLY

OVERVIEW: 2001-2002

In addition to nutrition programs for the elderly operated under Title III of the Older Americans Act (discussed in the chapter devoted to Older Americans Act Programs), the Federal Government supports 4 non-emergency food assistance programs affecting significant numbers of older persons: the Food Stamp program, the Commodity Supplemental Food program, the adult-care component of the Child and Adult Care Food program, and the Senior Farmers' Market Nutrition program.[1]

Only two major legislative items affecting the elderly were included in legislation during 2001 and 2002. The Farm Security and Rural Investment Act of 2002 (P.L. 107-171) changed food stamp law to allow eligibility for food stamps among all legally resident noncitizens who have been legally resident for at least 5 years. It also established legislative authority for the Senior Farmer's Market Nutrition program, which had been set up by an administrative decision in January 2001.

Participation in federally supported food assistance programs serving the elderly rose in the 2001-2002 period. After hitting a low for the modern Food Stamp program in fiscal year 2000, average monthly food stamp enrollment rose to 17.3 million persons in fiscal year 2001 and 19.1 million in fiscal year 2002. After rising to almost 10 percent in fiscal years 2000 and 2001, the proportion of all food stamp participants who were elderly (age 60+) dropped slightly to about 9 percent in fiscal year 2002; elderly food stamp recipients received some 6 percent of all food stamp benefits. In fiscal year 2001, only about 28 percent of food-stamp-eligible individuals, compared to a 60-percent rate among all eligible persons.

The number of elderly enrollees in the Commodity Supplemental Food program and the adult-care component of the Child and Adult Care Food program continued to rise in fiscal years 2001 and 2002 – increasing to 352,000 in the Commodity Supplemental Food program and some 82,000 in the Child and Adult Care Food program. Participation in the newly inaugurated Senior Farmers' Market Nutrition program was estimated at just over 400,000 persons in fiscal year 2001.

Reflecting increasing enrollment, Federal costs for all 4 programs increased in fiscal years 2001 and 2002. In fiscal year 2002, total Federal food stamp spending (including nutrition assistance grants to Puerto Rico and other outlying areas) was $21.7 billion, the Commodity Supplemental Food program spent $105 million, Federal subsidies for the adult-care component of the Child and Adult Care Food program totaled $57 million, and the Senior Farmers' Market Nutrition was funded at $15 million.

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[1]Nutrition programs that help some elderly persons, but are not included in this report, also include 2 emergency assistance programs. The Emergency Food Assistance Program (TEFAP) provides, through state agencies, support for food packages to those in immediate need served by emergency feeding organizations like food banks, food pantries, and emergency shelters and soup kitchens. This aid takes the form of federally donated commodities and funding for distribution costs. The Emergency Food and Shelter program makes grants to local agencies (through locally appointed boards) to provide services (including meals) to the homless.

A. BACKGROUND ON THE PROGRAMS

1. FOOD STAMP PROGRAM

The Food Stamp program operates under the Food Stamp Act of 1977, as amended (7 U.S.C. 2011 et seq); appropriations are authorized through fiscal year 2007. Food stamps are designed primarily to increase the food purchasing power of eligible low-income households to a point where they can buy a nutritionally adequate low-cost diet. Participating households are expected to devote 30 percent of their counted monthly cash income to food purchases.[2] Food stamp benefits then make up the difference between the household's expected contribution to its food costs and an amount judged to be sufficient to buy an adequate low-cost diet. This amount, the maximum food stamp benefit, is set at the level of the U.S. Department of Agriculture's lowest cost food plan (the Thrifty Food Plan or TFP), varied by household size, and adjusted annually for inflation. Thus, a participating household with no counted cash income receives the maximum monthly allotment for its household size while a household with some counted income receives a lesser allotment, normally reduced from the maximum at the rate of 30 cents for each dollar of counted income.

Benefits are available to most households that meet Federal eligibility tests for limited monthly income and liquid assets. But household members must fulfill requirements related to work effort and must meet citizenship and legal permanent residence tests. Recipients in the two primary cash welfare programs – Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) – generally are automatically eligible for food stamps, as are recipients of State general assistance (GA) payments, if their household is composed entirely of TANF, SSI, or GA beneficiaries.[3]

Administration, Program Variations, and Funding

The regular Food Stamp Program operates in all 50 States, the District of Columbia, Guam, and the Virgin Islands. The Federal Government is responsible for most of the rules that govern the program, and, with limited variations for Alaska, Hawaii, and the territories, these rules are nationally uniform. However, by law and regulation, States have a number of significant options to vary from Federal administrative, benefit calculation, and eligibility rules, especially for those who also are recipients of their State's cash welfare (TANF and GA) programs, and a number of waivers from regular rules and procedures have been (and continue to be) granted. Sales taxes on food stamp purchases may not be charged, and food stamp benefits do not directly affect other assistance available to low-income households, nor are they taxed as income.

Alternative programs are offered in Puerto Rico, the Northern Mariana Islands, and American Samoa, and program variations occur in a number of demonstration projects and in those jurisdictions that have elected to exercise the program options allowed.

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[2]Because not all of a households's income is actually counted when determining food stamp benefits, the program, in effect, assumes that most participants are able to spend 20-25 percent of their total cash monthly income on food.

[3]Except for (1) SSI recipients in California, where a state-financed adjustment to SSI benefits has replaced food stamp assistance and (2) General Assistance programs that do not meet minimum Federal standards for determining need.

Funding is overwhelmingly Federal, although the States and other jurisdictions have financial responsibility for significant administrative costs, as well as limited liability for erroneous benefit determinations.

Federal Administrative Responsibilities. At the Federal level, the program is administered by the Agriculture Department's Food and Nutrition Service (FNS). The FNS gives direction to welfare agencies through Federal regulations that define eligibility requirements, benefit levels, and administrative rules. It also is responsible for overseeing State programs for the electronic issuance of food stamp benefits, and for approving and overseeing participation by retail food stores and other outlets that may accept food stamps. Other Federal agencies that have administrative roles to play include: the Federal Reserve System (through which food stamp benefits are redeemed for cash, and which has some jurisdiction over "electronic benefit transfer" (EBT) methods for issuing food stamp benefits), the Social Security Administration (responsible for the Social Security numbers recipients must have, for providing limited application intake services, and for providing information to verify recipients' income), the Internal Revenue Service (providing assistance in verifying recipients' income and assets), the Bureau of Citizenship and Immigration Services of the Department of Homeland Security (helping welfare offices confirm alien applicants' status), and the Agriculture Department's Inspector General (responsible for many trafficking investigations).

State and Local Administrative Responsibilities. States, the District of Columbia, Guam, and the Virgin Islands, through their local welfare offices, have primary responsibility for the day-to-day administration of the Food Stamp Program. They determine eligibility, calculate benefits, and issue food stamp allotments (using coupons or, in most cases, electronic benefit transfer cards) following Federal rules. They also have a significant voice in carrying out employment and training programs and in determining some administrative features of the program (e.g., the extent to which verification of household circumstances is pursued, the length of eligibility certification periods, the structure of EBT systems). Most often, the Food Stamp Program is operated through the same welfare agency and staff that runs the State's TANF Program.

Puerto Rico, the Northern Mariana Islands, and American Samoa. In addition to the regular Food Stamp Program, the Food Stamp Act directs funding for a Nutrition Assistance Program in the Commonwealth of Puerto Rico and another in American Samoa. Separate legislation authorizes a variant of the Food Stamp Program in the Commonwealth of the Northern Mariana Islands.

Since July 1982, Puerto Rico has operated a Nutrition Assistance Program of its own design, funded by an annual Federal "block grant."[4] The Commonwealth's Nutrition Assistance Program differs from the regular Food Stamp Program primarily in that: (1) funding is limited to an annually indexed amount specified by law;[5] (2) the Food Stamp Act allows the Commonwealth a great deal of flexibility in program design, as opposed to the regular program's extensive Federal rules (e.g., 75 percent of benefits, paid through electronic benefit transfers, are earmarked for food purchases, the remainder may be claimed as cash, and rules barring certain not citizens do not apply); (3) income eligibility limits are about one-third those used in the regular Food Stamp Program; (4) maximum benefit levels are about 40 percent less than in the 48 contiguous States and the District of Columbia; and (5) different rules are used in counting income for eligibility and benefit purposes.

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[4]Prior to July 1982, the regular Food Stamp program operated in Puerto Rico, although with slightly different rules.

[5]For fiscal years 2003 and 2004, $1.395 billion and $1.397 billion are earmarked. The block grant funds the full cost of benefits and half the cost of administration.

In fiscal year 2002, Puerto Rico's Nutrition Assistance Program aided approximately 1 million persons each month with monthly benefits averaging $98 dollars a person ($244 a household).

Under the terms of the 1976 Covenant with the Commonwealth of the Northern Mariana Islands and implementing legislation (Public Law 96-597), a variant of the Food Stamp Program was negotiated with the Commonwealth and began operations in July 1982. The program in the Northern Marianas differs primarily in that: (1) it is funded entirely by Federal money, up to a maximum grant negotiated periodically ($7.1 million per year for fiscal years 2003 and 2004); (2) a portion of each household's food stamp benefit must be used to purchase locally produced food; (3) maximum allotments are about 5 percent higher than in the 48 contiguous States and the District of Columbia; and (4) income eligibility limits are about half those in the regular program. In September 2003, the Northern Marianas' program assisted 6,800 persons with a monthly benefit averaging $80 per person.

As with the Northern Marianas, American Samoa operates a variant of the regular Food Stamp Program. Under the Secretary of Agriculture's authority to extend Agriculture Department programs to American Samoa (Public Law 96-597) and a 2002 amendment to the Food Stamp Act made by the Farm Security and Rural Investment Act (Public Law 107-171), American Samoa receives an annually indexed grant ($5.6 million per year in fiscal years 2003 and 2004) to operate a Food Stamp Program limited to low-income elderly and disabled persons. While maximum monthly allotments are similar to those in the regular Food Stamp Program ($132 per person), income eligibility limits are about 25 percent lower. In September 2003, the program aided about 2,900 persons per month.

Program Options. The Food Stamp Act authorizes demonstration projects to test program variations that might improve operations. However, because of (1) the law's substantial limits on how much any demonstration can reduce benefits or restrict eligibility, (2) an administration policy that effectively bars demonstrations that have a significant cost to the Food Stamp Program, and (3) implementation of provisions for State flexibility included in the 1996 Welfare Reform Law (Public Law 104-193) and the 2002 Farm Security and Rural Investment Act (Public Law 107-171), no major demonstration projects are operational. Instead, a few small demonstrations are operating in some States (these deal with joint application processing and standardized food stamp benefits for SSI recipients, cash benefits for the elderly and SSI recipients, and "privatizing" program administration), and extensive waivers of administrative rules are routinely granted.

States also are allowed a number of significant options in how they implement the Food Stamp Program. States may establish their own administrative standards in areas such as application processing, ongoing recertification of recipient households, reporting of changes in household circumstances (and adjusting benefits to take these changes into account), counting child support payments, and standardizing the treatment of utility expenses in benefit calculations. In addition, States can use most of the rules they have established for TANF and Medicaid programs when deciding what income and resources (assets) to exclude in food stamp eligibility and benefit determinations, and may grant 5-month "transitional" food stamp benefits to those leaving the TANF program (without requiring them to reapply for food stamps). The states may issue benefits (at their own cost) to ineligible noncitizens and those ineligible under the work rule for able-bodied adults without dependents (ABAWDs; discussed below). With 50 percent Federal cost-sharing, they can operate "outreach" programs to inform low-income persons about food stamps and support nutrition education efforts. They may choose to operate a "simplified" program under which they can use many of their TANF rules and procedures when determining food stamp benefits for TANF recipients. States may sanction food stamp recipients failing to meet other public assistance program rules or failing to cooperate in child support enforcement efforts. They may, to a certain extent, waive the application of the work rule for ABAWDs; and they may choose to disqualify an entire household if the head of the household fails to fulfill work-related requirements. In some instances,

they may include the cash value of food stamp benefits when using welfare to subsidize recipients' wages. States and localities may opt to run "workfare" programs for food stamp recipients. Finally, States determine the content of employment and training programs for food stamp recipients (and, in many cases, who must participate).

Funding. The Food Stamp Act provides 100 percent Federal funding of food stamp benefits, except when States choose to "buy into" the program and pay for issuing food stamp benefits to ineligible noncitizens or those made ineligible by the work rule for ABAWDs. The Federal Government also is responsible for its own administrative costs: overseeing program operations (including oversight of participating food establishments), redeeming food stamp benefits through the Federal Reserve, and paying the Social Security Administration for certain intake services.

In most instances, the Federal Government provides half the cost of State welfare agency administration. In addition, the Federal Government shares the cost of carrying out employment and training programs for food stamp recipients: (1) each State receives a Federal grant for basic operating costs (a formula share of $90 million per year, plus a share of $20 million a year for those States pledging to serve all ABAWDs; and (2) additional operating costs, as well as expenses for support services to participants (e.g. transportation and child care) are eligible for a 50 percent Federal match. Finally, States are allowed to retain a portion of improperly issued benefits they recover (other than those caused by welfare agency error): 35 percent of recoveries in fraud cases and 20 percent in other circumstances. Federal and State Food Stamp Act spending in selected years since 1980 is shown in Table 1.

TABLE. 1 RECENT FOOD STAMP ACT EXPENDITURES: SELECTED YEARS, 1980-2002
(in millions)

Fiscal Year	Benefits[1] (Federal)	Administration[2]		Total
		Federal	State and local	
1980	$8,685	$ 503	$ 375	$9,563
1985	11,556	1,043	871	13,470
1990	15,090	1,422	1,174	17,686
1991	18,249	1,516	1,247	21,012
1992	21,883	1,656	1,375	24,914
1993	23,033	1,716	1,572	26,321
1994	23,736	1,789	1,643	27,168
1995	23,759	1,917	1,748	27,424
1996	23,510	1,984	1,842	27,336
1997	20,810	2,058	1,904	24,772
1998	18,228	2,169	1,988	22,385
1999	17,217	2,100	1,874	21,191
2000	16,320	1,935	2,086	20,341
2001	16,711	2,102	2,233	21,045
2002	19,393	2,264	2,397	24,054

[1] All benefit costs associated with the Food Stamp Program, Puerto Rico's block grant, and grants to American Samoa and the Northern Marianas are included. Over time, the figures reflect both changes in benefit levels and numbers of recipients.

[2] All Federal administrative costs associated with the Food Stamp Program appropriation and grants to Puerto Rico, American Samoa, and the Northern Marianas are included: Federal matching spending for the various administrative and employment and training program expenses of States and other jurisdictions, and direct Federal administrative costs. Figures for Federal administrative expenses paid out of other Agriculture Department appropriations accounts ($40-$60 million a year) are not included. State and local costs are estimated based on the known Federal shares of administrative and employment and training program expenses and represent an estimate of these costs to States and other jurisdictions; however, the State/local figures shown in the table generally do not include administrative expenses for State-financed benefits to noncitizens.

Source: U.S. Department of Agriculture budget justifications for fiscal years 1981-2004. Complied by the Congressional Research Service.

Eligibility

The Food Stamp Program has financial, employment/training-related, and "categorical" tests for eligibility. Its financial tests require that most of those eligible have monthly income and liquid assets below limits set by law; income limits are inflation indexed. Under the employment/ training-related tests, certain household members must register for work, accept suitable job offers, and fulfill work or training requirements (such as looking or training for a job) established by State welfare agencies. In addition, food stamp eligibility for ABAWDs is limited to 3-6 months in any 36-month period unless they are working at least half time or in a work or training activity. Categorical eligibility rules make some automatically eligible for food stamps (many TANF, SSI, and GA recipients), and categorically deny eligibility to others (e.g., strikers and many noncitizens, postsecondary students, and people living in institutional settings). Applications cannot be denied

because of the length of a household's residence in a welfare agency's jurisdiction or because the household has no fixed mailing address or does not reside in a permanent dwelling.

The Food Stamp Household. The basic food stamp beneficiary unit is the "household." A food stamp household can be either a person living alone or a group of individuals living together; there is no requirement for cooking facilities. The food stamp household is unrelated to recipient units in other welfare programs (e.g., TANF families with dependent children, elderly or disabled individuals or couples in the SSI Program).

Generally speaking, individuals living together constitute a single food stamp household if they customarily purchase food and prepare meals in common. Members of the same household must apply together, and their income, expenses, and assets normally are aggregated in determining food stamp eligibility and benefits. However, persons who live together can sometimes be considered separate "households" for food stamp purposes, related co-residents generally are required to apply together, and special rules apply to those living in institutional settings. Most often, persons living together receive larger aggregate benefits if they are treated as more than one food stamp household.

Persons who live together, but purchase food and prepare meals separately, may apply for food stamps separately, except for: (1) spouses; (2) parents and their children (21 years or younger); and (3) minors 18 years or younger (other than foster children, who may be treated separately) who live under the parental control of a caretaker. In addition, persons 60 years or older who live with others and cannot purchase food and prepare meals separately because of a substantial disability may apply separately from their coresidents as long as their coresidents' income is below prescribed limits (165 percent of the Federal poverty guidelines).

Although those living in institutional settings generally are barred from food stamps, individuals in certain types of group living arrangements may be eligible and are automatically treated as separate households, regardless of how food is purchased and meals are prepared. These arrangements must be approved by State or local agencies and include: residential drug addict or alcoholic treatment programs, small group homes for the disabled, shelters for battered women and children, and shelters for the homeless.

Thus, different food stamp households can live together, food stamp recipients can reside with nonrecipients, and food stamp households themselves may be "mixed" (include recipients and nonrecipients of other welfare benefits).

Income Eligibility. Except for households composed entirely of TANF, SSI, or GA recipients (who generally are automatically eligible for food stamps), monthly cash income is the primary food stamp eligibility determinant.[6] In establishing eligibility for households without an elderly or disabled member,[7] the Food Stamp Program uses both the household's basic (or "gross") monthly income and it's counted (or "net") monthly income. When judging eligibility for

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[6]Although they do not have to meet food stamp financial eligibility tests, TANF, SSI, and General Assistance households must still have their income calculated under food stamp rules to determine their food stamp benefits.

[7]In the Food Stamp program, "elderly" persons are those 60 years of age or older. The "disabled" generally are beneficiaries fo governmental disability-based payments (e.g., Social Security or SSI disability recipients, disabled veterans, certain disability retirement annuitants, and the recipients of disability-based Medicaid or General Assistance.

households with elderly or disabled members, only the household's counted monthly income is considered; in effect, this procedure applies a more liberal income test to elderly and disabled households.

Basic (or gross) monthly income includes all of a household's cash income *except* the following "exclusions" (disregards): (1) most payments made to third parties (rather than directly to the household); (2) unanticipated, irregular, or infrequent income, up to $30 a quarter; (3) loans (deferred repayment student loans are treated as student aid, see below); (4) income received for the care of someone outside the household; (5) nonrecurring lump-sum payments such as income tax refunds and retroactive lump-sum Social Security payments (these are instead counted as liquid assets); (6) Federal energy assistance; (7) expense reimbursements that are not a "gain or benefit" to the household; (8) income earned by schoolchildren 17 or younger; (9) the cost of producing self-employment income; (10) Federal postsecondary student aid (e.g., Pell grants, student loans); (11) advance payments of Federal earned income credits; (12) "on-the-job" training earnings of dependent children under 19 in the Workforce Investment Act (WIA), formerly the Job Training Partnership Act (JTPA), Programs, as well as monthly "allowances"; (13) income set aside by disabled SSI recipients under an approved "plan for achieving self-support"; and (14) payments required to be disregarded by provisions of Federal law outside the Food Stamp Act (e.g., various payments under laws relating to Indians, payments under the Older Americans Act Employment Program for the Elderly). In addition, States may, within certain limits, choose to exclude other types of income they disregard in their TANF or Medicaid programs.

Counted (or net) monthly income is computed by subtracting certain "deductions" from a household's basic (or gross) monthly income. This procedure is based on the recognition that not all of a household's income is equally available for food purchases. Thus, a standard portion of income (varying by household size to a limited extent), plus amounts representing work expenses or excessively high nonfood living expenses, are disregarded.

For households *without an elderly or disabled member*, counted monthly income equals gross monthly income less the following deductions:

- A "standard" monthly deduction that varies by household size and is indexed for inflation (for fiscal year 2004, this deduction in the 48 States and the District of Columbia is $134 for households of 1-4 persons, $149 for 5-person households, and $171 for households of 6 or more persons). Different standard deductions are used for Alaska, Hawaii, Guam, and the Virgin Islands (e.g., the fiscal year 2004 deduction for 4-person households is $229 in Alaska, $189 in Hawaii, $269 in Guam, and $127 in the Virgin Islands).
- Any amounts paid as legally obligated child support;
- Twenty percent of any earned income, in recognition of taxes and work expenses;
- Out-of-pocket dependent care expenses, when related to work or training, up to $175 per month per dependent, $200 per month for children under age 2; and
- Shelter expenses (including utility costs) that exceed 50 percent of counted income after all other deductions, up to a periodically adjusted ceiling that is $378 per month for fiscal year 2004. Different ceilings prevail in Alaska ($604), Hawaii ($509), Guam ($444), and the Virgin Islands ($298).

For households *with an elderly or disabled member*, counted monthly income equals gross monthly income less:

- The same standard, child support, earned income, and dependent care deductions noted above;
- Any shelter expenses, to the extent they exceed 50 percent of counted income after all other deductions, *with no limit*; and
- Any out-of-pocket medical expenses (other than those for special diets) that are incurred by an elderly or disabled household member, to the extent they exceed a threshold of $35 a month.

Except for those households comprised entirely of TANF, SSI, or GA recipients, in which case food stamp eligibility generally is automatic, all households must have net monthly income that does not exceed the annually indexed Federal poverty guidelines. Households without an elderly or disabled member *also* must have gross monthly income that does not exceed 130 percent of the inflation-adjusted Federal poverty guidelines. Both these income eligibility limits are uniform for the 48 contiguous States, the District of Columbia, Guam, and the Virgin Islands; somewhat higher limits (based on higher poverty guidelines) are applied in Alaska and Hawaii. The net and gross eligibility limits on income are summarized in Table 2.

TABLE 2. COUNTED (NET) AND BASIC (GROSS) MONTHLY INCOME ELIGIBILITY LIMITS FOR THE FOOD STAMP PROGRAM, FISCAL YEAR 2004

Household size	48 States, D.C., and the territories	Alaska	Hawaii
Counted (net) monthly income eligibility limits[1]:			
1 person	$ 749	$ 935	$ 861
2 persons	1,010	1,262	1,162
3 persons	1,272	1,590	1,463
4 persons	1,534	1,917	1,764
5 persons	1,795	2,245	2,065
6 persons	2,057	2,572	2,365
7 persons	2,319	2,900	2,666
8 persons	2,580	3,227	2,967
Each additional person	+262	+328	+301
Basic (gross) monthly income eligibility limits[2]:			
1 person	973	1,215	1,120
2 persons	1,313	1,641	1,511
3 persons	1,654	2,066	1,902
4 persons	1,994	2,492	2,293
5 persons	2,334	2,918	2,684
6 persons	2,674	3,344	3,075
7 persons	3,014	3,769	3,466
8 persons	3,354	4,195	3,857
Each additional person	+341	+426	+392

[1] Set at the applicable Federal poverty guidelines, updated for inflation through calendar 2002.
[2] Set at 130 percent of the applicable Federal poverty guidelines, updated for inflation through calendar 2002.

Source: U.S. Department of Agriculture, Food and Nutrition Service.

Allowable Assets. Except for households automatically eligible for food stamps because they are composed entirely of Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), or GA recipients, eligible households must have counted liquid assets that do not exceed federally prescribed limits. Households without an elderly or disabled member cannot have counted liquid assets above $2,000. Households with an elderly or disabled member cannot have counted liquid assets above $3,000.

Counted liquid assets include cash on hand, checking and savings accounts, savings

certificates, stocks and bonds, individual retirement accounts (IRAs) and Keogh plans (less any early withdrawal penalties), and nonrecurring lump-sum payments such as insurance settlements. Certain less liquid assets also are counted: a portion of the value of vehicles and the equity value of property not producing income consistent with its value (e.g., recreational property).

Counted assets do not include the value of the household's residence (home and surrounding property), business assets, personal property (household goods and personal effects), lump-sum earned income tax credit payments, burial plots, the cash value of life insurance policies and pension plans (other than Keogh plans and IRAs), and certain other resources whose value is not accessible to the household, would not yield more than $1,000 if sold (e.g., a car with a small equity value), or are required to be disregarded by other Federal laws.

Some special rules apply when counting allowable assets. Although the general rule is that the fair market value of a vehicle in excess of $4,650 is to be counted as an asset, States may (and often do) count vehicles as assets only to the extent they do under their TANF programs. Moreover, States generally may exclude additional assets to the extent they do so under their TANF or Medicaid programs.

Work-Related Requirements. To gain or retain eligibility, most able-bodied adults must: (1) register for work (typically with the welfare agency or a State employment service office); (2) accept a suitable job if offered one; (3) fulfill any work, job search, or training requirements established by administering welfare agencies; (4) provide the administering welfare agency with sufficient information to allow a determination with respect to their job availability; and (5) not voluntarily quit a job without good cause or reduce work effort below 30 hours a week. If the household head fails to fulfill any of these requirements, the entire household may, at State option, be disqualified for up to 180 days. Individual disqualification periods differ according to whether the violation is the first, second, or third; minimum periods, which may be increased by the State welfare agency, range from 1 to 6 months.

Those who are exempt by law from these basic work requirements include: persons physically or mentally unfit for work; those under age 16 or over age 59; individuals between 16 and 18 if they are not head of household or are attending school or a training program; persons working at least 30 hours a week or earning the minimum wage equivalent; persons caring for dependents who are disabled or under age 6; those caring for children between ages 6 and 12 if adequate child care is not available (this second exemption is limited to allowing these persons to refuse a job offer if care is not available); individuals already subject to and complying with another assistance program's work, training, or job search requirements; otherwise eligible postsecondary students; and residents of drug addiction and alcoholic treatment programs.

Those not exempted by one of the above-listed rules must, at least, register for work and accept suitable job offers. However, their State welfare agency may require them to fulfill some type of work, job search, or training obligation. Welfare agencies must operate an employment and training program of their own design for work registrants whom they designate, and they may require all work registrants to participate in one or more components of their program, or limit participation by further exempting additional categories and individuals for whom participation is judged impracticable or not cost effective. Program components can include any or all of the following activities: supervised job search or training for job search, workfare, work experience or training programs, education programs to improve basic skills, or any other employment or training activity approved by the Agriculture Department.

Recipients who take part in an employment or training activity beyond work registration cannot be required to work more than the minimum wage equivalent of their household's benefit.

Total hours of participation (including both work and any other required activity) cannot exceed 120 hours a month. Welfare agencies also must provide support for costs directly related to participation (e.g., transportation and child care), and they may limit this support to local market rates for necessary dependent care.

In addition to these work-related requirements, there is a work requirement for most able-bodied adults between 18 and 50 without dependents (ABAWDs). They are ineligible for food stamps if, during the prior 36 months, they received food stamps for 3 months while not working at least 20 hours a week or participating in an approved work/training activity. Those disqualified under this rule are able to reenter the Food Stamp Program if, during a 30-day period, they work 80 hours or more or participate in a work/training activity. If they then become unemployed or leave work/training, they are eligible for an additional 3-month period on food stamps without working at least 20 hours a week or participating in a work/training activity. But they are allowed only one of these added 3-month eligibility periods in any 36 months for a potential total of 6 months on food stamps in any 36 months without half-time work or enrollment in a work/training program. At State request, this rule can be waived for areas with very high unemployment (over 10 percent) or lack of available jobs. Moreover, States may, on their own initiative, exempt up to 15 percent of those covered under the new work rule.

In fiscal year 2002, States reported 2.3 million new work registrants. Of these, approximately 1.2 million -- including an estimated 450,000 ABAWDs--were subject to employment and training program placement.

Categorical Eligibility Rules and Other Limitations. Food stamp eligibility is sometimes denied for reasons other than financial need or compliance with work-related requirements. Many noncitizens are barred – eligibility is extended only to permanent residents legally present in the U.S. for at least 5 years, legal immigrant children (under 18), the elderly (age 60+) and disabled (recipients of government disability benefits like SSI) who were legally resident before August 1996, refugees and asylees, veterans and others with a military connection, those with a substantial history of work covered under the Social Security system, and certain other limited groups of aliens. Households with members on strike are denied benefits unless eligible prior to the strike. With some exceptions, postsecondary students (in school half time or more) who are fit for work and between ages 18 and 50 are ineligible. Persons living in institutional settings are denied eligibility, except those in special SSI-approved small group homes for the disabled, persons living in drug addiction or alcohol treatment programs, and persons in shelters for battered women and children or shelters for the homeless. Boarders cannot receive food stamps unless they apply together with the household in which they are boarding. Those who transfer assets for the purpose of qualifying for food stamps are barred. Persons who fail to provide Social Security numbers or cooperate in providing information needed to verify eligibility or benefit determinations are ineligible. Food stamps are denied those who intentionally violate program rules, for specific time periods ranging from 1 year (on a first violation) to permanently (on a third violation or other serious infraction); and States may impose food stamp disqualification when an individual is disqualified from another public assistance program. Automatic disqualification is required for those applying in multiple jurisdictions, fleeing arrest, or convicted of a drug-related felony. Finally, States may disqualify individuals not cooperating with child support enforcement authorities or in arrears on their child support obligations.

Benefits

Food stamp benefits are a function of a household's size, its net monthly income, and inflation-indexed maximum monthly benefit levels (in some cases, adjusted for geographic location). An eligible household's net income is determined (i.e., the deductions noted earlier are subtracted

from gross income), its maximum benefit level is established, and a benefit is calculated by subtracting its expected contribution (30 percent of its counted net income) from its maximum allotment. Thus, a 2-person household with $400 in counted net income (after deductions) would receive a monthly allotment of $139 (the fiscal year 2004 maximum 2-person benefit in the 48 States, $259, less 30 percent of net income, $120).

Allotments are not taxable and food stamp purchases may not be charged sales taxes. Receipt of food stamps does not affect eligibility for or benefits provided by other welfare programs, although some programs use food stamp participation as a "trigger" for eligibility and others take into account the general availability of food stamps in deciding what level of benefits to provide. In fiscal year 2002, monthly benefits averaged $80 per person.

Maximum Monthly Allotments. Maximum monthly food stamp allotments are tied to the cost of purchasing a nutritionally adequate low-cost diet, as measured by the Agriculture Department's Thrifty Food Plan (TFP). Maximum allotments are set at: the monthly cost of the TFP for a four-person family consisting of a couple between ages 20 and 50 and two school-age children, adjusted for family size (using a formula reflecting economies of scale developed by the Human Nutrition Information Service), and rounded down to the nearest whole dollar. Allotments are adjusted for food price inflation annually, each October, to reflect the cost of the TFP in the immediately previous June.

Maximum allotments are standard in the 48 contiguous States and the District of Columbia; they are higher, reflecting substantially different food costs, in Alaska, Hawaii, Guam, and the Virgin Islands (Table 3).

TABLE 3. MAXIMUM FOOD STAMP ALLOTMENTS, FISCAL YEAR 2004

Household size	48 States and D.C.	Alaska[1]	Hawaii[2]	Guam	Virgin Islands
1 person	$141	$167	$210	$182	$208
2 persons	259	307	386	333	382
3 persons	371	439	553	477	547
4 persons	471	558	702	606	695
5 persons	560	663	834	720	826
6 persons	672	795	1,001	864	991
7 persons	743	879	1,106	955	1,095
8 persons	849	1,005	1,264	1,092	1,252
Each additional person	+106	+126	+158	+137	+157

[1] Maximum allotment levels in rural Alaska are 27 percent to 55 percent higher than the urban Alaska allotments noted here. The allotment levels for Alaska noted here are those in effect as of October 1, 2003. However, under legislation pending as of December 15, 2003, they are scheduled to increase slightly: to $169, $309, $443, $563, $669, $803, $887, $1,014 and + $127.
[2] The allotment levels for Hawaii noted here are those in effect as of October 1, 2003. However, under legislation pending as of December 15, 2004, they are scheduled to increase slightly to $212, $389, $557, $707, $840, $1,008, $1,114, $1273, and +159.

Source: U.S. Department of Agriculture.

Minimum and Prorated Benefits. Eligible one-and two-person households are guaranteed a minimum monthly food stamp allotment of $10, no matter how the calculation of their benefits works out. Minimum monthly benefits for other household sizes vary from year to year, depending on the relationship between changes in the income eligibility limits (indexed to overall inflation) and the adjustments to the cost of the TFP (indexed to changes in food costs). In a few cases, benefits

for households larger than two persons can be reduced to zero before income eligibility limits are exceeded.

In addition, a household's calculated monthly allotment can be prorated (reduced) for one month. On application, a household's first month's benefit is reduced to reflect the date of application. If a previously participating household does not meet eligibility recertification requirements in a timely fashion, but does become certified for eligibility subsequently, benefits for the first month of its new certification period normally are prorated to reflect the date when recertification requirements were met.

Application, Processing, and Issuing Food Stamp Benefits. Food stamp benefits normally are issued monthly. The local welfare agency must either deny eligibility or make food stamps available within 30 days of initial application and must provide food stamps without interruption if an eligible household reapplies and fulfills recertification requirements in a timely manner. Households in immediate need because of little or no income and very limited cash assets, as well as the homeless and those with extraordinarily high shelter expenses, must be given expedited service (provision of benefits within 7 days of initial application).

Food stamp issuance is a welfare agency responsibility, and issuance practices differ among welfare agencies. Food stamp benefits have historically been issued as paper "coupons." Recipients were provided (usually by mail) with an authorization-to-participate card that was then turned in at a local issuance point (e.g., a bank, post office, or welfare office) when picking up their monthly allotment, or coupon allotments were mailed directly to recipients. However, in almost all States electronic benefit transfer (EBT) systems are now used. EBT systems replace coupons with an ATM-like card used to make food purchases at the point of sale by deducting the purchase amount from the recipient's food stamp benefit account. EBT issuance is used statewide in all States except California (which is scheduled for statewide issuance by the end of 2004); it also is used in Puerto Rico and the Virgin Islands (Guam is scheduled to convert to EBT in mid-2004).

Items That May Be Purchased With Food Stamp Benefits. Typically, participating households use their food stamp benefit EBT cards in approved grocery stores to buy food items for home preparation and consumption; food stamp purchases are not taxable. However, the actual list of approved uses for food stamps is more extensive, and includes: (1) food for home preparation and consumption, not including alcohol, tobacco, or hot foods intended for immediate consumption; (2) seeds and plants for use in gardens to produce food for personal consumption; (3) food purchased at approved farmers' markets; (4) in the case of the elderly and SSI recipients and their spouses, meals prepared and served through approved communal dining programs; (5) in the case of the elderly and those who are disabled to an extent that they cannot prepare all of their meals, home-delivered meals provided by programs for the homebound; (6) meals prepared and served to residents of drug addiction and alcoholic treatment programs, small group homes for the disabled, shelters for battered women and children, and shelters or other establishments serving the homeless; and (7) where the household lives in certain remote areas of Alaska, equipment for procuring food by hunting and fishing (e.g., nets, hooks, fishing rods, and knives). Food stamp benefits now normally are accessed through EBT cards. The card is swiped through an approved retailer's point-of-sale device, automatically debiting the recipient's food stamp account and crediting the retailer's bank account; unlike coupon transactions, recipients receive no cash change, and special arrangements must be made for nontraditional sites like farmers' markets.

Interaction with TANF, SSI, and GA Programs

The Food Stamp Program is intertwined with Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), and State/local General Assistance (GA) programs in several

ways: it is administratively linked withTANF and GA programs; TANF recipients can receive "transitional" food stamp benefits when leaving TANF; most TANF, SSI, and GA recipients are automatically (categorically) eligible for food stamps; States can choose to use many TANF rules for as to how they count income sources and asset types for food stamp eligibility; and the food stamp recipient population is, to a large extent, made up of TANF, SSI, and GA participants.

State and local offices and personnel administering TANF and GA programs are typically the same offices that enroll people for food stamps and issue food stamp benefits. States may choose to use many TANF rules on how to count income and assets when determining food stamp benefits. Joint food stamp-TANF/GA applications and interview procedures are common. Information about applicants and recipients is shared. TANF/GA cash benefits sometimes are included as part of the food stamp electronic benefit transfer (EBT) system (e.g., both TANF cans and food stamp benefits can be accessed with the same EBT debit card). This coadministration does not apply in the case of the SSI Program, which is administered separately through Social Security Administration offices – although these offices do provide limited intake and referral services for the Food Stamp Program, and some pilot projects provide standardized food stamp benefits to SSI recipients through SSI offices.

States have the option to give up to 5 months' transitional food stamp benefits to those leaving TANF – without requiring that the household apply for food stamps. The transitional benefit is the amount received prior to leaving TANF, adjusted to account for the loss of TANF income. Transitional benefit households may reapply during the 5-month period to have their benefits adjusted based on changed circumstances, and States may opt to change benefit based on information received from another program (like Medicaid) in which the household participates. At the end of the transitional period, households may reapply for continued food stamps under regular food stamp rules.

Food stamp rules generally make households in which all members are TANF, SSI, or GA recipients categorically eligible for food stamps, without reference to regular food stamp financial eligibility requirements. TANF recipients are broadly defined as anyone receiving benefits or services through a State's TANF program. SSI recipients eligibility for food stamps is barred in California, where the SSI benefit has been adjusted upward to account for the loss of food stamp eligibility; and GA programs must meet minimum Federal standards to qualify their recipients for food stamps. Categorical eligibility for food stamps is particularly important in cases where States have chosen TANF rules that are more liberal than food stamp rules (e.g., disregarding the value of vehicles for working households). In addition, States can, within limits, use their TANF rules directly when determining what types of *any* applicant household's income and assets to count.

For most persons participating in the Food Stamp Program, food stamp aid represents a second or third form of government assistance. Only about 20 percent of food stamp households rely solely on nongovernmental sources for their cash income, although about 30 percent have some income from these sources (e.g., earnings, private retirement income). According to 2002 data from Agriculture Department surveys, TANF contributed to the income of some 21 percent of food stamp households, SSI benefits went to 30 percent, and GA payments were received by just over 5 percent.

Participation

Table 4 shows national average food stamp participation (other than participants in the nutrition assistance grants for Puerto Rico, American Samoa, and the Northern Marianas) from fiscal year 1975 through fiscal year 2002. Food stamp enrollment is responsive to changes in the economy (i.e., recipients' employment status and income), food stamp eligibility rules (and potential applicants' perception of their eligibility status), and administrative practices – as well as the number of

recipients getting or losing public assistance eligibility or benefits. Participation has fluctuated widely over the last 27 years, reaching its peak in fiscal year 1994; in that year, it averaged 27.5 million persons a month, with an all-time high of 28 million in the spring of 1994.

Rates of participation *among those eligible* also changes over time. According to a July 2003 Agriculture Department study based on participation in September of each year, the participation rate among eligible individuals rose three points between September 1999 and 2001 – from 59 to 62 percent – after five consecutive years of falling rates. This same study also indicated that participation rates varied widely among segments of the food stamp eligible population – e.g., 80 percent for households with children, 28 percent for the elderly, 52 percent for those living in households with earnings.

TABLE 4. FOOD STAMP PARTICIPATION: SELECTED FISCAL YEARS, 1975-2002

Fiscal year	Average monthly number of food stamp participants (in millions)
1975	16.3
1980	19.2
1985	19.9
1990	20.0
1991	22.6
1992	25.4
1993	27.0
1994	27.5
1995	26.6
1996	25.5
1997	22.9
1998	19.8
1999	18.2
2000	17.2
2001	17.3
2002	19.1

Note: Participation under nutrition assistance grants for Puerto Rico, American Samoa, and the Northern Marianas is not shown in this table.

Source: U.S. Department of Agriculture; Food and Nutrition Service.

Elderly Persons and the Food Stamp Program

Participation in the Program. Food stamp participation among eligible elderly persons is relatively low. The most recent Agriculture Department estimates (average monthly participation during fiscal year 2001 as a percentage of the estimated eligible population) indicate that the

participation rate for eligible elderly individuals was 28 percent – noticeably below the revised 31 percent rate estimated for fiscal year 1999. This compared to a 60 percent participation rate among all individuals.

The Agriculture Department's survey of food stamp participants' characteristics during fiscal year 2002 showed that households with at least one elderly member accounted for 19 percent of all food stamp households. But, because the elderly receiving food stamps generally live in small households (80 percent live alone), they make up only 9 percent of all food stamp participants. Overall, the survey information also indicates 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 – e.g., half receive less than 25 percent of maximum benefits. Overall, elderly participants receive about 6 percent of all food stamp benefits paid out. The same survey also indicated that the average total monthly income of households with elderly members was 82 percent of the applicable Federal poverty income guidelines (compared to 56 percent among households with no elderly members) and that their average monthly benefit ($64) was some 37 percent of the average for all households in the program. A majority of food stamp households with elderly persons received SSI or Social Security income: 59 percent had SSI income and 69 percent received Social Security.

Special Rules and Projects. The Food Stamp program has a number of special rules for the elderly age 60 or above –

- Households composed entirely of SSI recipients are automatically eligible, except in California where SSI benefits have been adjusted upward to account for the loss of food stamp eligibility.

- 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 eligibility have been applied. While their income is compared against a lower standard than most other households (who must have total income, before deductions, below 130 percent of the poverty guidelines), the amount of income counted against the standard is significantly less for elderly households because of the various deductions (about $300 a month on average) have been subtracted out.

- A more liberal asset limit is used in judging eligibility. Households with elderly (or disabled) 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 $378 a month.

- When calculating benefits and income eligibility, elderly (or 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 $30 or more.

- Elderly (or disabled) persons who are applicants for or recipients of SSI benefits can make preliminary application for food stamps through their Social Security office and get assistance in completing their application.

- Households with elderly (or disabled) members may be granted longer eligibility certification periods than others – up to two years. Average certification periods for elderly households are 13 months (vs. 9 month for others).

- Elderly (or disabled) persons are excused from the Food Stamp program's work requirements.

- Elderly persons who live with others and cannot purchase food and prepare meals separately because of a substantial disability may apply separately from their co-residents and have their co-residents' financial resources disregarded for food stamp purposes – as long as their co-residents' income is below prescribed limits (165 percent of the Federal poverty guidelines).

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 $1 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 in their behalf in the application process and using food stamp benefits at grocery stores. Legally resident noncitizens are eligible after 5 years' legal residence.[8]

Two special food stamp projects affect the elderly. A "cash-out" project operating in all or part of 5 states (Minnesota, Ohio, Oregon, Utah, and Vermont) allows eligible persons age 65 or over and SSI recipients to receive their food stamp benefits in cash. A second project operating in 4 states (Mississippi, South Carolina, Texas, and Washington) provides single SSI recipients who only have SSI, or SSI and Social Security, income the option to receive standardized food stamp benefits, thereby foregoing the need to document specific expenses. In 3 states the project operates through SSI offices; in Texas, SSI offices are used as an "outreach" tool, and there is no direct SSI involvement in issuing the benefit.

2. COMMODITY SUPPLEMENTAL FOOD PROGRAM (CSFP)

The Commodity Supplemental Food Program (CSFP) provides supplemental foods to low-income elderly persons and to low-income infants, children, and pregnant, postpartum, and breastfeeding women. It operates under Section 4(a) of the Agriculture and Consumer Protection Act of 1973, as amended (7 U.S.C. 612c note), and appropriations are authorized through fiscal year 2007. The CSFP is available through over 100 local projects in 31 states, the District of Columbia, and 2 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, 82 percent of its recipients are now elderly – 352,000 out of 427,000 in fiscal year 2002. 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) foood items purchased with annually appropriated funds, (2) food commodities donated from excess Agriculture Department stocks, and (3) cash grants from annually appropriated funds to help cover costs for administration and food storage and distribution. Food packages distributed by local sponsors are

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[8]Another rule making elderly persons who were legally resident before August 1996 is effectively overtaken by this more general rule.

designed with the specific nutritional needs of the elderly, women, infants, and children in mind. They include foods such as canned fruits, vegetables, meats, and fish, peanut butter, cereal and grain products, juices, and dairy products.

FY2002 spending for the CSFP was $105 million ($23 million of which represented support for administrative and storage/distribution costs); in addition, commodities valued at about $10 million were donated from excess Federal stocks. While elderly participants made up over 80 percent of participants, the monthly value of food packages distributed to them (about $16 a person) was significantly less than for packages provided to women, infants, and children ($20 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 (and limited donations of commodities) 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 operates under Section 17 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1766), and appropriations are permanently authorized. This program offers the same subsidies given for meals and snacks served in child care center. Each meal (breakfast, lunch, supper) and snack is subsidized at a legislatively set (and inflation-adjusted) rate, with meals and snacks served to lower-income persons subsidized at a higher rate than others. For the July 2003 - June 2004 period, the subsidy rates range from $2.19 for lunches/suppers served 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 fiscal year 2002, average daily attendance at the 2,300 sites operated by 1,500 sponsoring organizations was 82,000 persons. Federal subsidies totaled $57 million.

4. THE SENIOR FARMERS' MARKET NUTRITION PROGRAM

The Senior Farmers' Market Nutrition Program (SFNMP) is a relatively new food assistance program for the elderly. It was established by administrative decision in the Agriculture Department (using funding available from the Commodity Credit Corporation) in January 2001. Section 4402 of the Farm Security and Rural Investment Act of 2002 (P.L. 107-171) created specific legislative authority to operate the program and provided mandatory appropriations of $15 million a year to fund it.

The SFNMP awards grants to states, as well as the District of Columbia, Puerto Rico, U.S. territories, and Indian tribal organizations to provide low-income seniors with coupons (vouchers) that can be exchanged for eligible foods at farmers' markets, roadside stands, and community-supported agriculture programs. The grant funds may be used only to support food costs; no administrative funding is available. Grants go to state departments overseeing agriculture, health, social services, and services for the elderly – depending on the state. They design the state's program (e.g., benefit levels) and determine who local operators will be.

The purposes of the program are to provide resources in the form of fresh, nutritious, unprepared, locally grown fruits, vegetables, and herbs to lower-income elderly persons, to increase the domestic consumption of agricultural commodities, and develop or aid in the development of new and additional farmers' markets, roadside stands, and community-supported agriculture programs. Lower-income seniors – generally, individuals age 60 or older – who have household income of not more than 185 percent of the Federal poverty income guidelines are the targeted recipients of SFMNP benefits. Some state agencies accept proof of participation or enrollment in a means-tested program like the CSFP or the Food Stamp program for SFMNP eligibility. Benefits are provided

for use during the growing/harvest season, which may vary by project area, and may only be used for fresh, nutritious, unprocessed fruits, vegetables, and fresh-cut herbs.

In fiscal year 2002, over 11,000 farmers at 1,600 farmers' markets, 1,500 roadside stands, and 200 community-supported agriculture projects participated. In fiscal year 2003, agencies of 35 states, the District of Columbia, Puerto Rico, and 3 tribal organizations received grants. The most recent information as to participation in this program shows that some 419,000 persons participated in fiscal year 2001.

B. LEGISLATIVE DEVELOPMENTS: 2001-2002

The Farm Security and Rural Investment Act of 2002 (P.L. 107-171) reauthorized appropriations for the Food Stamp program and the CSFP through fiscal year 2007. This law also established legislative authority for the Senior Farmers' Market Nutrition program and made the most extensive changes to the Food Stamp program since the 1996 omnibus welfare reform law. But it made only one significant change to the rules governing the Food Stamp program of note to elderly applicants or recipients – establishing a rule that any person with 5-years' legal residence in the United States is eligible for food stamps.

The 2002 law made eligible noncitizen legal immigrant children (under 18) and those who have been legally present in the U.S for 5 years. It raised benefits for larger households by increasing the amount of their income that is disregarded when setting benefits (i.e., indexing the "standard deduction" and varying it by household size) and liberalize the treatment of assets for disabled persons. It allowed states to guarantee 5-months' of "transitional" food stamp benefits for those leaving the Temporary Assistance Program for Needy Families. A number of state options also were established to ease access to the program and administrative burdens on applicants/recipients and program operators. These let states reduce recipient reporting requirements, simplify benefit calculations, and conform income and asset definitions to those used in the Temporary Assistance for Needy Families (TANF) and Medicaid programs. It ended Federal restrictions on spending of work/training funds and changed and generally reduced the Federal share of this spending. Finally, the new law revamped the Food Stamp program's "quality control" system to (1) dramatically reduce the number of states likely to be sanctioned for high rates of erroneous benefit/eligibility decisions (only those with persistently high error rates would be penalized) and (2) grant Federal bonus payments to states with exemplary administrative performance.

C. FOOD SECURITY AMONG THE ELDERLY

The United States Agriculture Department has conducted a recent series of studies/surveys addressing "food insecurity" among households in United States. The most recent (*Household Food Security in the United States, 1995-1998*, Advance Report, July 1999) shows estimated "prevalence levels" of food insecurity based on comparable data applied across the 4 years between 1995 and 1998. The overall trend shows that the food security of U.S. households improved through 1997 and declined in the 12 months ending August 1998. But, comparing the rates of overall U.S. food security/insecurity between 1995 and 1998 shows little overall change over the period as a whole. Food secure households – those with access at all times to enough food for an active healthy life – were estimated at about 90 percent. The most severe range of food insecurity reported – the category of "food insecure households with evidence of hunger among household members" – followed a similar year-to-year trend, but over the period as a whole registered a decline in the prevalence of hunger. In 1995 and 1998, about 4 percent were classified as "food insecure with hunger." The profile of households covered in the surveys shows that households with elderly persons were more likely to be "food secure" – 95% – than other types of households. Moreover, the studies/surveys

showed that households with elderly members were less likely to be "food insecure with evidence of hunger:" 2 percent vs. about 4 percent for all households.

The *U.S. Conference of Mayors - Sodexho Hunger and Homelessness Survey 2003* – a 25-city survey – provides another more recent indicator of the need for food assistance among the elderly. It estimates that, during the past year, requests for emergency food assistance increased in 88 percent of the surveyed cities, by an average of 17 percent in the cities reporting increases. For the elderly, 59 percent of the cities reported a higher level of requests for aid, and requests increased by an average of 13 percent in those reporting higher levels.

CHAPTER 7

HEALTH CARE

NATIONAL HEALTH CARE EXPENDITURES

1. INTRODUCTION

The nation's spending for health care in 1960 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 $696 billion, or 12.0 percent of the GDP, according to figures from the Centers for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration.) Health care spending increases of almost 10 percent between 1985 and 1992 focused attention on the problems of rising costs and led to unsuccessful health care reform efforts in the 103d Congress.

Changes in financing and delivery of health care in the mid–1990's, such as the emerging use of managed care by public and private insurers, decreased the rate of health care spending. While spending for health care reached $1 trillion for the first time in 1996, growth in spending between 1993 and 2000 was much lower than in previous years with an average annual growth rate of only 5.7 percent. 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.

National spending for health care, however, rose by 8.7 percent from 2000 to 2001, reaching $1.4 trillion. This represented the highest annual growth in health care spending in a decade. National health care spending's share of the GDP, a measure of the nation's economy devoted to health care, also jumped from 13.3 percent in 2000 to 14.1 percent in 2001. The Centers for Medicare and Medicaid Services attributes the growth in health spending to increased use of inpatient and outpatient hospital services and prescription drugs along with the declining influence of managed health care. CMS expects national health spending to grow to $3.1 trillion by 2012 or approximately 17.7 percent of GDP.

Expenditures are primarily influenced by 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 may also contribute significantly to increases in health care expenditures. For example, Meara, White,

and Cutler found that the average per capita health spending for Americans age sixty-five and older in 1999 was more than triple that for Americans ages 34–44. For Americans age 75 and older, many of whom rely on costly nursing home care, it was more than five times as high.[1]

National health expenditures include public and private spending on health care, services and supplies, funds spent on the construction of health care facilities, as well as public and private noncommercial research spending. In 2001, 87 percent of the $1.4 trillion spending for health care in the United States was for personal health care, or services used to prevent or treat illness and disease in the individual. The remaining 13 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 direct payments, cost-sharing, insurance premiums, taxes, and charitable contributions. 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 2001, individual out-of-pocket spending (including coinsurance, deductibles, and any direct payments for services not covered by an insurer) represented only 14.4 percent of all health expenditures.

Private funds represented 75.1 percent of national health expenditures in 1965, while public sources represented 24.9 percent of national health expenditures. Since the enactment of the Medicare and Medicaid programs, however, this gap between payments by private and public sources has closed. While all private sources combined (out-of-pocket, private health insurance, and other private funding such as philanthropy) continued to finance most health care spending in 2001 ($777.9 billion or 54.9 percent), public sources (Federal, state, and local governments) also provided a major share of funding ($646.7 billion or 45.4 percent.) The Federal Government's share rose from 11.4 percent in 1965 to represent one-third of all health spending in 1996 and 1997. Since that time, the Federal portion of health expenditures has decreased somewhat and, in 2001, the Federal Government spent $454.8 billion or 31.9 percent of total national health 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

[1] As quoted in Uwe E. Reinhardt, "Does the Aging of the Population Really Drive the Demand for Health Care?" *Health Affairs,* vol. 22, no. 6, November/December 2003, p. 27.

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) provides all benefits covered under Part A and Part B, and may include additional benefits not covered under traditional Medicare. Beneficiaries enrolled in Part C receive their care through private plans, such as health maintenance organizations (HMOs). 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.

During fiscal year 1967, the first full year of the program, total Medicare outlays amounted to $3.4 billion. In fiscal year 2002, Medicare expenditures totaled $256.9 billion. This increase in outlays since the program's first year represents an average annual growth rate of 13.2 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 1997 period, total outlays grew from $35.0 billion to $210.4 billion, for an average annual rate of growth of 11.1 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. Despite increases in enrollment, in FY1998, the Medicare growth rate slowed to a record low of just 1.4 percent with expenditures of $213.4 billion. In 1999, Medicare spending decreased for the first time in the program's history to $211.9 billion. Expenditures increased slightly (3.5 percent) in 2000 to $219.3 billion. The Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act of 2000 (BIPA 2000), however, restored some of the payment reductions. This is reflected in spending increases of 10 percent in 2001 to $241.2 billion and 6.5 percent in 2002 to $256.9 billion. According to CBO's August 2003 baseline projections (prior to passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), total Medicare outlays will be $523 billion in FY2013.

Medicaid is a joint Federal-state entitlement program that pays for medical services on behalf of certain groups of low-income persons. Medicaid funds long-term care for chronically ill, disabled, and aged individuals; provides comprehensive health insurance for low-income children and families; and assists hospitals with the cost of uncompensated care through the disproportionate share (DSH) program. Each state designs and administers its own program within broad Federal guidelines. The Federal Government shares in a state's Medicaid costs by means of a statutory formula

designed to provide a higher Federal matching rate to states with lower per capita incomes. These rates, or Federal medical assistance percentages (FMAPs) ranged from 50 percent to 76 percent in 2002.

Medicaid expenditures have historically been one of the fastest growing components of both Federal and state budgets. During the period from FY1965 to FY1972 when Medicaid was enacted and states began to develop programs, the portion of Medicaid expenditures paid by the Federal Government grew from $300 million to $4.6 billion, an average of 53 percent a year. From FY1973 to FY1980, Federal Medicaid expenditures grew from $4.6 to $14 billion. This annual growth rate of 15 percent reflected the implementation of the Supplemental Security Income (SSI) program for aged and disabled persons and new state options for institutional coverage. For the next 8 years, FY1981 to FY1989, the annual growth for Federal Medicaid expenditures was 11 percent. During this period, there were a number of conflicting Federal budget measures to either reduce costs or expand eligibility thus increasing spending. From FY1990 to FY1992, a time of economic downturn, some states used creative financing mechanisms to transfer part of the medical costs normally paid by states to the Federal Government. These increased Federal payments, particularly for DSH, caused Federal Medicaid spending to escalate at an annual rate of 28 percent from $41.1 billion to $67.8 billion. From FY1993 to FY1998, the economy strengthened, DSH payments were reformed slowing growth, Medicaid enrollment decreased due to implementation of welfare legislation and states used managed care to control costs. The average annual growth rate slowed to 6 percent during this period with expenditures increasing from $75.8 billion in 1993 to $100.1 billion in FY1998.[2]

Since 1998, Medicaid costs appear to have entered a new phase of growth, particularly for certain services such as prescription drugs. Federal expenditures for Medicaid grew 7.3 percent in FY1999 to $107.4 billion, 8.8 percent in FY2000 to $116.9 billion, and 11 percent in FY2001 to $129.8 billion. In FY2002, Federal and state expenditures for Medicaid benefits and program administration totaled $258.2 billion, with the Federal Government's share at $146.2 billion or 57 percent of total expenditures. This is an increase of 13 percent from the $129.8 billion spent by the Federal Government in FY2001. CMS attributes this growth to the recession, state program expansions for the uninsured, and relaxed Medicaid eligibility standards. Some states were also using "intergovernmental transfers" with county and city service providers in order to claim a higher Federal matching payment. The Congressional Budget Office (CBO) projects that Medicaid spending will grow at an average annual rate of 10.6 percent between FY2002 and FY2010.

3. Hospitals

Hospital care costs are a major component of the nation's health care bill and, in 2001, comprised 31.7 percent ($451.2 billion) of

[2] Andy Schneider and David Rousses, "Medicaid Financing," *The Medicaid Resource Book*, The Kaiser Commission on Medicaid and the Uninsured, July 2002, Chapter 3, pp.91–93.

total health care expenditures. In 1965, $13.8 billion was spent on hospital services, and by 1970, following passage of Medicare, spending had more than doubled to $27.6 billion. Between 1970 and 1980, total spending on hospital care increased at an average rate of 13.9 percent per year. From 1980 to 1990, however, with the implementation of Medicare's prospective payment system (PPS) in 1983, growth in national expenditures slowed to 9.6 percent annually. Total hospital care expenditures declined even further from 1990 to 1993 with an average growth rate of 8.0 percent, and 3.5 percent from 1993 to 1999. This continued slow down in growth of total expenditures was partially attributed to the impact of managed care and reforms in Medicare which is the largest single payer for hospital services. The Balanced Budget Act of 1997 (BBA) included a 1-year freeze on PPS rates for inpatient services and required the development of PPS for additional Medicare covered services, including outpatient hospital care and hospital-based home health agencies.

With these constraints on spending, hospitals became more efficient, downsized, and consolidated, and were able to bargain with insurance companies for increased payments. The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), a package of funding increases helped lessen the impact of the BBA on rural hospitals and hospitals with a disproportionate share of indigent patients. The Benefits Improvement and Protection Act of 2000 (BIPA 2000), further increased Medicare payment rates and national hospital expenditures grew by 5.8 percent in 2000. This increase in the rate of spending growth increased further in 2001 to 8.3 percent, its fastest growth in 10 years. CMS also attributes this growth to increased utilization due to a shift to less restrictive managed care plans.

In 2001, public (Federal, state, and local) sources accounted for 58.3 percent of hospital service expenditures, or $263.1 billion. The Federal Government is the single largest payer for hospital services, and with the passage of Medicare, its share grew from 14.6 percent in 1965 to 49.7 percent in 1997. Following BBA97, this portion dropped to 47.9 percent and was at 46.4 percent in 2001, ($209.4 billion). Included in Federal Government spending for hospital care are Medicare payments which were responsible for 29.9 percent of hospital expenditures in 2001, or $135 billion. Federal and state spending for hospital care under Medicaid has grown from $2.6 billion in 1970 to $77.1 billion in 2001 and represents 17.1 percent of hospital expenditures.

Out-of-pocket expenditures by consumers represented approximately 20 percent of payments for hospital care before the enactment of Medicare and Medicaid, but in 2001, represented only 3.1 percent. In 1965, private health insurance was responsible for 41.2 percent of all hospital spending. In 1990, this portion was at 38.3 percent. This share fell to 32.3 percent in 1995 as a larger amount of care was provided in ambulatory settings, and managed care plans negotiated lower prices for services. Since that time, this percentage has again increased to 33.7 percent in 2001.

Hospital utilization in the United States has undergone major change in the past twenty years, greatly influenced by technology, health care policy, and population dynamics. During the 1970's,

hospital admissions increased consistently reaching highs of over 36 million in the early 1980's. With the introduction of PPS in 1983, which encouraged more cost efficient treatment methods, admissions declined dramatically for several years. After 1987, total admissions continued to decrease, though more slowly, and reached a low of 30.7 million in 1994. Declines in inpatient admissions were attributed to advances in drug therapies, aggressive utilization controls by managed care organizations, and technological advances which enabled hospitals to provide services in more cost-effective outpatient settings favored by insurers. Since 1994, hospital admissions have again increased each year, due in part to the growing health care needs of adults 65 and older and the weakening impact of managed care. Close to 34 million people were admitted to hospitals in 2001, a level comparable to that of 1985.

The average length of a hospital stay also decreased as a result of Medicare PPS, from 7.3 days for persons of all ages in 1980 to 6.5 days in 1985. This was even greater for patients over 65 who saw a decline in length of stay from 10.7 in 1980 to 8.7 in 1985. In the latter part of the 1980's as outpatient visits increased, patients admitted to hospitals tended to be those with more severe illnesses which required longer hospitals stays and the average length of stay stabilized and even increased for those 65 and over. Beginning in the early 1990's, however, declines occurred which were even steeper than in the first years of PPS. This decline was attributed to greater insurance coverage of post-acute care alternatives to hospitalization, an increase in managed care and other cost-containment programs, as well as continuing advances in technology. The average length of stay in 2001 was 4.9 for all ages, compared to 6.4 in 1990, a decrease of 23 percent. For persons over the age of 65, the average length of stay declined 33 percent from 8.7 days in 1990 to 5.8 days in 2001.

4. Physicians' Services

Utilization of physicians' services increases with age. In 2001, the population as a whole made an estimated 880.5 million visits to physician offices, which translates to about 3.1 visits per person. In contrast, patients age 65 to 74 years of age had 6.3 visits and those over age 75 visited physician offices 7.4 times each during the year.

Physician services continue to be the second largest component of personal health care expenditures and, in 2001, represented 22 percent of all health care expenditures. In 1965, $8.3 billion was spent on physician services, and by 1970, spending had reached $14 billion. This increase represented an average annual growth rate of 11 percent. Over the next two decades (1970–1990), growth in physician expenditures was slightly higher at approximately 13 percent. In the 1990's, however, the annual rate of growth in payments for physician services was slower than the previous three decades and grew only 6.3 percent annually from 1990 to 2000. This slowdown in the rate of growth has been attributed to several factors, including adjustments in private sector payment systems which reflected Medicare's fee schedule, and increased use of managed care. In 2001, however, spending once again grew by 8.6 percent to $313.6 billion. CMS links this growth to a decline in man-

aged care utilization review policies and an increase in imaging procedures and office visits for prescription drugs.

In 2001, out-of-pocket payments covered approximately 11.2 percent of the cost of physician services. 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 mid–1960's when out-of-pocket expenditures were 58.5 percent of total physician spending. However, unlike hospital services, the single largest payer for physician services is not the Federal Government, but rather private health insurance companies. In 1965, private health insurers contributed 33 percent of the total and by 1993, this figure had reached 47.8 percent. Since 1993, the share of physician services financed by private insurance has remained relatively stable. In 2001, private health insurers paid for 48.1 percent of all physician services.

The share of spending for physician services paid by public financing grew from 6.9 percent of total physician expenditures in 1965 to 30.0 percent in 1975. Since that time, however, this portion has increased more slowly to 33.6 percent ($105.4 billion) of total physician expenditures in 2001. Spending for physicians services under the Medicare program represented 20.4 percent ($63.9 billion), of total funding for care by physicians. In 1970, Medicare paid for only 11.8 percent, or $1.6 billion, of total physician service expenditures. Between 1970 and 1990, the average annual rate of growth in Medicare payments for physician services was 15.8 percent. Total 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 only 7.1 percent between 1990 and 2001, while national physician payments rose 6.5 percent 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 disability. Services are provided in institutions or a wide variety of 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 basic human 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 necessary for independent community living. While it is predicted that long-term care services will be in greater demand in the coming decades due to increased numbers of older persons, the need for long-term care assistance affects persons of all ages, not just the elderly.

In 2002, of the $1.34 trillion spent on all U.S. personal health care services, $163.2 billion, or 12.2 percent was spent on long-term care. This amount includes spending for institutional care (nursing

homes and intermediate care facilities for the mentally retarded (ICFs/MR)), and a wide range of home and community-based services, such as home health services, personal care services, and adult day care.

Long-term care is financed chiefly through the Federal-state Medicaid program. Of all U.S. long-term care spending in 2002, the Medicaid program financed 51 percent, or $82.1 billion. Most of this spending, 70 percent, was for institutional care in nursing facilities and ICFs/MR. The balance was spent on home and community-based services (HCBS). In order to correct a perceived bias in Medicaid's eligibility and benefit structure toward institutional care, in 1981, Congress authorized the Secretary of Health and Human Services (HHS) to waive certain Medicaid provisions in order to assist states in expanding HCBS. Spending for the Section 1915c home and community based waiver program has increased rapidly since FY1990, reaching $16.4 billion in FY2002.

After Medicaid, private out-of-pocket spending is the next primary source of funding for long-term care. The average cost of nursing home care is in excess of $3,600 a month, and persons who enter a nursing home encounter significant uncovered liability for this care. In 2003, out-of-pocket spending for long-term care was $32.4 billion, representing almost 20 percent of all U.S. spending on long-term care. Most out-of-pocket long-term care spending was for nursing home care (80 percent of the $32.4 billion total). Private insurance coverage is limited and covered only 8.8 percent of spending in 2002, or $14.4 billion. The private long-term care insurance market is growing, however, with the number of policies purchased increasing by about 18 percent per year, on average, between 1987 and 2001.

Medicare is not intended to be a primary funding source for long-term care. Its role is limited to financing care in skilled nursing facilities (up to 100 days after a hospitalization for persons who need continued skilled care), and home health services for persons who need skilled nursing care on a part-time or intermittent basis, or physical or speech therapies. Medicare spent $24.3 billion on skilled nursing facility care and home health care services in 2002, representing almost 15 percent of all U.S. spending on long-term care. Of this amount, about 53 percent was for skilled nursing facility care, and the balance was for home health care.

In addition to health expenditures for long-term care, a variety of other Federal social service programs provide support for long-term care though funding is more limited. Primarily these are the Older Americans Act and the Social Services Block Grant Program, both of which fund a variety of home and community-based services. The Older Americans Act authorizes the National Family Caregiver Support program which offers assistance to family caregivers of the frail elderly. Over 80 percent of adults who receive long-term care assistance reside in the community, not in institutions, and family and friends (unpaid caregivers) are the major providers of this care. Of those persons age 65 and older receiving assistance in the community, almost 60 percent depend on care from unpaid caregivers, while 7 percent rely exclusively on paid services.

The percent of people 65 years and over living in nursing homes declined from 5.1 percent in 1990 to 4.5 percent in 2000. While

Americans are not entering nursing homes at the same rate as they have in previous years, nursing home residence increases dramatically with age. In 1994, of persons age 65–74 receiving long-term care assistance, about 1 percent reside in nursing homes. However, of persons 85 years and older receiving assistance, 23 percent resided in nursing homes. This latter age group which is most likely to need nursing home care, is projected to increase from 4.2 million in 2000 to 8.9 million in 2030.

6. Prescription Drugs

CMS's National Health Expenditures provides data on spending for prescription drugs purchased from retail pharmacies, including community pharmacies, grocery store pharmacies, mail-order facilities, and mass-merchandising establishments. According to this data, in 2001, prescription drug expenditures in the United States were approximately $140.6 billion, or about 10.0 percent of total health care spending. 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 2001, spending on hospital care grew 27.0 percent, physician services spending rose 36.7 percent, and nursing home spending grew 23.7 percent. Spending on prescription drugs in the same period grew 109.2 percent. The increase in spending is due to an increase in the amount of drugs being prescribed, new and more expensive drugs, and inflation in the cost of drugs.

Most older Americans receive health care coverage through Medicare, but the program provides limited coverage for drugs. There are circumstances where coverage is provided. Drugs administered to beneficiaries who are hospital inpatients are covered as part of the Medicare payment to the hospital. Medicare also pays physicians for drugs provided to beneficiaries. These are drugs that 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. (However, if a drug is generally self-administered by injection (such as insulin), it is not covered.) Medicare law also specifically authorizes coverage for certain classes of outpatient drugs that may be self-administered: those used for the treatment of anemia in dialysis patients, immunosuppressive drugs following an organ transplant paid for by Medicare, certain oral cancer and associated anti-nausea drugs, and certain immunizations. In 2001, Medicare, which covered approximately 40 million beneficiaries (35 million of whom were elderly), paid $2.4 billion for outpatient prescription drugs.

In general, however, Medicare does not provide coverage for outpatient prescription drugs, such as those obtained through pharmacies or through the mail. Many Medicare beneficiaries have no coverage for these prescription drugs. According to an analysis of the 1998 Medicare Current Beneficiary Survey, in 1999, 34.5 percent of beneficiaries aged 65–74, 40.5 percent of those aged 75–84, and 45.1 percent of those over age 85 had no coverage. For the beneficiaries who had coverage, employer-sponsored plans were the primary source, followed by Medicare+Choice plans, Medigap plans, and Medicaid. In addition, several states and the pharmaceutical industry offer assistance with prescription drug costs for low-in-

come individuals. Beneficiaries with supplementary prescription drug coverage use prescriptions at a considerably higher rate than those without supplementary coverage.[3]

The Congressional Budget Office (CBO) has estimated that in 2003, average per capita spending for prescription drugs will be $2,318. CBO projected that this figure will rise to $5,727 by 2013. However, expenditures on drugs by Medicare beneficiaries are skewed. For example, in 2000, about 26 percent of beneficiaries had expenditures of $2,000 or more, accounting for 65 percent of the Medicare population's total drug spending. On the other hand, 32 percent of beneficiaries had expenditures of $500 or less, accounting for 4 percent of total spending.[4]

Much of this spending is not covered by insurance. Despite the presence of insurance coverage, on average, beneficiaries pay almost half of their drug costs out-of-pocket. The percentage of out-of-pocket expenses varies, depending on whether the beneficiary has supplementary coverage. For example, in 2003, persons without coverage paid an average of $1,356 for prescription drugs, 100 percent of it out-of-pocket. Beneficiaries with coverage through Medigap policies or Medicare+Choice plans incurred $2,091 in costs, but paid $1,094, or 52 percent, out-of-pocket. Those with coverage through an employer-sponsored plan had average costs of $2,775, but paid only $880, or 31.7 percent, out-of-pocket.[5]

As indicated above, beneficiaries with supplemental drug coverage spend more on prescription drugs than those with no coverage. In 1998, persons with coverage used an average of 24.3 prescriptions per year while those without coverage used an average of 16.7 prescriptions per year. This can have an effect on the health of beneficiaries with no supplemental coverage. A 2001 survey[6] indicated that beneficiaries who lack drug coverage did not fill prescriptions or skipped doses to make thir medications last longer. Regardless of supplemental insurance coverage, 22 percent of seniors indicated that, due to cost, they had either not filled a prescription or skipped doses. The percentage was higher (35 percent) for those with no supplemental coverage and lower (18 percent) for those with coverage.

The cost of the 50 drugs used most frequently by seniors rose an average of 3.4 times the rate of inflation from 2002 to 2003, according to a study by Families USA.[7] Some drugs, such as Lipitor, Norvasc, Prevacid, and Zocor, rose at approximately twice the rate of inflation. However, Miacalcin, Klor-Con, and Claritin rose at more than 10 times this rate. For beneficiaries living on fixed incomes adjusted only for inflation, this leads to a larger portion of their incomes being spent on drugs.

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[3] A more detailed discussion of the extent of beneficiary prescription drug coverage is available in Laschober, Mary et al. Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996–1999, *Health Affairs,* Web Exclusive. February 27, 2002.

[4] *Prescription Drug Coverage and Medicare's Fiscal Challenges,* Congressional Budget Office testimony before the House Ways and Means Committee, April 9, 2003. http://www.cbo.gov/showdoc.cfm?index=4159&sequence=0

[5] *Medicare and Prescription Drug Spending Chartpack,* Kaiser Family Foundation, June 2003. http://www.kff.org/medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14382

[6] *Seniors and Prescription Drugs: Findings from a 2001 Survey of Seniors in Eight States,* Kaiser Family Foundation, et al, July 2002. http://www.kff.org/medicare/6049-index.cfm

[7] *Out-of-Bounds: Rising Prescription Drug Prices for Seniors,* Families USA, July 2003. http://www.familiesusa.org/site/DocServer/Out—of—Bounds.pdf?docID=1522

On several occasions, the Congress has considered adding coverage for at least a portion of beneficiaries' drug costs. Coverage for catastrophic prescription drug costs was included in the Medicare Catastrophic Coverage Act of 1988, but that law was repealed in the following year. The Health Security Act, proposed by the Clinton Administration in 1994, would have added a prescription drug benefit to Medicare, however that legislation was not enacted. The issue was considered again in the 106th and 107th Congresses. During the 108th Congress, both the House and Senate considered and passed legislation adding a prescription drug benefit to the Medicare program. See Chapter 8, "Medicare," for a discussion of this legislation.[8]

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

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. Growth did slow somewhat during the 1990's because of the relatively small number of babies born during the Great Depression of the 1930's. This is reflected in the 2000 Census which, for the first time in the history of the census, indicated that the 65 years and over population did not grow faster than the total population (12.4 percent and 13.2 percent respectively). During the 1990's, the most rapid growth in the older population occurred in the oldest age groups. The population 85 years and over increased by 38 percent from 3.1 million to 4.2 million in 2000 and is projected to reach 8.9 million in 2030. The total number of persons 65 and older, 35 million in 2000, will more than double between the years 2010 and 2030 when the "baby boom" generation reaches age 65. By 2030, there will be 70 million older persons comprising 20 percent of the 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 2000, the average life expectancy at birth increased from 46.3 years to 74.1 years for men, and from 48.3 to 79.5 years for women. Life expectancy at age 65 has also increased over the last half of the twentieth century from 13.9 to 17.9 years for both sexes. 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 2000 Medicare Current Beneficiary Survey (MCBS), 78.6 percent of the elderly aged 65- 74 rated their health as good, very good, or excellent. However, this number falls to 64.4 percent in the 85+ group. While only 6.1 percent of the 65–74 age group reported that their health was poor, 9.1 percent of the 85+ group reported their health as poor.

Age is not the only factor affecting health status; a person's race is also important. Among individuals aged 65–74, 18.2 percent of whites and 13.2 percent of Hispanics reported their health as excellent, compared to 10.9 percent of blacks. Only 8.7 percent of whites and 10.3 percent of Hispanics aged 85 and over reported their

[8] For a complete discussion of this issue, see *Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues,* by Jennifer O'Sullivan, Congressional Research Service, January 6, 2003.

health as poor while 13 percent of blacks in the same age group reported their health as poor.

Another factor affecting self-reported health status is insurance coverage. Persons with both individually purchased and employer-sponsored private health insurance to supplement their Medicare coverage reported the best health in 2000: 84.3 percent in the good-very good-excellent category and only 4.7 percent in the poor category. This is followed by those enrolled in Medicare managed care: 77.7 percent reported excellent, very good, or good health and 6.4 percent reported poor health. Of those beneficiaries with only Medicare fee-for-service coverage, 62.9 percent reported their health as excellent, very good, or good while 13 percent reported poor health. Beneficiaries with Medicaid as their insurance to supplement Medicare reported the poorest health (20.4 percent) with only 46.4 percent reporting their health was excellent, very good, or good.

Although most elderly Medicare beneficiaries consider their health good, limitations in activities as a result of chronic conditions and disability increase with age. In 2001, among those 65–74 years old, 26 percent reported a limitation caused by an activity limitation (defined as any limitation due to a physical, mental, or emotional problem). Of those 75 years and over, 45 percent reported they were limited by chronic conditions. The most common of these are arthritis and hypertension. With age, rates of hearing and visual impairments also increase rapidly. According to the National Institute on Aging (NIA), as many as 4.5 million people in the U.S. and about half the persons 85 years and older have symptoms of Alzheimer's disease. Because of the growing numbers of persons age 85 and older, caring for persons with Alzheimer's will be a major concern over the next several decades.

The extent of need for assistance with activities of daily living (ADLs) and Instrumental Activities of Daily Living (IADLs) also increases with age and is an indicator of need for health and social services. According to the MCBS, elderly persons reporting the need for personal assistance with everyday activities increases with age, from 33.1 percent of persons aged 65–74 to 78 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 2001, 74 percent of persons 65 years of age and older reported incomes of less than $25,000, and 31 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 persons with disability, women over the age of 85, and the poor elderly. A large proportion of Medicare payments on behalf of elderly beneficiaries is directed toward those with modest incomes: 26 percent is on behalf of those with incomes of less than $10,000 and 67 percent is for those with incomes of less than $25,000. Medicaid also plays an important role in helping very low-income elderly with health benefits not covered under Medicare such as long-term care services and prescription drugs or with payment for Medicare premiums and cost-sharing.

According to the U.S. Administration on Aging's report, *A Profile of Older Americans: 2002*, the elderly averaged $3,493 in out-of-pocket health care expenditures, an increase of more than half since 1990. This can be compared to the average out-of-pocket costs for the total population of only $2,181. The elderly also direct more of their household expenditures toward health care. In 2000, for older Americans, 12.6 percent of their total household expenditures were for health care which is more than twice that of all consumers who spent only 5.5 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.

While policymakers are concerned about planning for the long-term care needs of an aging population, it is difficult to predict the impact of longer life expectancies and growing number of elderly Americans on health care expenditures. Some researchers have suggested that increases in longevity will not necessarily lead to an increased demand for health care.[9] If improvements in medical technology and health behavior can continue to improve the health status of the elderly, future health care spending on the elderly may grow more slowly.

[9] David M. Cutler, "Declining Disability Among the Elderly," *Health Affairs,* vol. 20, no. 6, November/December 2001, pp. 11–27.

CHAPTER 8

MEDICARE

A. BACKGROUND

Medicare was enacted in 1965 to insure older Americans against 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 2002, Medicare insured approximately 40.5 million aged and disabled individuals at an estimated cost of $265.7 billion. Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

Medicare (authorized under title XVIII of the Social Security Act) provides health insurance protection to most individuals age 65 and older, to persons who have been entitled to Social Security or Railroad Retirement benefits because they are disabled, and to certain workers and their dependents who have end-state renal disease. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. It is a non-means-tested program, that is, protection is available to insured persons without regard to their income or assets. Medicare is composed of the Hospital Insurance (HI) program (Part A) and the Supplementary Medical Insurance (SMI) program (Part B). The Medicare+Choice program (Part C), established by the Balanced Budget Act of 1997 (BBA, P.L. 105–33), provides managed care options for beneficiaries. These options include preferred provider organizations, provider-sponsored organizations, private fee for service plans, and, on a demonstration basis, a limited number of medical savings accounts in conjunction with a high deductible health insurance plan.

Although Medicare provides broad protection against the costs of many, primarily acute care, services, it covers only about one-half of beneficiaries' total health care expenses. Most individuals have some coverage in addition to basic Medicare benefits. Some persons have additional benefits through a managed care plan. Most other individuals have some supplemental coverage through individually purchased policies, commonly referred to as a "Medigap" policies, employer-sponsored retiree plans, or public programs such as Medicaid.

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. BBA and subsequent legislation provided for program savings through new payment methodologies for various service categories, including skilled nursing facilities, home health agencies, and out-

patient hospital services. Benefits have been added to the program, especially in the area of preventive care.

1. Hospital Insurance Program (Part A)

Most Americans age 65 and older are automatically entitled to premium-free benefits under Part A because they have worked 40 quarters of Social Security-covered employment. Those who are not automatically entitled may obtain Part A coverage provided they pay the monthly premium. Persons with fewer than 30 quarters of Medicare-covered employment pay $316 per month in 2003; those with 30–39 quarters pay $174. Also eligible for Part A coverage are disabled persons under age 65 who have received monthly Social Security or Railroad Retirement benefits on the basis of disability for 2 years.

Part A is financed principally through a special hospital insurance (HI) payroll tax levied on employees, employers, and the self-employed. Each worker and employer pays a tax of 1.45 percent on covered earnings; the self-employed pay both the employer and employee shares. In 2002, payroll taxes for the HI Trust Fund accounted for $152.7 billion, 85.5 percent of the fund's total income. An estimated $149.9 billion in Part A benefit payments were made in 2002.

Benefits included under Part A, in addition to inpatient hospital care, are skilled nursing facility (SNF) care, home health care, and hospice care. For inpatient hospital care, the beneficiary is subject to a deductible ($840 in 2003) for the first 60 days of care in each benefit period or "spell of illness.". For days 61–90, a coinsurance payment is required ($210 per day in 2003). For hospital stays longer than 90 days, a beneficiary may elect to draw upon a 60-day "lifetime reserve." A coinsurance payment is required for each lifetime reserve day ($420 in 2003).

Medicare covers up to 100 days of skilled nursing facility (SNF) services during a spell of illness for beneficiaries who, following a hospital stay of at least 3 days, need daily skilled nursing care or other rehabilitative services. Medicare does not cover SNF care for beneficiaries who need only custodial care, such as assistance with walking or bathing. A spell of illness begins when a beneficiary receives inpatient hospital or covered SNF services and ends when the beneficiary has not been a hospital inpatient or in a Part A-covered SNF stay for 60 consecutive days. For each spell of illness, beneficiaries make no coinsurance payment for the first 20 days; a daily coinsurance payment is required for days 21 through 100 ($105 in 2003).

The home health benefit covers homebound beneficiaries who are in need of intermittent skilled nursing care, physical or occupational therapy, or speech language pathology services. There is no coinsurance payment required. Hospice care is provided for terminally ill beneficiaries and their families. The hospice benefit has a limited coinsurance payment required for prescription drug coverage and inpatient respite care.

Hospital payment.—Most hospitals are paid for their Medicare patients under a prospective payment system or PPS. The inpatient prospective payment system (IPPS) pays hospitals predetermined amounts adjusted for a specific diagnosis. Each beneficiary

admitted to a hospital is assigned to one of approximately 500 diagnosis-related groups (DRGs). 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 cannot charge beneficiaries any more than the coinsurance amounts listed above.

In addition to the basic DRG payment, some hospitals receive added funds in the form of adjustments to their IPPS payment or separate payments. Teaching hospitals receive payments for their direct graduate medical education (GME) costs, such as resident salaries and faculty costs. Their IPPS payment is adjusted to reflect their indirect medical education (IME) costs, i.e., 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, also receive an adjustment to their Medicare payments called a disproportionate share hospital (DSH) adjustment. Adjustments are also made to hospitals for atypically costly cases, known as "outliers."

In general, the IPPS payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket index (MBI). This is a fixed price index that measures the change in the price of goods and services purchased by hospitals. The update is established by statute. The update for FY2003 was the MBI minus 0.55 percentage points.

Certain types of rural hospitals receive special consideration under the hospital IPPS: sole community hospitals (facilities located in geographically isolated areas and deemed to be the sole provider of inpatient acute care hospital services in a geographic area), Medicare dependent hospitals (small rural hospitals with a high proportion of patients who are Medicare beneficiaries), and rural referral centers (relatively large hospitals, generally in rural areas, that provide a broad array of services and treat patients from a wide geographic area). Certain other hospitals (inpatient rehabilitation facilities, long-term care hospitals) are paid using prospective payment systems tailored for their patient care costs. Psychiatric hospitals children's cancer hospitals, and critical access hospitals are excluded from the IPPS and are paid on the basis of reasonable costs.

A full discussion of Medicare's skilled nursing facility, home health, and hospice benefits is provided in the next chapter.

2. Supplementary Medical Insurance (Part B)

Part B of Medicare, also called supplementary medical insurance (SMI), covers physicians' services, outpatient hospital services, physical and occupational therapy, durable medical equipment, and certain other services. It is a voluntary program. Anyone eligible for Part A and anyone over age 65 can obtain Part B coverage by paying a monthly premium ($58.70 in 2003). Beneficiary premiums finance 25 percent of program costs with Federal general revenues covering the remaining 75 percent. In general, Part B beneficiaries using covered services are subject to a $100 deductible and 20 percent coinsurance charges.

Physician Payment.—The Omnibus Budget Reconciliation Act of 1989 established a fee schedule for physician payment 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 physician work (based on time, skill, and intensity involved), practice expenses (office rents and employee salaries), and malpractice expenses. These values are adjusted for geographic variations in the costs of practicing medicine. These geographically adjusted relative values are converted into a dollar payment amount by a conversion factor. The 2003 conversion factor is $36.7856. Thus, for a service with a relative value of 2.6, the payment would be $95.64. Several factors enter into the calculation of the formula used to update the conversion factor. These include: 1) the sustainable growth rate (SGR) which is essentially a target for Medicare spending growth; 2) the Medicare economic index (MEI) which measures inflation in physicians services; and 3) the update adjustment factor which modifies the update which would otherwise be allowed by the MEI, to bring spending in line with the SGR target.

Physicians are required to submit claims for services provided to their Medicare patients. They are subject to limits on the amounts they can bill these patients. Prior to BBA, the law was interpreted to prohibit physicians from entering into private contracts with Medicare beneficiaries to provide services for which no Medicare claim would be submitted. BBA 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 fully responsible for payments for services rendered under the contract and the beneficiary must acknowledge that no Medicare charge limits apply. An affidavit, filed with the Secretary of Health and Human Services, must be in effect at the time the services are provided. The affidavit, signed by the physician, must state that the physician will not be reimbursed under the Medicare program for any item or service provided to any Medicare beneficiary for 2 years from the date of the affidavit.

Certain non-physician practitioner services are paid under the physician fee schedule. In most cases, these services must be provided under the supervision of or in conjunction with a physician's services. Providers are paid a certain percentage of the fee schedule, depending on their specialty. These providers include physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and outpatient physical and occupational therapists.

Outpatient services.—Medicare beneficiaries receive services in a variety of outpatient settings, including hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), rural health clinics (RHCs), and comprehensive outpatient rehabilitation centers (CORFs). Under the HOPD prospective payment system, which was implemented in August 2000, the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). In most cases, all services and items for a procedure are included or "bundled" within each APC. For example, an APC for a surgical procedure will include operating and recovery room services, anesthesia, and surgical supplies. Medicare's payment for HOPD services is calculated by multiplying

the relative weight associated with an APC by a base payment amount or "conversion factor." Most conversion factors are geographically adjusted to reflect wage differences. Unlike other Part B services in which the beneficiary pays 20 percent of the Medicare-approved payment amount, for HOPD services the beneficiary pays 20 percent of the actual charges which can be in excess of the Medicare-approved amount. BBA addressed this issue by freezing beneficiary copayments at 20 percent of the national median charge for the service in 1996, updated to 1999. Over time, as PPS payments amounts rise, the frozen beneficiary copayments will decline as a share of the total payment until the beneficiary share is 20 percent of the Medicare payment.

Medicare uses a fee schedule to pay for ASC facility services. The associated physician services (surgery and anesthesia) are paid under the physician fee schedule. There are currently over 2,400 procedures approved for ASC payment and categorized into one of nine payment groups that reflect the national median cost of procedures. These rates are adjusted to reflect geographic price variation using a hospital wage index. Payments are also adjusted when multiple surgical procedures are performed at the same time.

RHCs are paid on the basis of an all-inclusive rate for each beneficiary visit. An interim payment is made to the RHC based on estimates of allowable costs and number of visits; a reconciliation is made at the end of the year to reflect actual costs and visits. Per-visit payment limits are established for all RHCs (other than those in hospitals with fewer than 50 beds). Payment limits are updated by the MEI. CORFs provide (by or under the supervision of physicians) outpatient diagnostic, therapeutic, and restorative services. Payments for services are made on the basis of the physician fee schedule.

Durable Medical Equipment (DME) and Prosthetics and Orthotics (PO).-Medicare covers a wide variety of DME and PO. DME (including such items as walkers, wheelchairs, oxygen and oxygen supplies, and hospital beds) must be prescribed by a physician and must be able to withstand repeated use, be medically necessary, and be appropriate for use in the home. Prosthetics and orthotics are items which replace all or part of an internal organ or body part, such as cardiac pacemakers and artificial limbs. Most items of DME and PO are paid on the basis of a fee schedule which is generally updated by the consumer price index for urban consumers (CPI-U). BBA required the establishment of competitive bidding demonstration projects in which suppliers competed for contracts to furnish Medicare beneficiaries with specific items of DME. Standards were set to ensure quality of items and services, beneficiary access and choice of suppliers, and financial viability of the suppliers. Demonstrations were established in Polk County, FL, and San Antonio, TX. Savings to Medicare ranged from 17 percent to 22 percent at the two sites.

Preventive care benefits.—In general, Medicare does not cover preventive services. In recent years, however, Congress has added a number of specific benefits to the program. The following preventive services are covered (unless otherwise noted, beneficiaries are liable for regular Part B cost-sharing charges: $100 annual deductible and 20 percent coinsurance):

- Pneumococcal Pneumonia Vaccination. Not subject to deductible or coinsurance.
- Hepatitis B Vaccination.
- Influenza Vaccination. Not subject to deductible or coinsurance.
- Screening Pap Smears and Pelvic Examinations. Covered once every 3 years. Annual screening pelvic examination are covered for certain high-risk individuals. Not subject to deductible; beneficiaries are liable for coinsurance for the screening pelvic exam.
- Screening Mammography. Annual screening mammography for all women over age 39. The benefit is not subject to the deductible; coinsurance is required.
- Prostate Cancer Screening. Annual prostate cancer screening tests for men over age 50. The benefit will cover digital rectal examinations and prostate specific antigen (PSA) blood tests. The PSA test is not subject to deductible or coinsurance.
- Colorectal Cancer Screening.
  - Annual screening fecal-occult blood tests for beneficiaries over age 49, not subject to deductible or coinsurance
  - Screening flexible sigmoidoscopy, every 4 years for beneficiaries over age 49
  - Screening colonoscopies every 2 years for beneficiaries at high-risk for colon cancer, or every 10 years for beneficiaries not at high risk.
  - Barium enema tests can be substituted for either of the two previous procedures.
- Diabetes Self-Management. Educational and training services, including instructions in self-monitoring of blood glucose, education about diet and exercise, and insulin treatment plans 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. Coverage for certain high-risk beneficiaries.
- Glaucoma screening for high-risk beneficiaries and diabetics.
- Medical nutrition therapy for beneficiaries with diabetes or renal disease.

3. MEDICARE+CHOICE (PART C)

The Medicare+Choice program (M+C) was established by the Balanced Budget Act of 1997. It provides managed care options for Medicare beneficiaries who are enrolled in both Parts A and B. These can be a coordinated care plan (such as an HMO, a preferred provider organization, or a provider sponsored organization), a private fee-for-service plan, or a high deductible plan offered with a M+C medical savings account (although no Medicare MSA plans have ever joined the Program). A number of protections were established, including a guarantee of beneficiary access to emergency care, quality assurance and informational requirements for M+C

organizations, and external review, grievance, and appeal requirements.

In general, the program makes monthly payments in advance to participating health plans for each enrolled beneficiary in a payment area (typically a county). Each year the Secretary of Health and Human Services (HHS) is required to determine the annual M+C per capita rate for each payment area, and the risk and other factors to be used in adjusting such rates. Payments to M+C organizations are made from the Medicare Trust Funds in proportion to the relative weights that benefits under Parts A and B represent of the actuarial value of total Medicare benefits.

For each enrolled beneficiary, Medicare pays M+C organizations a monthly capitation payment which is based on the M+C per capita rate. This rate is set at the highest of one of three amounts: 1) a blended rate, which is the sum of a percentage of the annual local area-specific M+C capitation rate for the year and a percentage of the input-price-adjusted national M+C capitation rate for the year (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); 2) a minimum payment (or floor) rate; or 3) a minimum percentage increase which is generally 102 percent of the previous year's payment. Once the preliminary rate is determined for each county, a budget neutrality adjustment is required by law to determine final payment rates.

4. Supplemental Health Coverage

At its inception, Medicare was not designed to cover beneficiaries' total health care expenditures. Several types of services, such as long-term care for chronic illnesses and most outpatient prescription drugs, are not covered at all, while others are partially covered and require the beneficiary to pay deductibles and coinsurance. Medicare covers approximately half of the total medical expenses for non-institutionalized, aged Medicare beneficiaries. Remaining health care expenses are paid for out-of-pocket or by private supplemental health insurance (such as Medigap), by employer-based retiree coverage, by Medicaid, or other sources. Over 80 percent of beneficiaries have insurance to supplement their Medicare coverage.

The term "Medigap" is commonly used to describe an individually purchased private health insurance policy that is designed to supplement Medicare's coverage. These plans offer coverage for Medicare's deductibles and coinsurance and pay for some services not covered by Medicare. Generally, there are 10 standardized Medigap benefit packages that 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. Two additional high-deductible plans offer the same benefits as either Plan F or J, but the deductible is $1,650 for 2003 and will be 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. There are no Federal limits set regarding premium prices.

Some Medicare beneficiaries get supplemental coverage through retiree plans offered by their former employers. These plans typically assist with cost-sharing requirements of the Medicare program and paying for services not covered by Medicare, such as prescription drugs. Estimates of the availability of this coverage vary. A 2001 survey by Mercer/Foster Higgins[1] shows that over an 8-year period (1993–2001) the number of employers (with over 500 employees) offering health plan coverage to Medicare-eligible retirees fell from 40 percent to 23 percent. Coverage of the Medicare-eligible population increases by size of employer. In 2001, 17 percent of employers with 500–999 employees offered coverage. This percentage increased to 25 percent for employers with 1,000–4,999 employees, 37 percent for those with 5,000–9,999 employees, 37 percent for those with 10,000–19,999 employees, and 54 percent for those with 20,000 or more employees. A 2002 survey conducted by Hewitt and the Kaiser Family Foundation[2] of employers with more than 1,000 employees found that the average monthly premium for the age 65+ retirees was $194; the retiree paid $79 of this amount. In the future, the survey found that most employers are considering changing their retiree plans in order to address the increasing costs of providing coverage. The employers stated they are considering such means as increasing retiree contributions, raising cost-sharing requirements, or raising retiree out-of-pocket limits.

Some low-income aged and disabled Medicare beneficiaries are also eligible for full or partial coverage under Medicaid. 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 covered under both programs. Medicaid picks up Medicare cost-sharing charges and provides protection against the costs of services generally not covered by Medicare. Perhaps the most important service for the majority of dual eligibles is prescription drugs.

Federal law specifies several population groups that are entitled to more limited Medicaid protection. These are:

- Qualified Medicare Beneficiaries (QMBs)- aged or disabled persons with incomes at or below the Federal poverty level having 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 Medicaid.
- Specified Low-Income Medicare Beneficiaries (SLIMBs). These are persons who meet the QMB criteria, except that their income limit is between 100 percent and 120 percent of the Federal poverty level. Medicaid protection is limited to payment of the Medicare Part B premium unless the individual is otherwise eligible for Medicaid.
- Qualifying Individuals (QI–1). These are persons who meet the QMB criteria, except that their income is between 120 percent and 135 percent of poverty and they are not otherwise eligible for Medicaid. Medicaid protection for these persons is limited to payment of the monthly Medicare Part B premium.

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[1] Mercer, William M. *National Survey of Employer-Sponsored Health Plans, Key Findings for 2001.* April 8, 2002.

[2] Hewitt and Kaiser Family Foundation. *The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey.* December 2002.

Other sources of supplemental coverage are available to certain beneficiaries. Those with a military service connection may receive coverage through the Department of Defense or the Department of Veterans Affairs. In addition, as of September 2003, 35 states have enacted laws creating pharmaceutical assistance programs that provide financial assistance (through subsidies or discount cards or a combination of both) for purchasing prescription drugs to low-income Medicare beneficiaries who do not qualify for Medicaid.

B. ISSUES

1. Prescription Drugs

Medicare provides coverage for prescription drugs used as part of a hospital stay, but in general does not cover outpatient prescription drugs. There are some exceptions, which include:

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

Some Medicare beneficiaries have outpatient prescription drug coverage through Medicare+Choice plans, employer-sponsored retiree plans, Medigap policies (Plans H, I, or J), Medicaid, military-service-related coverage, or state pharmaceutical programs. However, approximately one quarter of beneficiaries have no drug coverage. According to the Congressional Budget Office, the 75 percent of beneficiaries who do have some coverage pay nearly 40 percent of their drug expenditures out-of-pocket. Although this is the same percentage paid out of pocket by the U.S. population as a whole, Medicare beneficiaries, because they are elderly or disabled and more likely to have chronic health conditions, tend to use more prescription drugs than the general population. For example, in 1999, Medicare beneficiaries made up 15 percent of the population, but accounted for 40 percent of expenditures on outpatient prescription drugs.[3]

2. Medicare Solvency and Cost Containment

Part A (Hospital Insurance [HI]) and Part B (Supplementary Medical Insurance [SMI]) are financed differently. HI is financed primarily through payroll taxes levied on current workers and their employers. Income from these taxes is credited to the HI trust fund. SMI is financed through a combination of monthly premiums

[3] Congressional Budget Office. Statement of Dan L. Crippen, Director, before the United States Senate Committee on Finance. *Projections of Medicare and Prescription Drug Spending.* March 7, 2002.

paid by current enrollees (25 percent) and general revenues (75 percent). Income from these sources is credited to the SMI trust fund. Each fund is overseen by a Board of Trustees who make annual reports to Congress concerning the financial status of the funds.

The 2003 report projects that, under the trustees' intermediate assumptions, the HI trust fund would become insolvent in 2026, 4 years earlier than projected in the 2002 report. This revision is due to lower-than-expected HI taxable payroll and higher-than-expected hospital expenditures. Although the fund meets the trustees' test for short-range solvency, it fails by a considerable margin to meet their test for long-range solvency. Because of the way it is financed, the SMI fund does not face insolvency; however the trustees are concerned with the program's continued rapid growth rate. Taken together, Part A and B costs are projected to more than triple, relative to growth in the gross domestic product (GDP), over the next 75 years, growing from 2.6 percent of the GDP in 2002 to 5.3 percent by 2035 to 9.3 percent by 2077.

Beginning in 2011, the program will also begin to experience the impact of major demographic changes. First, baby boomers (persons born between 1946–1964) begin to turn age 65 and become eligible for Medicare. The baby boom population is likely to live longer than previous generations. This will mean an increase in the number of "old" beneficiaries (i.e., those 85 and over). The combination of these factors is estimated to contribute to the increase in the size of the Medicare population from 41.1 million in 2002 to 48.2 million in 2011 and 71.5 million in 2025. There will also be a shift in the number of covered workers supporting each HI enrollee. In 2002, there were nearly 4.0 workers per beneficiary. This number is predicted to decrease to 2.4 in 2030 and 2.0 in 2077.

The trustees stress the importance of considering the entire Medicare program's impact on the economy. They assume that Medicare per beneficiary expenditures will rise at the rate of per capita GDP plus 1 percentage point, faster than either the economy or workers' earnings and thus payroll tax income. There will also be a shift in the sources of Medicare income. In 2002, HI payroll taxes accounted for 57 percent of non-interest income to the program, with general revenues representing 30 percent. By 2025, payroll tax income will account for a smaller portion (39 percent) while the portion paid for by general revenues will grow to 42 percent.

Because of its rapid growth, both in terms of aggregate dollars, and as a share of the Federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by the Congress since 1980. With few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers. Of particular importance were the implementation of the prospective payment system for hospitals beginning in 1984 and the fee schedule for physicians services beginning in 1992. The BBA and subsequent legislation established prospective payment systems skilled nursing facilities, hospital outpatient departments, home health agencies, and other service categories. BBA also established the Medicare+Choice program which increased managed care options for beneficiaries. Controlling costs

and the solvency of the program continues to be a concern for the trustees as well as for Congress and the Administration.

CHAPTER 9

LONG-TERM CARE

OVERVIEW

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 or frailty. Chronic illness or conditions often result in both functional impairment and physical dependence on others for an extended period of time. Major groups of persons needing long-term care services and supports include the elderly as well as younger persons with disabilities, including persons with developmental disabilities, physical disabilities, and mental illness. The likelihood of needing long-term care assistance occurs more frequently with advancing age. However, advances in medical care are enabling persons of all ages with disabilities to live longer. The demand for long-term care services is expected to increase as the population ages.

The presence of a chronic illness or condition alone does not necessarily result in a need for long-term care services. For many individuals, an illness or a chronic condition does not result in functional impairment or dependence and they are able to conduct daily routines without assistance. When the illness or condition results in a functional or activity limitation, long-term care services may be required. The range of chronic illnesses and conditions resulting in the need for long-term care services and supports is extensive. Unlike acute medical illnesses which may be solved in a relatively short period of time, chronic conditions last for an extended period of time and are not typically curable.

Long-term care services include a continuum of health and social services provided in institutions, in the community and at home. However, the predominant source of long-term care support for persons with disabilities is through informal support services provided by unpaid family and friends. Despite the enormous amount of care provided by informal sources, long-term care spending – over $151 billion in 2001 – represents more than 12% of all personal health care spending.

The long-term care system is comprised of multiple types of providers financed by a myriad of federal health and social service programs primarily, but also income assistance and housing support programs to a lesser extent. The principal source of public support for long-term care is the Medicaid program, chiefly through its coverage of nursing home care. Over the years, federal and state policymakers have devoted efforts to expand home and community-based long-term care services that most people prefer over institutional care. A significant Supreme Court decision in 1999 (*Olmstead v. L.C.)* has sharpened federal policy attention on federal and state programs that provide this care. The private long-term care insurance market is a growing option to provide protection against the high cost of long-term care for some people.

This Appendix presents an overview of long term care, including information on current recipients, future need, providers, federal programs and the private long-term care insurance market.

Measuring the Need for Long-Term Care

The need for long-term care assistance is measured by assessing a person's need for assistance with *activities of daily living (ADLs)* and/or *instrumental activities of daily living (IADLs)*. ADLs are activities necessary to carry out basic human functions, and include the following: bathing, dressing, eating, getting around inside the home, toileting, and transferring from a bed to a chair. *IADLs* are tasks necessary for independent community living, and include the following: shopping, light housework, laundry, taking medication, telephoning, money management, and meal preparation. IADLs are sometimes used to measure a person's need for assistance as a result of mental or cognitive disabilities as well as physical disabilities.

Recipients of Long-Term Care

About nine million persons over age 18 received long-term care assistance, either in community settings or in nursing homes. This includes 5.5 million persons aged 65 and older (in 1999) and 3.5 million persons aged 18-64 (in 1994) (61% and 39% of the total, respectively) (see Tables 1 and 2).[1]

The vast majority of adults who receive long-term care assistance reside in the community, *not* in institutions. About 7.2 million persons aged 18 and older received long-term care assistance in community settings, representing over 80% of all persons receiving assistance. Of all persons receiving assistance in the community, just over half are aged 65 and older, and about 47% are age 18-64.

Less than 5% of persons aged 65 and older – just under 1.7 million persons – received care in institutions in 1999. Less than one-tenth of one percent of persons age 18-64 received care in nursing homes in 1994 – about 138 thousand persons (see Tables 1 and 2). About another 400 thousand persons receive care in residential care facilities for persons with mental retardation or developmental disabilities or mental illness (Spector, Pezzin, and Spillman).

The likelihood of receiving long-term care assistance increases dramatically with age. However, while use of nursing home care occurs more frequently as a person ages, *regardless of age*, in 1999, most older people received long-term care assistance in community settings rather than in nursing homes, even those 85-94. It is only among the very old – those persons aged 95 and older – that persons have about an equal chance of being cared for in an institution or in the community (see **Table B-15**).

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[1] Estimate based on data from the 1999 National Long-Term Care Survey (for persons aged 65 and older; and the 1994 National Health Interview Survey and the 1996 Medical Expenditure Panel Survey (for persons aged 18-64).

Table 1. Persons Aged 65 and Older Receiving Long-Term Care Services, 1999

(population in thousands)

Characteristics of persons aged 65 and older	Persons aged 65 or older	% receiving long-term care*	% receiving long-term care in the community**	% receiving long-term care in institutions***
Total, persons age 65 or older	34,459	5,479 15.9%	3,824 11.1%	1,654 4.8%
Age				
65-69	9,443	5.7%	5.0%	0.7%
70-74	8,785	8.8%	7.2%	1.7%
75-79	7,305	13.6%	10.1%	3.5%
80-84	4,797	24.8%	17.3%	7.4%
85-89	2,601	39.8%	24.8%	15.0%
90-94	1,133	59.8%	33.7%	26.1%
95 years and older	396	72.1%	35.7%	36.4%
Gender				
Women	20,200	18.8%	12.8%	6.0%
Men	14,260	11.9%	8.8%	3.1%
Race				
White	30,367	15.6%	10.6%	5.0%
Black	2,869	20.8%	16.6%	4.2%
Other	1,223	12.5%	10.7%	1.8%
Marital Status				
Married	17,990	9.7%	8.3%	1.4%
Widowed	12,020	24.8%	15.7%	9.1%
Never Married	1,293	23.5%	12.1%	11.5%
Other	3,157	14.9%	9.4%	5.5%

Source: Unpublished tabulations of the 1999 National Long-Term Care Survey by Brenda C. Spillman. The Urban Institute, 2003.

*Receipt of long-term care is defined as receiving human assistance or standby help with at least one of 6 ADLs or being unable to perform at least one of 8 IADLs without help. The ADLs included are eating, transferring, toileting, getting around inside, dressing, and bathing. The IADLs are meal preparation, grocery shopping, light housework, laundry, financial management, taking medication, telephoning, and getting round outside.

**This does not include about 1.3 million persons with disabilities who do not receive chronic help, but use special equipment to manage their disabilities.

***This includes about 1.5 million persons in nursing homes and slightly more than 150,000 persons in other care facilities.

Table 2. Persons Age 18-64 Receiving Long-Term Care Services, 1994
(Population in thousands)

Population age 18-64 not receiving long-term care assistance	155,200
Persons age 18-64 receiving long-term care assistance*	3,502
Persons age 18-64 receiving long-term care in the community	3,364 (2.1%)
Persons age 18-64 receiving long-term care in nursing homes**	138 (0.1%)

Source: William Spector, et al. *Characteristics of Long-Term Care Users.* Prepared for the Institute on Medicine, 1998. For persons receiving services in the community, the 1994 National Health Interview Survey, Disability Supplement. For persons receiving care in nursing homes, the 1996 Medical Expenditure Panel Survey Nursing Home Component.

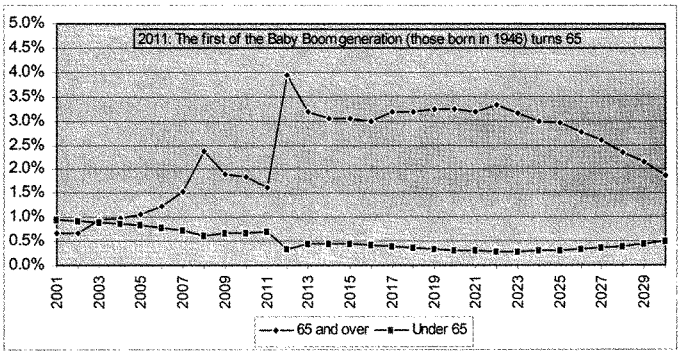
*Receipt of long-term care is defined as receipt of human help for ADLs and IADLs, including reminders and standby help, due to a physical, mental, or emotional problem. ADLS include bathing, dressing, getting around inside, transferring, toileting, and eating. IADLs include shopping, light housework, telephone, money management and meal preparation.
**The number of persons in nursing homes does not include about 0.4 million persons in intermediate care facilities for the mentally retarded (ICFs/MR) and state mental hospitals.

Future Need for Long-Term Care

While some research shows that the incidence of disability among the older population has decreased over time, the sheer numbers of older persons in the future will strain private and public resources devoted to long-term care. The increasing numbers of older persons, especially those who are in the oldest age categories will affect public and private financing for care and demand for services from long-term care service providers. The growth in the older population will also affect caregiving demands on families who are the primary source of long-term care assistance.

Experts predict that in the coming decades long-term care services will be in greater demand due to increased numbers of older persons, especially those in the oldest age categories. After 2011, the rate of growth for the population age 65 and older will considerably outpace the growth of the rest of the nation, and at its peak the elderly population will be growing eight-times faster than the population under age 65. This growth will lead to significantly higher ratios of elderly to non-elderly in the future. **Figure 1** shows the percent increase in the number of the elderly for each year from 2001-2030 compared to the change in the population under 65. The large increase in the elderly population in 2011 will present challenges for families.

Figure 1. Projected Rate of Growth from Previous Year for Selected Populations in the United States, 2001-2030



Source: Congressional Research Service (CRS) calculations based on data from the U.S. Census Bureau, *State Population Projections: Every Fifth Year*. 1996; available on-line at: [http://www.census.gov/population/www/projections/st_yrby5.html].

In 2010, just before the first of the baby-boom generation (those born in 1946) turns 65, the U.S. Census Bureau projects that 13.2% of the U.S. population will be 65 and over; by 2030, when the last of the baby-boom generation (those born in 1964) will already have turned 65, 20% of the population will be 65 and older. Between 2000 and 2030, the number of persons 65 and older will more than double, from 35 million to more than 70 million persons. Furthermore, in 2030, 33 million of those people will be 75 and older, and almost 9 million will be 85 and older (see Table 3).

Table 3. Elderly Population as a Percent of Total Population in the United States, 2030

	2030		
Age group	**Number (in millions)**	**Percent of population**	**Percent increase 2000 to 2030**
65+	70.3	20.0	101.9
65-74	37.7	10.7	107.4
75-84	23.7	6.7	91.9
85+	8.9	2.5	107.1
Under 65	280.8	80.0	16.8
Total population	351.1	100	27.5

Source: Congressional Research Service (CRS) calculations based on data from the U.S. Census Bureau, *State Population Projections: Every Fifth Year*. 1996; available on-line at: [http://www.census.gov/population/www/projections/st_yrby5.html].

The number of persons with disabilities will grow as the population ages. According to data prepared for the Department of Health and Human Services (DHHS), the number of persons receiving long-term care assistance will increase by over 80% from 2005-2035. Users of institutional care (nursing facilities and alternative living facilities, such as assisted living facilities) age 65 and older are estimated to increase by about 70% over this same period. Users of home care services are estimated to increase by 85% (see Table 4). The number of persons aged 65 and older with at least two or more ADLs is estimated to increase by over 30% from 2000-04 to 2030-34.

Table 4. Projected Growth in the Long-Term Care Population, Age 65 and Older, 2005-2035*
(number in millions)

Year	Total number of persons age 65 and older receiving care	Number of persons age 65 and older receiving home and community-based care	Number of persons age 65 and older receiving institutional care
2005	7.3	5.2	2.1
2015	8.8	6.5	2.3
2025	11.2	8.2	3.0
2035	13.2	9.6	3.6

Source: The Long-Term Care Financing Model. Prepared by The Lewin Group, Inc. for DHHS, Office of the Assistant Secretary for Planning and Evaluation, 2000.

*Projected number of persons receiving paid care throughout the year. Public policies are assumed to remain constant.

PROVIDERS OF LONG-TERM CARE

The primary source of long-term care assistance is from informal caregivers – families and friends of persons with disabilities who provide care and assistance without compensation. Estimates of the number of caregivers to persons of all ages receiving long-term care assistance range from 7 million to 54 million persons, depending upon the population served and the amount and intensity of care provided. Research has shown that while adults of all ages provide long-term care assistance, persons in middle to late middle age are most likely to be caregivers. While women are most likely to be in the caregiver role, both men and women provide care. In addition, caregivers often have competing demands – about one-half are employed and one-third have minor children in the home (Administration on Aging, August 2002).

Informal Care Provided by Families and Friends

Of the 3.9 million persons[2] aged 65 and older who received long-term care assistance in the community in 1994, nearly 60% relied *exclusively* on unpaid caregivers, primarily spouses and children. Only 7% relied exclusively on paid services; slightly more than a third relied on a combination of paid and unpaid care. Of the 3.4 million persons aged 18-64 who received assistance in the community, nearly three-quarters of persons relied *exclusively* on unpaid caregivers. Only 6% relied exclusively on paid services (see Table 5).

[2] Total number of persons receiving care in the community differs slightly from number in Table B-17 due to differences in year of data collection.

Table 5. Type of Care Received by Persons Aged 18 and Over Living in the Community, 1994

Persons receiving long-term care assistance in the community	Persons age 65 and older	Persons age 18 – 64
Total	3.9 million	3.4 million
Percent receiving care from unpaid providers only	57%	71%
Percent receiving paid care only	7%	6%
Percent receiving unpaid and paid care	36%	6%
Unknown	Not applicable	17%

Source: For persons aged 65 and older: 1994 National Long-Term Care Survey; for persons 18-64, 1994 National Health Interview Survey, Disability Supplement. William Spector et. al. *Characteristics of Long-Term Care Users*. Prepared for the Institute of Medicine, 1998.

Formal Care Providers

In addition to the extensive informal care provided by families and friends, the long-term care services system includes thousands of formal care providers. They range from institutional providers, including nursing homes and residential care facilities for persons with mental retardation and developmental disabilities, to a variety of agencies and programs that provide a wide array of home and community-based services. These services include home health care, personal care, homemaker and chore assistance, adult day care services, home-delivered meals, transportation, and many others. In addition, assisted living facilities, adult foster care homes and other group homes provide both room and board as well as personal care and other assistance to persons who have lost the capacity to live independently in their own homes because of their need for assistance with ADLs or IADLs.

The growth in many formal providers has been influenced by the availability of federal financing sources. For example, the growth in the nursing home industry during the last fifty years has largely been a result of financing available through the Medicaid program and, to a lesser extent, the Medicare program. Before then, homes for the aged were supported by state-only funds and through private resources. On the other hand, home care agencies have a long history of support from the private sector through charitable and volunteer organizations, dating from the late 19th century. Like nursing homes, growth in the home care industry has been influenced by the availability of federal financing under Medicare and Medicaid. Adult day care services were modeled after programs that originated in Europe, and then were later adopted in the U.S. to fit available financing mechanisms through the Medicaid, Social Services Block Grant (SSBG), and Older Americans Act programs. A relatively new model of care – assisted living – has recently become an important component of the formal long-term care system and is primarily financed by individuals' own resources – not through public sources.

Nursing Homes. While only a small proportion of persons receiving long-term care services reside in nursing homes, the largest proportion of public spending on long-term care is for this care. The growth in the nursing home industry was influenced by the creation of benefits under the Medicare, but especially, the Medicaid programs in 1965. Significant growth in number of nursing

homes occurred during the 1960s – from 1960 to 1970, the number of homes more than doubled, from 9,582 to almost 23,000, and the number of beds more than tripled, from 331,000 to more than one million (U.S. Congress. Senate. Special Committee on Aging). While the number of homes has fluctuated over the years, the number has declined from the 1970 level. In 2003, there are about 1.8 million beds in more than 16,400 nursing facilities (Centers for Medicare and Medicaid Services, May 2003).

Residential Settings for Persons with Mental Retardation and Developmental Disabilities. The early history of services to persons with mental retardation is characterized by the development of large state institutions or training schools begun during the latter part of the 19th century and continuing through the first part of the 20th century. Between 1920 and 1967, institutions quadrupled in size and peaked to almost 200,000 individuals nationwide in 165 free-standing state-operated mental retardation institutional facilities (Braddock, 1998). In 1971, federal financing for intermediate care facilities for the mentally retarded (ICFs/MR) was authorized under the Medicaid program; states that were able to meet the federal requirements governing care for persons with mental retardation in ICFs/MR shifted their state-financed facilities to the Medicaid program. Today, although some states are still faced with the legacy of large state-operated and state-financed institutions, a major change has occurred toward care in smaller, community-based residences as well as home-based services for this population. In 2002, there were an estimated 125,415 distinct residential settings for persons with developmental disabilities nationwide (Prouty et. al.).

Home Care. Home care services comprise a wide array of services designed to assist persons with disabilities and the frail elderly to reside in their own homes with appropriate health and supportive services. Home care services may include nursing, physical, occupational, and speech therapies, social services, case management and assessment, personal care, and homemaker/chore services, among others. Home care may be provided by agencies certified to participate in the Medicare and Medicaid program and area agencies on aging operating under the Older Americans Act, as well as other voluntary organizations. In 1997, there were an estimated 20,000 agencies that provide home care services (National Association for Home Care).

Adult day care programs. Adult day care programs provide health and social services in a group setting on a part-time basis to frail older persons and other persons with physical, emotional, or mental impairments who require assistance, supervision and rehabilitation to restore or maintain optimal functioning. Services generally provided in adult day care settings include client assessment, nursing services, social services, therapeutic activities, personal care, physical, occupational, and speech therapies, nutrition counseling, and transportation to and from the center. These programs have grown from a handful of federally-supported research and demonstration projects in the late 1960s and early 1970s to more than 3,400 centers in 2003 (Cox).

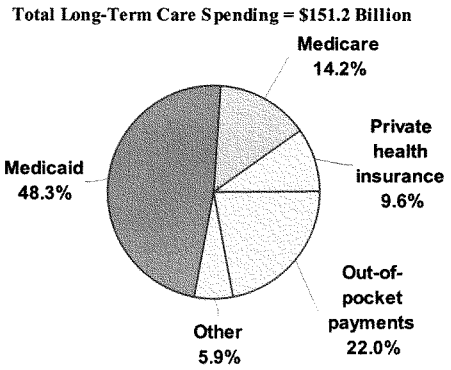
Assisted Living Facilities. Assisted living facilities are designed for persons who need some assistance due to functional or cognitive impairment, but who do not need sustained nursing care. In general, these facilities provide room and board, personal care and supportive services while also providing some health-related care. They have become alternatives to nursing homes and are based on a philosophy that values consumer independence and choice. However, unlike nursing homes which receive Medicaid and Medicare funding, assisted living facilities are primarily financed by residents out of their own resources. It is estimated that there are about 30,000 assisted living facilities providing care to about one million persons.

LONG-TERM CARE SPENDING

Of the $1.24 trillion spent on all U.S. personal health care services in 2001, $151.2 billion, or about 12.2%, was spent on long-term care. This amount includes spending for institutional care (nursing homes and intermediate care facilities for the mentally retarded (ICFs/MR)), and a wide range of home and community-based services, such as home health care services, personal care services, and adult day care, among others.

Long-term care is chiefly financed through the federal-state Medicaid program. Of all U.S. long-term care spending in 2001, the Medicaid program financed 48.3%, or $73.1 billion. After Medicaid, private out-of-pocket spending is the next primary source of funding for long-term care. In 2001, out-of-pocket spending for long-term care was $33.2 billion, representing 22% of all U. S. spending on long-term care. Medicare plays a relatively smaller role in long-term care than Medicaid and out-of-pocket spending. In 2001, of total long-term care spending, Medicare accounted for 14.2% (see Figure 2).

Figure 2. Sources of Long-Term Care Spending, 2001



Source: Chart prepared by CRS based on data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Does not include costs of some federal and state social service and housing programs nor imputed value of informal caregiving.

The spending in Figure 2 excludes some other spending for care of persons with disabilities. For example, it does not include spending for home and community-based services under federal social service programs such as the Social Services Block Grant (SSBG) and the Older American Act. It also fails to account for spending for supportive housing services financed through the Department of Housing and Urban Development (HUD) programs. It also excludes spending for state-only funded long-term care programs.

In addition to these costs, spending shown in Figure 2 does not take into account the economic value of care provided to persons with disabilities by uncompensated informal care providers. The value of informal caregiving is estimated to be quite significant. Placing a value on unpaid caregiving hours is dependent upon estimates of the number of persons who need help, the cost of caregiving, and the number of unpaid hours that are provided. According to one analysis, the economic value of informal caregiving to adults in 2000 ranged from $140 billion to $389 billion depending upon the number of caregivers (24.4-29.2 million), caregiving hours (24-27 billion), and an imputed value of hourly wages ($5.15 to $12.46) (Arno, 2002). Another study estimated the imputed value of informal caregiving at $168 billion based on 18.7 billion of caregiving hours priced at $9 per hour (LaPlante, Harrington, and Kang, 2002).

FEDERAL PROGRAMS THAT PROVIDE LONG-TERM CARE

Many federal programs assist persons needing long-term care services, either directly or indirectly through a range of health and social services, through cash assistance, and through tax benefits. While Medicaid is the primary source of public financing for long-tem care, other programs, including Medicare, and social service programs provide assistance to persons who need long-term care support. No one program, however, is designed to support the full range of long-term care services needed by persons with disabilities. Eligibility requirements, benefits, and reimbursement policies differ among major programs. Many observers indicate that these varying features often result in a fragmented and uncoordinated service system.

Many observers indicate that federal support for long-term care provides more support for institutional care (primarily through Medicaid) than for home and community-based care which most people prefer. A significant 1999 Supreme Court case (Olmstead v. L.C.) has had important implications for federal and state long-term care programs. In its decision, the Court stipulated that, under certain circumstances, institutionalization of persons who could live in community settings, and desire to do so, violates the Americans with Disabilities Act (ADA). In the case, physicians had determined that two patients living in a state psychiatric hospital in Georgia were able to live in community settings. When the state refused to transfer them to a less restrictive setting, the patients brought suit under the ADA. The Court ruled that the state had violated Title II of ADA which prohibits "unjustified isolation" and that it was discriminatory to force someone to remain in an institutional setting when (1) treatment professionals determine that a community setting is appropriate; (2) the individuals do not oppose the placement; and (3) the placement can be reasonably accommodated, taking into consideration the resources of the state and needs of other persons with disabilities. The federal government has taken a number of steps to implement the *Olmstead* decision, including issuance of a series of policy guidance letters from DHHS/Centers for Medicare and Medicaid Services (CMS) and through an Executive Order issued by President Bush in June 2001 (Executive Order).[3]

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[3] On June 18, 2001, President Bush issued Executive Order 13217, *Community-Based Alternatives for Individuals with Disabilities*, calling for swift implementation of the *Olmstead* decision. The Executive Order states that the Attorney General, and the Secretaries of DHHS, Education, Labor, and Housing and Urban Development and the Commissioner of the Social Security Administration shall work cooperatively to see that this goal is accomplished (with DHHS as the designated lead agency).

The order was based on the following justifications: the nation is committed to community-based alternatives for individuals with disabilities; the nation seeks to ensure that community-based programs

(continued...)

The following briefly describes selected major federal programs. Not discussed are a host of other federal programs dealing with other aspects of long-term care, including housing assistance programs through HUD, as well as services administered by the Veterans Administration (VA).

Medicaid

The largest single public financing source for long-term care services in the nation is the federal-state Medicaid program. Medicaid is administered by states within broad federal guidelines. Medicaid pays for a wide range of long-term care services for persons who meet Medicaid's categorical and financial eligibility requirements (see section on Medicaid eligibility). Medicaid covers services in nursing facilities, intermediate care facilities for persons with mental retardation (ICFs/MR), and a wide range of home and community-based services, including case management, home health care, personal care, homemaker services, among others.

Nursing Home Care. Medicaid's coverage of long-term care is driven primarily by its coverage for nursing home care which is the largest component of Medicaid long-term care spending. The Social Security Amendments of 1965 required that states cover skilled nursing facility services and gave these services the same level of priority as hospital and physician services. People eligible under the state's Medicaid plan are entitled to nursing home facility care; that is, if a person meets the state's income and asset requirements, as well as the state's functional eligibility requirements for entry into a nursing home, he or she is entitled to the benefit. In 2003, there are an estimated 1.6 million nursing home beds certified to participate in the Medicaid program (American Health Care Association).

Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Institutional care provided to persons with mental retardation and developmental disabilities in intermediate care facilities for the mentally retarded (ICFs/MR) is an optional benefit under the Medicaid program. All states opt to provide this care under Medicaid. Services include room and board and a wide range of specialized therapeutic services to assist persons with mental retardation and developmental disabilities to function at optimal levels. Medicaid-certified ICFs/MR must offer "active treatment"[4] to residents. Federal Medicaid law and regulations govern standards of care that ICFs/MR must provide, including staffing and resident care requirements and inspection and certification rules. In 2002, there were 6,623 Medicaid ICFs/MR nationwide serving about 110,600 residents; the average size of these facilities was 16.7 residents (Prouty et al.).

Home Health Care Services. All states are also required to provide home health services to persons entitled to nursing facility coverage under a state's Medicaid plan. Home health services

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[3] (...continued)
effectively foster independence and participation in the community for Americans with disabilities; unjustified isolation or segregation of qualified individuals with disabilities through institutionalization is a form of disability-based discrimination prohibited by the ADA; and the federal government must assist states and localities to implement the *Olmstead* decision to ensure that all Americans have the opportunity to live close to their families and friends, to live independently, to engage in productive employment, and to participate in community life.

[4] *Active treatment* is defined by regulation as aggressive, consistent implementation of a program of specialized and generic training, treatment, health and related services directed toward acquisition of behaviors necessary for the client to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of optional functional status. (45 CFR 483.440)

are nursing services and home health aide services provided on a part-time or intermittent basis to persons who need assistance for an illness or condition; services may be provided through home health agencies or, under certain circumstances, by a registered nurse. Services also include medical supplies, medical equipment and appliances suitable for use in the home. States may also choose to provide optional services, such as physical therapy, occupational therapy, speech pathology and audiology services.

Personal Care Services. States have the option to cover personal care services for Medicaid beneficiaries who need assistance with ADLs and IADLs. Medicaid statute defines personal care as services furnished to an individual at home or in another location (excluding hospital, nursing facility or ICF/MR, or institution for mental diseases) that are authorized by a physician, at state option, otherwise authorized under a plan of care. Services offered under the personal care option include assistance with bathing, dressing, eating, toileting, personal hygiene, light housework, laundry, meal preparation and grocery shopping. In 2002, 36 states covered personal care services as part of their state Medicaid plans.

Home and Community-Based Waiver Program. In 1981 Congress authorized expansion of home and community-based services under Medicaid. The program, known as the home and community-based waiver program (authorized under Section 1915(c) of the Social Security Act) allows the Secretary of the Department of Health and Human Services (DHHS) to waive certain statutory requirements to assist states in financing care at home and in other community-based settings for persons who, without these services, would be in an institution.[5]

States may choose to cover a range of community-based long-term care services for persons of all ages who meet the state's eligibility requirements. Services may include personal care assistance, homemaker/home health aid services, personal care assistance, adult day care, case management, and respite for caregivers, and habilitation,[6] among others. Spending for the Section 1915(c) waiver program has increased rapidly since FY1990 when it was $1.2 billion, reaching $16.4 billion in FY2002.

The home and community-based waiver program has been a significant source of support to care for persons with mental retardation and developmental disabilities. In FY2002, about three-quarters of waiver spending was for persons with mental retardation and developmental disabilities; the balance was spent on other persons with disabilities, including the elderly and persons with physical disabilities (Eiken and Burwell). Despite the growth in the waiver programs, many states have waiting lists for services, especially for persons with mental retardation and developmental disabilities.

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[5] States may waive the following Medicaid requirements: (1) statewideness – states may cover services in only a portion of the state, rather than in all geographic jurisdictions; and (2) comparability of services – states may cover state-selected groups of persons, rather than all persons otherwise eligible. In addition to waiving these requirements, states may use more liberal income requirements than would ordinarily apply to persons living in the community. That is, they may use the eligibility standard used to determine financial eligibility for nursing home care – income up to 300% of the SSI level ($1,656 in 2003).

[6] Habilitation refers to services to assist individuals in developing skills necessary to reside successfully in home and community-based settings. It includes such activities as prevocational, educational, and supported employment.

In January 2000, and in subsequent policy memoranda DHHS issued guidance to states in the implementation of the *Olmstead* decision as it relates to Medicaid home and community-based programs. (Centers for Medicare and Medicaid Services, January 2000) Specifically, DHHS indicated that *Olmstead* applied to all persons with disabilities and to persons already in institutional settings as well as those being assessed for institutionalization. Furthermore, DHHS recommended that states take a number of actions, including development of comprehensive plans to strengthen community service systems and serve persons with disabilities in the most integrated setting appropriate to their needs.

(For more information on Section 1915(c) waiver programs see the section on Medicaid.)

Medicaid Long-Term Care Spending

In FY2002, Medicaid spent $82 billion on long-term care services – representing more than one-third of all Medicaid spending (see Table 6). In FY2002, of total Medicaid long-term care services, most – 70% or $57.4 billion – was spent for care in institutions. Of the $57.4 billion spent for institutions, slightly more than 80% was spent for care in nursing facilities, with the balance for care in ICFs/MR.

While overall long-term care spending increased by 178% over the period, the proportion of Medicaid funds spent on long-term care declined from 42% in FY1990 to slightly more than 35% in FY2002. This decline in the proportion of total spending used for long-term care services is influenced by a number of factors. These include, for example, the increased share of Medicaid spending for other services, such as prescription drugs, and changes in enrollment patterns.

The downward shift in the overall proportion spent for long-term care is also influenced by the changing patterns of long-term care service utilization. Despite the large proportion of funds for institutional care, over the last 12 years, there has been a shift in how Medicaid funds are used for long-term care. From FY1990 to FY2002, the proportion of Medicaid long-term care spending devoted to institutional care declined. In FY1990, almost 87% of long-term care spending was devoted to institutional care; in FY2002, it had declined to just over 70% (see Table 6). This is in part due to a decreasing share of institutional spending used for care in ICFs/MR as states have made greater use of home and community-based waiver funds to serve persons with mental retardation and developmental disabilities.

In general, there has been a rather large shift in spending toward home and community-based care over this period. In FY1990, slightly more than 13% of Medicaid long-term care spending was for home and community-based care; in FY2002, this proportion had increased to about 30%. This shift is primarily due to increased spending on home and community-based services under the Section 1915(c) waiver program which represented almost one-fifth of Medicaid long-term care spending in FY2002 (see Table 6).

Table 6. Medicaid Long-Term Care Spending in the U.S. FY1990-FY2002

Total U.S. (50 states and the District of Columbia)	FY1990	FY1995	FY2000	FY2002
Total Medicaid spending (in billions)	**$69.7**	**$151.4**	**$194.3**	**$243.5**
Total long-term care spending (in billions)	**$29.5**	**$49.4**	**$68.4**	**$82.1**
Long-term care spending as a percent of Medicaid spending	**42.4%**	**32.6%**	**35.2%**	**35.1%**
Institutional care spending as a percent of long-term care spending	**86.7%**	**80.8%**	**72.5%**	**70.5%**
Nursing home spending as a percent of long-term care spending	60.9%	61.4%	57.9%	56.8%
ICF/MR* spending as a percent of long-term care spending	25.8%	19.4%	14.6%	13.7%
Total home and community-based services (HCBS) spending as a percent of long-term care spending**	**13.3%**	**19.2%**	**27.5%**	**29.5%**
HCBS waivers spending as a percent of long-term care spending	4.2%	9.4%	18.5%	19.1%

Source: Congressional Research Service (CRS) calculations based on CMS/HCFA 64 data provided by The Medstat Group, Inc. for various years. 1990 total Medicaid spending, based on HCFA 64 data provided by Urban Institute, Washington, D.C.

*Intermediate care facilities for persons with mental retardation.
**Includes HCBS waivers, home health and personal care services.

Medicare

The Medicare program covers skilled nursing home and home health care services for persons who need skilled or rehabilitative services of relatively short duration. It is not intended to be a primary funding source for long-term care for persons who need assistance with chronic conditions. Medicare's role is limited to financing care in skilled nursing facilities (SNFs) (up to 100 days after a hospitalization for persons who need continued skilled care), and home health services for persons who need skilled nursing care on a part-time or intermittent basis, or physical or speech therapies. Of the $21.5 billion Medicare spent on long-term care in 2001, about 54% was for skilled nursing facility care, and the balance was for home health care services.

Skilled Nursing Facility Services. Medicare covers SNF services for beneficiaries who require skilled nursing care and/or rehabilitation services following a hospitalization of at least 3 consecutive days. A physician must certify that the beneficiary needs daily skilled nursing care or other skilled rehabilitation services that are related to the hospitalization, and that these services, can only be provided on an inpatient basis. Medicare does not cover SNF care for persons who need care for chronic conditions or disabilities alone. In 2003, of the almost 1.8 million nursing facility beds nationwide, about 1.2 million were certified to participate in both the Medicare and Medicaid programs, and another 63,000 were certified for Medicare only (American Health Care Association).

Home Health Care Services. Medicare covers home health care services for beneficiaries who are homebound based on the need for intermittent skilled nursing care, physical therapy or speech therapy. Beneficiaries receiving at least one of these services may also receive, as covered benefits, home health aide services, medical social work services, and occupational therapy. Services provided must be medically necessary and carried out under a plan of care prescribed by a physician. Medicare's home health benefit is not intended to cover personal care for persons who need care for a chronic condition or disability alone. In 2001, about 3.5 million persons qualified for Medicare on the basis of disability received care from nearly 7,000 Medicare-certified home health agencies (Centers for Medicare and Medicaid Services, March 2003) .

Other Federal Programs

A variety of other federal programs support long-term care services. Primarily these are the Older Americans Act and the SSBG (Title XX of the Social Security Act). Both support a variety of home and community-based services, such as homemaker and chore services, home-delivered meals services, transportation, and other services for persons who have chronic and disabling conditions. While total spending under these program is small compared to Medicaid spending devoted to long-term care, in many communities these programs represent an important source of support for the frail elderly and other persons with disabilities by filling gaps in services not met by Medicaid or Medicare.

The Older Americans Act supports a wide variety of services for persons age 60 and older through state and area agencies authorized under Title III of the Act. A majority of its spending for home and community-based long-term care services is for home-delivered meals programs. State and area agencies use Title III funds for home care, adult day, congregate nutrition services, and transportation among other services. In FY2002, Title III spending for home-delivered meals, personal care, homemaker, and adult day care services totaled almost $920 million (Administration on Aging, 2002). In addition, the National Family Caregiver Support program, authorized in 2000, offers assistance to informal caregivers of the frail elderly; FY2003 funding is $142 million.

The SSBG authorizes grants to states for a wide range of services to diverse populations, including children and families as well as the elderly and persons with disabilities. States are allowed considerable discretion in their support for social services as long as services are aimed at achieving a number of goals, including preventing or reducing inappropriate institutional care through home and community-based care. Under the program, home and community-based long-term care services must compete with many other social services for other population groups, including children and at risk youth (in 2001, the largest expenditures categories for SSBG services were for child protective services and children's foster care).

Many states supplement the federal Supplemental Security Income (SSI) cash welfare payments to low income elderly and disabled persons to enable them to pay for home and community-based services, or to reside in non-medical residential services, such as board and care homes. In addition, certain programs authorized under the Rehabilitation Act of 1973 provide a range of supportive services to persons with disabilities to enable them to be employed. The Department of Veterans Affairs (DVA) provides a wide range of long-term care services to the Nation's veterans, including nursing home, domiciliary, home health care, and assistance to caregivers. Finally, programs administered by HUD support limited assistance to persons with disabilities through its Congregate Housing Service Programs (CSHP) and Assisted Living Conversion Program (ALCP), and through services coordinators who work in multifamily housing projects.

PRIVATE LONG TERM CARE INSURANCE

Private long-term care insurance is considered by some to be a promising private sector option. This insurance provides persons needing assistance with ADLs protection against the high cost of long-term care services without relying on public sector programs such as Medicaid. Although it is a relatively new insurance product, the market has grown rapidly. Since 1987, when the Health Insurance Association of America (HIAA) began surveying the industry, the market has grown by an average 18% per year, reaching more than 700,000 policies sold in 2001 by 137 companies (with 80% accounted for by the ten largest sellers). HIAA reports that at the end of 2001, about 7 in 10 policies sold since 1987 remained in force (based on 77% of all policies sold in the individual and group association market as of the end of 2001). (Health Insurance Association of America, 2003).

Care in a variety of settings may be covered, including nursing facilities or assisted living facilities, or the individual's own home through home health, respite care for caregivers, homemaker and chore services, and medical equipment, among others. Some policies will pay relatives for providing care; others pay only for licensed professionals. Eligibility is based on limitations in ADLs.

Long-term care policies vary with regard to features. These include criteria to qualify for benefits; a waiting ("elimination") period between the onset of qualifying impairments and commencement of payment; dollar limits on payments and possible inflation adjustments of the limits; whether payments are a flat daily amount regardless of expenses or are paid only as reimbursement for approved expenditures; and the length of time over which benefits may be paid (such as 1 year, 3 years, or longer).

Long-term care insurance policies may be sold to an individual, based on that individual's age and health-related factors, or may be sold to a group; they may also be employer-sponsored, or be part of a life insurance policy. Of the cumulative 8.3 million policies sold over the period 1987-2001, 80% had been sold to individuals or group associations; about 16% were employer-sponsored with the balance sold as part of life insurance policies (see Table 7).

The age of purchase of policies varies with the type of product purchased. As shown in Table B-22, in 2001, the average age of purchase for policies sold in the individual and group association market was 62 years; the age of purchase in the employer-sponsored market was 46 years, and as part of life insurance was 66 years. According to HIAA, the average age of purchasers who buy policies in the individual market has steadily decreased – decreasing from age 72 in 1990 to 62 in 2001.

Table 7. Long-Term Care Insurance Products by Percentage of Policies Sold and Average Age of Buyer

Long-Term care product	Percent of companies* n=137	Percent of policies sold 1987- Dec. 2001 (n=8.26 million)	Percent of policies sold in 2001 (n=732,000)	Average age of buyer
Individual and group association	81%	80%	76%	62
Employer-sponsored	10%	16%	24%	46
Long-term care as part of a life insurance policy	13%	5%	Not applicable	66

Source: Health Insurance Association of America. *Long-Term Care Insurance in 2000-2001*. Washington. January 2003.

*Totals more than 100% because some companies sell their products in more than one type of market.

Individual policies are sold with substantial ``underwriting" – meaning the carrier requires detailed information regarding one's medical history – while group policies may or may not be sold with full or partial underwriting. Age rating is very important because the probability of claims is highly correlated with age. Underwriting is used by insurers to protect against the "adverse risk selection" that can occur if individuals buy policies when they know or suspect that they may soon need to make use of the insurance.

Affordability of Long-Term Care Insurance

One of the key issues in considering the role private insurance can play in long-term care is affordability, and the price for these insurance policies depends greatly on the individual's age at the time he or she first purchases the policy – the older the individual, the higher the premiums. Once the policy is purchased, premiums generally remain fixed throughout the policyholder's lifetime. Under certain circumstances, a carrier may seek approval from state insurance commissioners to raise rates for all policyholders (in the same class). An unexpected rate increase may affect a policyholder's desire and ability to continue the policy. According to HIAA, however, average premiums reported by leading insurers in 2001 had remained fairly constant compared to premiums for leading companies in 1999.[7]

[7] Health Insurance Association of America. *Long-Term Care Insurance in 2000-2001*. Washington. January 2003.

The cost of polices varies depending not only upon age of purchase, but also policy features. According to an HIAA survey (based on 11 insurance sellers selling 80% of all individual and group association policies in 2001), the average annual premium for a policy paying a $100 per day benefit (with a 5% compounded inflation protection, a 20-day elimination period, and four years of coverage) was $849 if purchased at age 50, rising to $1,726 if purchased at age 65 and $5,821 at age 79 (see Table 8; based on data from eleven insurance sellers having sold 80% of all individual and group policies in 2001).

Very likely, most people would find this product too expensive if they started considering purchase when already retired; others may not be able to afford it while still working. Generally speaking, the prime market for long-term care insurance is for persons who have average to somewhat above average income levels. At high levels of accumulated wealth, individuals can bear the financial risks without purchasing insurance. At low levels of wealth, insurance is unaffordable. At middle income levels, many will find insurance desirable, especially if they are concerned about providing income or assets for a spouse or passing on their wealth to their children. Others may be willing to take the chance of spending down their assets to qualify for Medicaid if necessary.

Table 8. Average Annual Premiums for Leading Long-Term Care Insurance Sellers in 2001*

Age	Base	With 5% Compounded Inflation Protection (IP)	With a Nonforfeiture Benefit**	With Inflation Protection and Nonforfeiture Benefit
Coverage amount: $100 daily benefit amount, 4 years of coverage, and a 20-day elimination period				
40	$310	$641	$387	$786
50	$401	$849	$502	$1,022
65	$996	$1,726	$1,219	$2,261
79	$4,180	$5,821	$5,087	$7,002
Coverage amount: $150 daily benefit amount, 4 years of coverage, and a 90-day elimination period				
40	$396	$834	$498	$1,001
50	$510	$1,009	$642	$1,369
65	$1,263	$2,273	$1,554	$2,988
79	$5,265	$7,588	$6,379	$8,883

Source: Health Insurance Association of America. *Long-Term Care Insurance in 2000-2001.* Washington. January 2003.

*Eleven insurance sellers were identified as having sold 80% of all individual and group association long-term care insurance policies in 2001.
** A nonforfeiture benefit refers to benefits that returns a portion of policy holders' benefits if they drop coverage, commonly through return of premiums or through coverage for a shortened period.

Employer-based Group Coverage

Affordability could be enhanced if insurance were purchased at group rates by individuals still in their working years. Even though most group plans to date have not featured employer contributions toward the premiums, some research shows that the plans can be as much as 15 to 30% less costly than policies purchased individually. Employment-based group premiums are lower because: (1) marketing can be targeted to younger individuals who generally have lower rates; (2) savings can be achieved through lower administrative costs and lower commissions; and (3) employers can bargain for reduced profit percentages and improved benefits. According to the HIAA, employer-based activity has been growing faster than the individual market, and accounted for almost one-quarter of policies sold in 2001 (see Table 6). These employer- based plans may cover employees, their spouses, retirees, parents, and parents-in-law.

In 2002, pursuant to the Long Term Care Security Act, P.L. 106-265, the federal government became the largest employer to offer group long-term care insurance. One of the intended purposes (aside from increasing the attractiveness of federal employment) is a possible demonstration effect; that is, encouraging more private-sector employers to offer such an insurance plan and ultimately having some impact on public spending. Some 20 million people are eligible to participate in the federal program, including active and retired federal employees, their spouses and some relatives. However, only active employees and their spouses can enroll with minimal medical qualification, and these only within two months of being hired or during an initial open season in 2002. In that open season, 265,000 applications were received. The program is administered by a joint venture of Metropolitan Life and John Hancock Life for an initial contract period of 7 years.

Tax Treatment of Long-Term Care Insurance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) established new rules regarding the tax treatment of long-term care insurance and other long-term care expenses, effective January 1, 1997. Qualified long-term care insurance is treated as accident and health insurance, and its benefits are treated as amounts received for personal injuries and sickness and for reimbursement of medical expenses actually incurred. As a consequence, long-term care insurance benefits are excluded from the gross income of the taxpayer (that is, they are exempt from taxation). The exclusion for insurance benefits paid on a per diem or other periodic basis is limited to the greater of (1) $220 a day (in 2003) or (2) the cost of long-term care services.

Employer contributions to the cost of qualified long-term care insurance premiums are excluded from the gross income of the employee. The exclusion does not apply to insurance provided through employer-sponsored cafeteria plans or flexible spending accounts.

Unreimbursed long-term care expenses are allowed as itemized deductions to the extent they and other unreimbursed medical expenses exceed 7.5% of adjusted gross income. Long-term care insurance premiums can be counted as these expenses subject to age-adjusted limits. In 2003, these limits range from $250 for persons age 40 or less to $3,130 for persons over age 70.

Self-employed individuals are allowed to include long-term care insurance premiums in determining their above-the-line deduction (a deduction not limited to itemizers) for health insurance expenses. Only amounts not exceeding the age-adjusted limits can be counted.

HIPAA also provided definitions for key long-term care insurance terms:

- *Qualified long-term care insurance* is defined as a contract that covers only long-term care services; does not pay or reimburse expenses covered under Medicare; is guaranteed renewable; does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed; applies all refunds of premiums and all policy holder dividends or similar amounts as a reduction in future premiums or to increase future benefits; and meets certain consumer protection standards. Policies issued before January 1, 1997, and meeting a state's long-term care insurance requirements at the time the policy was issued are considered qualified insurance for purposes of favorable tax treatment.

- *Qualified long-term care services* are defined as necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which are required by a chronically ill individual, and are provided according to a

plan of care prescribed by a licensed health care practitioner. However, amounts paid for services provided by the spouse of a chronically ill person or by a relative directly or through a partnership, corporation, or other entity will not be considered a medical expense eligible for favorable tax treatment, unless the service is provided by a licensed professional.

- *Chronically ill persons* are defined as those individuals:

  (1) unable to perform without substantial assistance from another individual at least two of the following six limitations in ADLs for a period of at least 90 days due to a loss of functional capacity: bathing, dressing, transferring, toileting, eating, and continence;
  (2) having a level of disability similar to the level of disability specified for functional impairments (as determined by the Secretary of the Treasury in consultation with the Secretary of Health and Human Services); or
  (3) requiring substantial supervision to protect them from threats to health and safety due to severe cognitive impairment.

A qualified long-term care insurance contract must take into account at least five of the six ADLs identified above.

HIPAA required that a licensed health practitioner (physician, registered professional nurse, licensed social worker, or other individual prescribed by the Secretary of the Treasury) certify that a person meets these criteria within the preceding 12-month period.

CHAPTER 10

EMPLOYER HEALTH BENEFITS FOR RETIREES

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 work force. 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.

The *Employer Health Benefits Annual Surveys,* conducted by the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET), show a significant decline since 1988 in the percent of public and private employers offering health benefits to retirees of all ages. Sixty-six percent of all large firms (200+ workers) offered retiree health coverage in 1988, but that figure had fallen to 36 percent by 1993. The percent of employers offering coverage then rose to 41 percent in 1999, perhaps encouraged by the economic expansion of the 1990's, and low health care inflation from 1994 to 1998. Since that time, however, retiree health coverage has once again fallen from 37 percent in 2000 to 34 percent for 2001 and 2002.[1] (The survey found no statistical difference in

[1] Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits 2002 Annual Survey,* p. 142.

offer rates by year since 1998, suggesting that coverage has not declined significantly since 1998.)

Another employee benefit survey, the *Mercer National Survey of Employer-Sponsored Health Plans 2002,* however, provides a breakdown of beneficiaries into those who are early retirees versus those who are eligible for Medicare. Mercer found 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 27 percent in 2002. For early retirees, not yet eligible for Medicare, coverage declined from 46 percent in 1993 to 34 percent in 2002.[2] (The survey does not indicate if the changes each year were statistically significant.) Because they report on employers that offer coverage on a continuing basis—to new hires as well as retirees, the decrease may be indicative of changes by employers that will impact future rather than current retirees.

Other survey results give cause for increasing concern about the level of retiree health coverage by the nation's employers. The largest firms (5,000 or more employees) provide health insurance coverage for more than 65 percent of retirees, but these firms were also the most likely to have dropped retiree coverage.[3] Small companies are much less likely to have ever provided retiree health benefits. According to the *2002 Kaiser/HRET Survey,* just 5 percent of all small firms (3–199 workers) offered retiree health benefits, compared to 34 percent of large firms (200+ workers).[4] The Employee Benefit Research Institute (EBRI) projects that because retiree health coverage is generally offered only by large employers, and "more than half of private-sector workers are in firms with fewer than 500 employees, very few employees are expected to be eligible for retiree health benefits in the future."[5] A study by Stuart and Singhal, using data from the 2000 Medicare Current Beneficiary Survey, determined there has also been a significant decrease in the past several years of offer rates to younger Medicare-eligible retirees (ages 65–69). The proportion of all aged community-dwelling Medicare beneficiaries with health coverage from an employer hovered at 39–40 percent from 1996 to 2000, and coverage for retirees age 70 and older remained fairly stable, but the percentage of Medicare beneficiaries in the 65–69 age group covered by employer-sponsored health insurance fell from 46 percent to just over 39 percent.[6]

Curtailments of retiree health insurance benefits 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 such as through a contract or union agreement. Even if employees are promised cov-

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[2] Mercer Human Resource Consulting, *Mercer National Survey of Employer-Sponsored Health Plans 2002,* p. 41.

[3] McCormack, p. 174.

[4] Kaiser/HRET, p. 142.

[5] Fronstein, Paul and Dallas Salisbury, *Retiree Health Benefits: Savings Needed to Fund Health Care in Retirement,* Issue Brief No. 254 (Washington, DC: Employee Benefit Research Institute, February 2003), p. 5.

[6] Stuart, Bruce, Puneet K. Singhal, Cheryl Fahlman, Jalpa Doshi, and Becky Briesacher, "Employer-Sponsored Health Insurance and Prescription Drug Coverage for New Retirees: Dramatic Declines in Five Years," *Health Affairs,* Web Exclusive, July 23, 2003, p. W 3–334.

erage, 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. According to the *Kaiser/Hewitt 2002 Retiree Health Survey* of private-sector businesses with 1000+ employees, 13 percent have recently terminated all subsidized health benefits for future retirees and almost one in four employers plan to eliminate future retiree health benefits in the next 3 years.[7]

1. Who Receives Retiree Health Benefits?

Employment-based retiree health benefits are the primary source of coverage for the nearly 2.3 million retirees under 65 who do not yet qualify for Medicare. According to 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, and 21 percent have employment coverage through their spouse. Almost 37 percent have another form of insurance such as private policies, veteran's health care, or Medicaid, and 17 percent are uninsured.[8]

Health insurance coverage is a major consideration for persons making the decision on whether to retire before the age of 65. 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, 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).[9] 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.[10]

For those 23.4 million retirees 65 or older, employer-based benefits are an important source for filling coverage gaps in Medicare, such as deductibles and copayments or prescription drug benefits.

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[7] Henry J. Kaiser Family Foundation and Hewitt Associates, *The Current State of Retiree Health Benefits—Findings from the Kaiser/Hewitt 2002 Retiree Health Benefit Survey,* p. 43.

[8] Fronstein, Paul, *Retiree Health Benefits: Trends and Outlook,* Issue Brief No. 236 (Washington, DC: Employee Benefit Research Institute, August 2001), p. 4. Percentages cannot be totaled to 100 as individuals may receive coverage from more than one source.

[9] Monheit, Alan C. Jessica P. Vistnes, and John M. Eisenberg, "Moving to Medicare: Trends in the Health Insurance Status of Near-Elderly Workers, 1987–1996," *Health Affairs,* March/April 2001, p. 210.

[10] Simantov, Elisabeth, Cathy Schoen and Stephanie Bruegman, "Market Failure? Individual Insurance Markets for Older Americans," *Health Affairs,* July/August 2001, p. 145.

According to GAO analysis of the March 2000 Current Population Survey, 98 percent of retirees age 65 and over were covered by Medicare, with 32 percent also covered by health benefits from prior employment, and 36 percent by Medigap supplemental coverage.[11] Employer-based supplemental coverage is generally more comprehensive and affordable than is coverage purchased individually. In 1999, annual out-of-pocket costs for Medicare beneficiaries with Medigap coverage were approximately $3,400, versus $2,200 for those with employer-sponsored supplemental coverage.[12]

2. Design of Benefit Plans

Employers who 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 him or her 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.[13] 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.

During the 1990's, large employers also controlled health care costs by moving employees and pre-Medicare eligible retirees into managed care plans in which companies could negotiate discounts with providers. According to the Kaiser/Hewitt *2002 Retiree Health*

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[11] United States General Accounting Office, Testimony before the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, House of Representatives, *Retiree Health Insurance—Gaps in Coverage and Availability,* GAO–02–178T, November 1, 2001, p.5.

[12] McCormack, p. 169.

[13] Coppock, Steve, Hewitt Associates, LLC., Testimony before U.S. Senate Committee on Finance Hearing, "Finding the Right Fit: Medicare, Prescription Drugs and Current Coverage Options," April 24, 2001.

Survey, 78 percent of retiree plan sponsors now provide coverage for pre-65 retirees under PPOs, 56 percent under HMOs, 44 percent offer traditional indemnity plans, and 37 percent, POS plans. For age 65+ retirees, 57 percent of employers continued to maintain a traditional indemnity plan to supplement Medicare.[14] Medicare+Choice or other HMO plans are offered by 48 percent of employer plans and allow Medicare-eligible retirees access to routine physicals, immunizations, and prescription drug coverage not currently 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 employers to return to the traditional Medicare program.

Retirees who have employer coverage may find that it is of less value as employers reduce coverage for drugs, vision, and dental services. While retiree prescription drug coverage from employers plans held constant slightly above 34 percent from 1996–2000, coverage for younger Medicare beneficiaries (65–69) declined 4.7 percent from 40 percent in1996 to 35 percent in 2000.[15] Employers are increasingly also using financial incentives for retirees to choose less expensive drugs, such as two-tier or three-tier cost-sharing, mail order discount plans, and formularies.

Employer-sponsored retiree health insurance benefits are also eroding as employers tighten eligibility requirements or shift costs to retirees. According to Watson Wyatt's 2001 survey of 56 large employers, 72 percent of surveyed plans require more than 5 years of service for the largest group of current post-65 retirees, and 86 percent imposed the same requirement on future retirees.[16] The Kaiser/Hewitt 2002 survey, over the last 2 years, found 44 percent of companies have increased the retiree's share of the premium, and 36 percent indicate they have increased cost-sharing requirements such as deductibles and copayments.[17] More than 80 percent of employers plan to raise premiums or copays for current retirees in the next 3 years.[18]

Large employers also responded to the early–1990's changes in the Financial Accounting Standards Boards rules (FAS106) by capping the firm's contribution to retiree health benefits. The Kaiser/Hewitt survey found that in 2002, 45 percent of large firms that offer pre-65 retiree health coverage and 50 percent of the firms that offer age 65+ coverage have such a cap. This means that retirees will be picking up more costs as medical costs rise above the level of the pre-determined amount. Of the companies that have established caps, 49 percent of those that offer pre-65 retiree health coverage and 57 percent that offer 65+ coverage have already met their limit.[19] In some cases, employers may elect to raise the cap,

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[14] Kaiser/Hewitt, p. 3.
[15] Stuart, p. W 3–334.
[16] McDevitt, Roland D., Janemarie Mulvey, and Sylvester J. Schieber, *Retiree Health Benefits: Time to Resuscitate?,* Watson Wyatt Research Report, Watson Wyatt Worldwide, 2002, p. 16.
[17] Kaiser/Hewitt, pp. 37–38.
[18] Ibid, p. 43.
[19] Ibid, pp. vii–viii.

but there is concern about the accounting implications if this happens regularly.

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.

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. According to a 2002 Watson Wyatt report, "only 35 percent of Fortune 1000 companies have set aside assets to fund their future retiree health liabilities, and, on average, these assets will cover only about one-third of future costs."[20]

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 vehi-

[20] McDevitt, p. 47.

cles 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.

Some employers are considering 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 ac-

count 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.

The WatsonWyatt report, *Retiree Health Benefits: Time to Resuscitate?,* warns that prefunding of retiree health benefits will not become an attractive option for employers unless tax incentives are provided, similar to those available for pensions.[21] The Department of Labor's Advisory Council on Employee Welfare and Pension Benefits also recommended in November 1999 that Section 420 be expanded to allow prefunding of current retirees' entire future medical obligations.

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

[21] McDevitt, p. iii.

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 Omnibus 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 Omnibus 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 63½ 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.

3. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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 condi-

tions. 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 2002 Mercer/Foster Higgins Survey found that, over the past 2 years, employer costs for providing health benefits for pre-Medicare eligible retirees rose 13.3 percent. For Medicare-eligible retirees, this figure increased 14.2 percent.[22] 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 Medicare reform and other Federal legislation on employer coverage of retiree health care is also uncertain. 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 retirees qualify for Medicare, these early retirees are twice as expensive for employers to cover as older retirees who receive Medicare.

Other reforms have been proposed 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.

[22] Mercer, p. 43.

The Emergency Retiree Health Benefits Protection Act, introduced in the 106th and 107th Congresses would more directly address loss of retiree coverage by prohibiting profitable 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, and creates a loan guarantee program to help firms restore benefits. It 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, P.L. 90–202) 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 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. Many 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 appears stable at this time, there are many concerns that this will erode as coverage is decreased for future retirees. Employees may never qualify for retiree health benefits if their employers offer coverage only to workers hired before a specific date. Retirees will bear a much greater portion of their own medical costs in the years to come. The strength of the economy and employment levels will also play an important part in em-

ployer 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 approximately 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. With passage of the appropriation for fiscal year 2003, Congress completed a 5-year effort to double the NIH budget. The budget grew about 14–15 percent each year, from a starting point of $13.6 billion in fiscal year 1998 to a level of $27.1 billion for fiscal year 2003.

The National Institute on Aging (NIA) is the largest single recipient of funds for aging research. Fiscal year 2003 NIA appropriations increased 11.5 percent over fiscal year 2002 funding levels, from $890.8 million in fiscal year 2002 to $993.6 million in fiscal year 2003. This increase in aging research funding is significant not only to older Americans, but to the American population as a whole. Research on Alzheimer's disease, for example, focuses on causes, treatments, and the disease's impact on care providers. Any positive conclusions that come from this research will help to reduce the cost of long-term care that burdens society as a whole. In addition, research into the effects that caring for an Alzheimer's victim has on family and friends could lead to an improved system of respite care, extended leave from the workplace, and overall stress management. Therefore, the benefits derived from an investment in aging research apply to all age groups.

Several other institutes at NIH are also involved in considerable research of importance to the elderly. The basic priority at NIA, be-

sides Alzheimer's research, is to understand the aging process. What is being discovered is that many changes previously attributed to "normal aging" are actually the result of various diseases. Consequently, further analysis of the effects of environmental and lifestyle factors is essential. This is critical because, if a disease can be specified, there is hope for treatment and, eventually, for prevention and cure. One area receiving special emphasis is women's health research, including a multiyear, trans-NIH study addressing the prevention of cancer, heart disease, and osteoporosis in postmenopausal women. The study is ongoing, but some early results concerning hormone replacement therapy (discussed below) demonstrated the critical importance of controlled clinical trials in developing evidence for or against common health practices.

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. Nearly all of the NIH research institutes and centers report that they investigate areas of particular importance to the elderly. They are:

National Institute on Aging
National Cancer Institute
National Heart, Lung, and Blood Institute
National Institute of Dental and Craniofacial Research
National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Neurological Disorders and Stroke
National Institute of Allergy and Infectious Diseases
National Institute of Child Health and Human Development
National Eye Institute
National Institute of Environmental Health Sciences
National Institute of Arthritis and Musculoskeletal and Skin Diseases

National Institute on Deafness and Other Communication Disorders
National Institute of Mental Health
National Institute on Drug Abuse
National Institute of Alcohol Abuse and Alcoholism
National Institute of Nursing Research
National Human Genome Research Institute
National Institute of Biomedical Imaging and Biomedical Engineering
National Center for Research Resources
National Center for Complementary and Alternative Medicine
National Center on Minority Health and Health Disparities
John E. Fogarty International Center
Office of the Director

(A) NATIONAL INSTITUTE ON AGING

The National Institute on Aging (NIA) was established in 1974 in recognition of the many gaps in the scientific knowledge of aging processes. NIA conducts and supports a multidisciplinary program of geriatric research, including research into the biological, social, behavioral, and epidemiological aspects of aging. Through research and health information dissemination, its goal is to prevent, alleviate, or eliminate the physical, psychological, and social problems faced by many older people.

Specific NIA activities include: diagnosis, treatment, and cure of Alzheimer's disease; investigating the basic mechanisms of aging; reducing fractures in frail older people; researching health and functioning in old age; improving long-term care; fostering an increased understanding of aging needs for special populations; and improving career development training opportunities in geriatrics and aging research. 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.

NIA scientists and grantees have studied drugs to prevent the progression of mild cognitive impairment to Alzheimer's disease, and to target specific abnormal cellular formations in the brain. Advances have also been made in diagnosis of Alzheimer's through tracking changes in brain metabolism and structures. In studies on the biology of aging, investigators have created a mouse model of premature aging, and have found that adult neural stem cells can make new functional neurons. Work on chronic diseases such as cancer, arthritis, and heart disease holds the promise of reducing disability through use of appropriate drugs and behavioral approaches such as exercise.

The longest running scientific examination of human aging, the Baltimore Longitudinal Study of Aging, is being conducted by NIA at the Gerontology Research Center 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 assess-

ments, 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 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, also influences all areas of research.

(B) NATIONAL CANCER INSTITUTE

The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection, and treatment of cancer. It also supports prevention and control programs, such as programs to stop smoking. In 2001, 70 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 32 percent of deaths in 2001. Because cancer is primarily a disease of aging, longer life expectancies and fewer deaths from competing causes, such as heart disease, are contributing to the increasing cancer incidence and mortality for people aged 65 and over. In addition, studies show that the elderly are less likely to be screened for common cancers such as breast and colorectal cancers.

NCI is partnering with NIA to integrate research priorities in cancer and aging. Further work is needed to address the differences in elderly cancer patients' response to drugs, survivorship and symptom control, and susceptibility to disease progression.

(C) NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

The National Heart, Lung, and Blood Institute (NHLBI) focuses on diseases of the heart, blood vessels, blood and lungs, and on the management of blood resources. Three of the most prevalent chronic conditions affecting the elderly—hypertension, heart conditions, and arteriosclerosis—are studied by NHLBI. In 2000, approximately 1.2 million deaths were reported from all of the diseases under the purview of the institute (49 percent of all U.S. deaths that year). The projected economic cost in 2003 for these diseases is expected to be $489 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 Wom-

en's Health Initiative, a 15-year research project established in 1991 to investigate the leading causes of death and disability among postmenopausal women. In July 2002, surprising results ended one arm of the study early. It was found that hormone replacement therapy with estrogen plus progestin for postmenopausal women did not have the beneficial effects that had been expected on cardiovascular disease. Instead, it somewhat increased the risks of heart attack, stroke, invasive breast cancer, and blood clots.

NHLBI also conducts an extensive professional and public education program on health promotion and disease prevention, particularly as related to blood pressure, blood cholesterol, and coronary heart disease. This has played a significant role in the decline in stroke deaths and heart disease deaths since 1970.

(D) NATIONAL INSTITUTE OF DENTAL AND CRANIOFACIAL RESEARCH

The National Institute of Dental and Craniofacial Research (NIDCR) supports and conducts research and research training in oral, dental, and craniofacial health and disease. Major goals of the institute include the prevention of tooth loss and the preservation of the oral tissues. Other research areas include birth defects affecting the face, teeth, and bones; oral cancer; infectious diseases; chronic pain; epidemiology; and basic studies of oral tissue development, repair, and regeneration.

The institute sponsors research on many conditions that affect older adults. Oral cancers, with an average age at diagnosis of 60 years, cause about 7,200 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. With the population becoming increasingly overweight, preventing Type 2 diabetes is critical. A clinical trial called the Diabetes Prevention Program found that a lifestyle modification including modest weight loss and physical activity reduced the incidence of diabetes by 58 percent. 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 predisposition; 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.

Stroke, 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. NINDS convened a group of leading stroke experts to develop a national research plan and set priorities. The institute also leads a public educational campaign called "Know Stroke" to raise awareness of the symptoms of stroke and the need to quickly seek medical care.

(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, particularly important because pneumococcal disease kills more Americans each year than all other vaccine-preventable diseases combined. NIAID is working on an experimental shingles vaccine with the Department of Veterans Affairs and Merck & Co., the vaccine's developer. Also important is research 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. NEI's Low Vision Education Program is aimed at helping people with visual impairment, primarily the elderly, to make the most of their remaining sight. One feature, called EYE SITE, is a traveling interactive educational exhibit of kiosks with touchscreens, which is designed for use in shopping centers and other consumer areas.

(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. In 2002 NIEHS launched a new initiative of collaborative centers on Parkinson's disease that will bring together scientists working on basic Parkinson's disease research and geneticists, clinicians, and epidemiologists.

(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 40 specialized and comprehensive research centers.

Approximately 43 million Americans are affected by the more than100 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, and 34 million more have low bone mass, putting them 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. Rheumatic diseases are the leading cause of disability among the elderly.

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 breakdown of joint cartilage by enzymes, 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. New drugs that block certain inflammatory reactions of the immune system are being studied, and some are already available.

(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. The NIMH Aging Research Consortium was established in January 2002 to stimulate research and provide better coordination, information, and training on late life mental disorders.

(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. A growing problem is prescription drug abuse in elderly populations. NIDA has a current research program investigating prescription opioid abuse and dependence in the elderly.

(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. The institute sponsors a program of research on the epidemiology of alcohol consumption and alcohol-related problems in older persons.

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.

NIAAA has worked with AARP on outreach to older persons on National Alcohol Screening Day.

(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 HUMAN GENOME RESEARCH INSTITUTE

The National Human Genome Research Institute (NHGRI) leads the NIH's contribution to the Human Genome Project, a worldwide effort to completely decipher the genetic instructions in human DNA. It also researches and develops genome technologies that can be used to understand and treat diseases with genetic components, and studies the ethical, legal, and social implications of these fields of research. Of special interest to aging research, NHGRI has sponsored discoveries in the genetics of prostate cancer, Alzheimer's disease, Parkinson's disease, and the molecular genetics of aging.

(R) NATIONAL INSTITUTE OF BIOMEDICAL IMAGING AND BIOMEDICAL ENGINEERING

The National Institute of Biomedical Imaging and Biomedical Engineering (NIBIB), established by Congress in 2000, supports research and training on imaging technologies and engineering and informatics tools that can be used broadly for diagnosis, treatment and prevention of disease. It tries to link the disciplines of biomedical and physical scientists and engineers to allow rapid translation of research findings into clinically useful applications. Currently sponsored work includes targeted drug treatments for osteoporosis, new diagnostic imaging techniques for Parkinson's disease, tissue-covered scaffolds to replace damaged cartilage in joints, and microsensors for quickly diagnosing urinary tract infections.

(S) 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. These resources, often shared among many researchers, include a network of General Clinical Research Centers, Biomedical Technology Research Centers, and a variety of resources for animal research, instrumentation, and research infrastructure.

NCRR-funded investigators have reported a number of advances in their fields. Research on osteoporosis has uncovered a gene mutation that may help in the search for drugs to build bone, not just

prevent bone loss. Researchers at Duke University identified genes in families of patients with Alzheimer's disease and Parkinson's disease that control age at onset. Other scientists have found a mutant gene associated with glaucoma and have proposed screening the general population to diagnose the disease before symptoms appear.

(T) 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 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.

(U) 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 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 are of interest to the Center.

NCMHD worked with the other components of NIH to develop the first NIH Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities, a 5-year plan covering fiscal years 2002–2006. The institute also implemented three programs mandated by Congress to expand research capabilities in health disparities research: a Centers of Excellence program called Project EXPORT, an endowment program for institutions training minority researchers, and two loan repayment programs.

(V) JOHN E. FOGARTY INTERNATIONAL CENTER

The John E. Fogarty International Center (FIC) for Advanced Studies in the Health Sciences addresses disparities in global health by supporting research and training internationally. It funds training and research grants in a wide variety of areas of concern to less-developed countries: infectious diseases, nutrition, environmental and occupational health, genetics, maternal and child health, and medical informatics, among others. Elderly populations are increasing rapidly in the developing world, and there are great burdens from chronic disease. Several FIC programs ad-

dress clinical and health services research training, research on brain disorders, and research on the relationship between health and economic growth in low- and middle-income nations.

(W) OFFICE OF THE DIRECTOR, NIH

The Office of the Director (OD) is responsible for setting overall policies for NIH and for planning, managing, and coordinating the programs of the 27 institutes and centers. Several program offices within OD focus on planning and stimulating specific areas of research, and also fund some research through the institutes. Program areas, all of which have relevance to the aging population, include women's health, AIDS research, disease prevention, and behavioral and social sciences research.

The Office of Research on Women's Health has been particularly active in funding and co-funding research addressing the health of older Americans. Areas of funding have included chronic diseases such as diabetes, arthritis, breast cancer, cardiovascular diseases, and urinary incontinence, as well as the impact of diet, physical fitness, obesity, and tobacco and alcohol use.

C. ISSUES AND CONGRESSIONAL RESPONSE

1. NIH APPROPRIATIONS

Congress provided NIH with $27.1 billion for fiscal year 2003. 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 fiscal years 1988 and 1998. Starting with the fiscal year 1999 appropriation, Congress increased NIH's budget at an even faster rate, commencing a 5-year plan to double the appropriation by fiscal year 2003. From the fiscal year 1998 level of $13.6 billion, the appropriation increased to $15.6 billion in fiscal year 1999, $17.8 billion in fiscal year 2000, $20.4 billion in fiscal year 2001, $23.5 billion in fiscal year 2002, and finally reached $27.1 billion for fiscal year 2003.

In report language accompanying the fiscal year 2003 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. The conference report stressed that research funding should be allocated on the basis of scientific opportunity, taking into consideration many factors about the burden of different diseases and the promise of various areas of research. 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.

With the additional resources available because of the doubling effort, NIH has focused on promising research areas across all institutes and centers. These areas of research potential, aimed at uncovering new scientific knowledge and applications for diagnosing, treating, and preventing disease, 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. An additional major focus since 2001 has been biodefense and support of research and facilities that improve our ability to prevent and respond to bioterrorism.

Out of its total appropriation of $27.07 billion for fiscal year 2003, NIH estimates spending of $2.05 billion on research related to aging. Appropriations levels for the NIH institutes, including estimates for aging research, are as follows:

FISCAL YEAR 2003 APPROPRIATIONS FOR NIH

[Dollars in millions]

Institute or Center	Fiscal year 2003 Appropriation	Fiscal year 2003 Aging Research (Estimates)
National Institute on Aging	$993.6	$957.6
National Cancer Institute	4,592.3	153.0
National Heart, Lung, and Blood Institute	2,793.7	95.6
National Institute of Dental and Craniofacial Research	371.6	15.7
National Institute of Diabetes and Digestive and Kidney Diseases	1,622.7	109.0
National Institute of Neurological Disorders and Stroke	1,456.5	173.0
National Institute of Allergy and Infectious Diseases	3,705.5	81.9
National Institute of General Medical Sciences	1,847.0	—
National Institute of Child Health and Human Development	1,205.9	8.3
National Eye Institute	633.1	124.2
National Institute of Environmental Health Sciences	697.8	16.3
National Institute of Arthritis and Musculoskeletal and Skin Diseases	486.1	58.1
National Institute on Deafness and Other Communication Disorders	370.4	16.8
National Institute of Mental Health	1,341.0	114.5
National Institute on Drug Abuse	961.7	2.1
National Institute of Alcohol Abuse and Alcoholism	416.1	5.8
National Institute of Nursing Research	130.6	19.0
National Human Genome Research Institute	465.1	1.1
National Institute of Biomedical Imaging and Bioengineering	278.3	4.1
National Center for Research Resources	1,138.8	52.0
National Center for Complementary and Alternative Medicine	113.4	34.4
National Center on Minority Health and Health Disparities	185.7	2.2
Fogarty International Center	63.5	0.5
National Library of Medicine	300.1	—
Office of the Director	266.2	3.1
Buildings and Facilities	628.7	—
Total, NIH,	$27,065.5,	$2,048.1

Note: Totals may not add due to rounding. FY2003 includes Superfund appropriation to NIEHS. FY2003 estimates for aging research are based on the President's request for FY2003, not on the appropriation.

2. NIH Authorizations and Related Issues

Congress completed the 5-year doubling of the NIH budget in fiscal year 2003, bringing the total appropriation to $27.1 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, includ-

ing use of particular funding mechanisms, such as centers of excellence. In addition, report language accompanying the appropriations bills shapes NIH's research priorities, although almost always without specific dollar earmarks.

The 107th Congress was not as active as the 106th in adding new authorizing language affecting NIH. The 106th Congress enacted laws addressing children's health, clinical research, minority health, and biomedical imaging, with creation of a new institute and a new center. The 107th Congress, absorbed to a large degree with homeland security issues, added or refined authorities in only a few areas.

Research on various forms of muscular dystrophy was the focus of the MD-CARE Act (P.L. 107–84), which also provided for a study on the impact of and need for centers of excellence at NIH. Expansion of research and education on blood cancers, especially leukemia, lymphoma, and multiple myeloma, was mandated by P.L. 107–172, while P.L. 107–280 addressed rare diseases, codifying in statute the NIH Office of Rare Diseases and authorizing regional centers of excellence. Additional funding for Type 1 diabetes research was provided by P.L. 107–360. The Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (P.L. 107–188) included several provisions of interest to NIH (related to antimicrobial resistance, animal trial data, research on bioterrorism countermeasures, security of research facilities, regulation of dangerous biological agents, and food safety) but did not create any new authorities.

Sponsors and advocates for new authorizing 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 opportunities. A new NIH Director, Dr. Elias Zerhouni, came on board in May 2002 and is leading a reexamination of how NIH as a whole is focusing its resources. A congressionally mandated study of the organizational structure of NIH has renewed discussion of the relative roles of the NIH Director, the individual institutes and centers, the Congress, and the public in setting NIH's research priorities.

Potential topics for continued debate in the 108th 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. Aging-related diseases are among those that research advocates assert could be benefited by continued investigation and discovery in these disputed areas.

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 half of AD patients are cared for at home, while the rest are in different kinds of care facilities. According to the 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. A recent study estimated that the annual cost of caring for an AD patient in 1996 was between $18,400 and $36,100, depending on how advanced the disease was and whether or not the person was at home. Nursing home care for dementia patients can be as much as $64,000 annually, according to the Alzheimer's Association. Overall, AD is thought to cost 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 15 years, almost all of it funded by NIH, have rapidly expanded our understanding of AD. NIH estimates FY2003 AD research spending at $640 million, which is twice what was spent on AD research in FY1997. The National Institute on Aging (NIA) accounts for 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), and the National Institute of Nursing Research (NINR).

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 60. Recent studies suggest that as many as four additional and as yet unidentified genes may also be risk factors for late-onset AD. Identification of 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 develop amyloid plaques, but not neurofibrillary tangles. In 2001, scientists created a transgenic mouse strain that expresses one of the human tau mutations and develops neurofibrillary tangles. However, the tangles in these mice do not usually form in areas of the brain that are vulnerable to AD. Researchers have since crossbred the tau mutant mice with the APP mutant mice to produce a new model, the TAPP mouse. The TAPP mice produce both amyloid plaques and neurofibrillary tangles in AD-susceptible regions of the brain, suggesting that APP or beta-amyloid protein can influence the formation of neurofibrillary tangles. The TAPP mice provide an opportunity to investigate the connection between plaque and tangle formation. Investigators have also found that treatment with an antibody that recognizes beta-amyloid protein results in the clearance of plaques from the brain of APP mutant mice. That raises the possibility that a vaccine might be able to stimulate the immune system to produce antibodies for the treatment and prevention of AD.

Another major focus of research has been the 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 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 under-

stand 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 certain studies, about 40 percent of persons diagnosed with MCI develop AD within 3 years. The NIA is supporting numerous dementia-related clinical trials. They include investigations of experimental drugs, prevention strategies, brain imaging, behavioral interventions, and genetic and lifestyle risk factors. 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 four drugs for the treatment of AD. The first, tacrine (Cognex), has been replaced by three newer drugs: donepezil (Aricept); rivastigmine (Exelon); and galantamine (Reminyl). These drugs help boost the level of acetylcholine—the chemical messenger involved in memory—which falls sharply as AD progresses. They 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 31 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 human 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. 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. A number of other studies are examining the factors that contribute to stress and depression in family caregivers.

As part of the AD Prevention Initiative, NIA and NINR support the Resources for Enhancing Alzheimer's Caregiver Health (REACH) program, a large, multi-site intervention study designed to characterize and test promising interventions for enhancing family caregiving. In the initial phase of the study, more than 1,200 culturally and ethnically diverse caregiver/patient pairs participated in trials involving nine different social and behavioral interventions and two types of control conditions (i.e., usual care or minimal support). The interventions included psychological education support groups, behavioral skills training, environmental modifications, and computer-based information and communications systems. Investigators found that the interventions helped alleviate caregiver burden, and that active treatments to enhance caregiver behavioral skills reduced depression. They also found that specific subgroups of caregivers (e.g., women caregivers, Hispanic caregivers, and non-spouse caregivers) benefited in different ways from the same interventions. The second phase of the study, REACH II, has combined elements of diverse interventions tested in the first phase into a single, multi-component intervention for further evaluation.

In addition to the AD research programs supported by NIH, two other Federal agencies support AD programs. The Administration on Aging (AoA) administers the Alzheimer's Disease Demonstration Grants to States program, which provides funds to 33 states to develop and replicate innovative models of service for Alzheimer's families in underserved areas, particularly minority and rural communities. The program focuses on making existing services work better through coordination, family caregiver support, and physician education. The grants have resulted in a number of best practices, and the emphasis of the program is now on developing materials, training, and mentoring to replicate the successful models in new communities. Additionally, the Justice Department funds the Safe Return Program, which 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 were 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 funds specialized centers for research in osteoporosis, and was 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 af-

fect 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. Although no cure exists for the many forms of arthritis, progress has been made through clinical and basic investigations. The two most common forms of arthritis are osteoarthritis and rheumatoid arthritis.

Osteoarthritis (OA) is a degenerative joint disease, affecting more than 20 million Americans. OA causes cartilage to fray, and in extreme cases, to disappear entirely, leaving a bone-to-bone joint. Disability results most often from disease in the weight-bearing joints, such as the knees, hips, and spine. Although age is the primary risk factor for OA, age has not been proven to be the cause of this crippling disease. NIH scientists are focusing on studies that seek to distinguish between benign age changes and those changes that result directly from the disease. This distinction will better allow researchers to determine the cause and possible cures for OA.

Other areas of research involve using animal models to study the very early stages of OA, work on diagnostic tools to detect and treat the disease earlier, genetic studies to elucidate the role of inheritance, and development of comprehensive treatment strategies. 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. A new public-private partnership consisting of NIAMS, NIA, several other NIH institutes and centers, and four pharmaceutical companies has launched the Osteoarthritis Initiative. The 7-year project will work with patients at risk for knee arthritis to search for biomarkers and surrogate endpoints for osteoarthritis clinical trials.

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 research registry on RA in the African-American population is being funded, and the NIAMS intramural program is investigating the effects of a plant root extract on the pain and inflammation of RA.

In March 2002, President George W. Bush proclaimed the Bone and Joint Decade, from 2002 to 2011. NIH institutes are collaborating with other entities to promote awareness, prevention, and research on musculoskeletal disorders.

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 FY2003 totaled $27.8 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. Research has found that a greater level of depression in the patient leads to greater depression in the family caregiver, indicating that the needs of caregivers must be addressed early in the course of illness.

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, annual Federal spending for Alzheimer's disease research has surpassed the $600 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

On October 22, 1999, Congress created the Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century (Seniors Housing Commission) (P.L. 106–74). The Seniors Housing Commission was directed to study the housing and health facility needs of seniors today and over the next generation and to report back to Congress with its findings and recommendations by June 30, 2002.

The Seniors Housing Commission authorized a number of studies and reports that paint a picture of the current and future housing and health facility needs of seniors. They found that 70 percent of seniors live in owner-occupied housing (over 17 million units). About 10 percent live in unsubsidized rental housing (over 3 million units). Another 4 percent live in rental housing that is subsidized by the Federal Government (over 1 million units). About 7 percent live in housing with a non-elderly head of household (over 2 million units) and just under 9 percent live in supportive seniors housing units, such as congregate care, assisted living or skilled nursing facilities (just over 2.5 million units).

The Commission also reported on the incomes of seniors. They found that almost 40 percent of seniors have incomes less than 40 percent of the area median income in their local statistical area, which, by the Department of Housing and Urban Development's (HUD) standards, would qualify them as very low income. Ten percent of seniors earn less than the Federal poverty level. The low incomes of some seniors can lead them to face serious housing problems, defined as inadequate housing or housing that costs more than half of a household's income. The Seniors Housing Commission found that over 3 million senior households faced serious housing problems and only one unit of subsidized housing is available for every six of these senior households.

Given these statistics, the Seniors Housing Commission concluded the following about the future housing needs of seniors:

- One-third of senior households are expected to have unmet housing needs in the future;
- Almost one-fifth of seniors will likely have service needs, and current programs are not well structured to meet those needs;
- Current production of affordable housing does not meet demand;

- Subsidized rental units are being lost due to expiring Section 8 project-based rental assistance contracts and mortgage prepayments; and
- Federal housing and health policies are not synchronized, often leading to premature institutionalization as a more costly, yet practical option.

Based on their conclusions, the majority of the Seniors Housing Commission made the following five broad recommendations to Congress

- Preserve the existing assisted housing stock;
- Expand successful housing production, rental assistance program, home and community based services and supportive housing models;
- Link shelter and services to promote and encourage aging in place;
- Reform existing Federal financing programs to maximize flexibility and increase housing production and health service coverage; and
- Create and explore new housing and service programs, models and demonstrations.

The majority report of the Seniors Housing Commission stopped short of recommending specific unit production goals to Congress, which is why a minority of the Commission members chose to release their own recommendations that included specific unit production goals.

While the non-partisan Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century laid out a set of next steps for Congress, thus far, little legislation has been introduced in the 108th Congress to address their recommendations. The following sections explore current programs and policies designed to meet the housing needs of seniors.

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.

The Harvard Joint Center for Housing Studies in its 2003 State of the Nation's Housing study, reported that 30 percent of all households, both owners and renters, have "affordability problems," meaning they pay more than 30 percent of their income toward housing. Data indicate that the 4.8 million assisted units available at the end of fiscal year 2002 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 has been for low-income elderly households. The relative lack of management problems and local opposition to elderly units make elderly projects relatively popular. Yet, even with this preference for the construction of units for the low-income 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 low-income 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 the 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

Originally created in 1949, the Section 202 Supportive Housing for the Elderly program has been the Federal Government's primary financing vehicle for constructing subsidized rental housing for elderly persons. Since its revision in 1974 the Section 202 program has provided capital grants to non-profit sponsors to develop supportive housing for low-income seniors. These grants are paired with project-based rental assistance, which allows low-income seniors to pay income-based rents to live in Section 202 units.

Since 1990, the capital advance has been provided in the form of a no-interest 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 can 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.

Project-based rental assistance is provided through 20-year contracts between HUD and the project owners, and will pay operating costs not covered by tenant's rents. To be eligible, tenants must be 62 years of age or older and have income equal to or below 50 percent of their area median income. Tenants' portion of the rent payment is 30 percent of their adjusted income.

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 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.

The FY2000 HUD appropriations bill (P.L. 106–74) authorized the Assisted Living Conversion Program (ALCP). The ALCP provides grants to non-profit providers of Section 202 facilities to cover the physical conversion of common spaces and residential units in current 202 projects to assisted living facilities. The funds cannot be used to pay for or to deliver services.

Although the Seniors Housing Commission recommended several changes to the Section 202 program, no legislation impacting the program was enacted during the 107th Congress. The Section 202 program was funded at $783 million in FY2002, enough to fund ap-

proximately 6,800 new units, and $776 million in FY2003, enough to fund approximately 6,600 new units.

(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 payments 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.

HUD has neither solicited nor funded applications for new grants under CHSP since 1995. Congress, however, has provided funds to extend expiring grants on an annual basis. Today there are approximately 240 projects that receive Federal assistance under the Congregate Housing Services Program.

3. PUBLIC HOUSING

The public housing program was conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing. There are currently approximately 1.2 million units of public housing. However, net new units

of public housing are no longer constructed, so the number of units is declining. Approximately 32 percent of public housing units are occupied by elderly persons.

The public housing program is federally financed, but is operated by State-chartered local public housing authorities (PHAs). 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 tenants' rents would pay for the operating costs of the project such as management, maintenance, and utilities. Tenants pay 30 percent of their adjusted income toward rent. Tenant rents have not kept pace with increased operating expenses, so PHAs receive a Federal subsidy to help defray operating and modernization costs. 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.

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 reach few residents, leaving a large unmet need. The Seniors Housing Commission Minority Report included a recommendation that public housing be eligible for conversion to assisted living, as in the case of Section 202 properties and project-based Section 8 properties. No legislation authorizing such a conversion has been introduced.

Under the National Affordable Housing Act of 1990, Congress permitted PHAs to use their operating subsidies to hire service coordinators to serve residents of public housing. The law also allowed PHAs to claim up to 15 percent of the cost of providing services to the frail elderly in public housing as an eligible operating subsidy expense. 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 that surfaced in public housing in recent years was the mixing of the elderly and the disabled in designated public housing buildings. In the original housing legislation, the elderly and disabled were both included under the definition of elderly used to designate public housing for the elderly. The definition of "disabled" was broadened to include any individuals who formerly abused drugs and alcohol. Furthermore, the disabled population with mental illness who needed housing grew as institutions were closed. Often, elderly households in these mixed population settings expressed fear of their neighbors and cultural clashes emerged between the two populations. The Housing and Community Development Act of 1992 addressed the problem of mixed populations in public housing projects by providing separate definitions of elderly and disabled persons. It also permitted public housing authorities to designate housing for separate or mixed populations within cer-

tain 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.

Over the past several decades, 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, instead, current public housing tenants should be provided 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 with some type of "reward" system that offers incentives to PHAs to improve public housing. The HOPE VI program, created in 1992, seeks to improve the condition of public housing. It provides competitive grants to local PHAs that can be used, in conjunction with other public and private financing, to redevelop distressed public housing.

Title V of the FY1999 VA-HUD Authorization Act (P.L. 105–276) made many changes to the public housing program designed to promote work among residents. These provisions did not impact the elderly, who were exempted from the mandatory work or community service requirements. No major public housing legislation was enacted in the 107th Congress. Public housing was funded at a combined total (including the Operating Fund, Capital Fund and HOPE VI) of $6.92 million in FY2002 and $6.85 million in FY2003.

4. Section 8 Rental Assistance

Families who live in public housing have few choices as to what neighborhood they can live in and what type of unit they can rent . Also, public housing tends to be in neighborhoods with high rates of poverty and their typical design high density, multifamily high-rises serves to further concentrate poverty. Studies have shown that high-poverty neighborhoods are characterized by high crime rates, stress and negative health outcomes. To provide consumers with more choice and to integrate the private market into the low-income housing business, the Section 8 rental assistance program was created in 1974.

Section 8 was 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 in paying rents, but also for promoting new construction and substantial rehabilitation. The buildings were usually secured by FHA mortgage insurance. By the early 1980's, the program's costs were escalating and, as a result, authority to enter into contracts for new construction and rehabilitation was eliminated in the early 1980's. 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 in previously constructed units, and introduced the Section 8 tenant-based voucher program. Although no new Section 8 construction contracts are being entered into, the rental assistance contracts on a number of the original buildings funded with Section 8 new construction and substantial rehabilitation funds are coming up for renewal. Unless the rental contract on these buildings is somehow maintained, it is feared that the buildings will either become market-rate and therefore unaffordable, or go into default, which will have costs for the FHA program. (See "Preservation of Affordable Rental Housing" below.) There are approximately 1.6 million units under Section 8 contract; approximately 60 percent are occupied by elderly households.

5. Project-based and Tenant-based Vouchers

The voucher program was created in 1983 and became the sole Section 8 program for new contracts in 1998. Vouchers are portable subsidies that low-income families can use to lower their rents in private market units. There are two types of vouchers: project-based vouchers and tenant-based vouchers. Under project-based vouchers, rents and the rent-to-income ratio is capped and the subsidy depends on the rent. A family who rents a project-based voucher unit pays 30 percent of their income as rent, and HUD pays the rest based on a fair market rent formula. Units are rented from private developers who have vouchers attached to up to 25 percent of the units in their building. Under the tenant-based voucher program, there are no caps and the subsidy is fixed. Families pay the difference between the rent in a unit they choose and a maximum subsidy as determined by their local PHA. Families generally pay no less than 30 percent of their incomes and no more than 40 percent. The family is free to find an apartment and nego-

tiate a rent with a landlord. Since the voucher is tied to the family, if the family moves, the voucher moves with them. PHAs can choose to designate up to 20 percent of their tenant-based vouchers to be used as project-based vouchers. Also, families who live in units with project-based vouchers can choose to convert to a tenant-based voucher and move after 1 year if a tenant-based voucher is available.

Advocates of tenant-based vouchers argue that this system avoids segregation and warehousing of the poor in housing projects, and allows them to live where they choose. Critics of tenant-based vouchers are concerned that they can present 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. Advocates for the elderly often argue that project-based vouchers are the best option for elderly tenants because the vouchers can be tied to accessible units.

Since 2000, some households with vouchers have been permitted to use their vouchers for purchasing a home. The voucher can either be used to supplement monthly mortgage payments, or, the value of 1-year's worth of voucher payments can be used by the household toward a downpayment on a home. The use of vouchers for homeownership is growing, but it is not considered an option for all households with vouchers because in order to use a voucher for homeownership, a family must have a higher income than the average voucher recipient.

Congress has grappled over the past several years with the escalating costs of the voucher program at the same time that many vouchers have gone unused. In the FY2003 HUD budget (P.L. 108–7), Congress included provisions designed to increase utilization and hold costs down. Despite demands from low-income housing advocates who argue that only one in four eligible families receives a housing subsidy, Congress did not create any new vouchers in FY2003.

In FY2002, Congress appropriated $15.6 billion for Section 8 rental assistance and vouchers. In FY2003, Congress appropriated $17.2 billion for Section 8. In FY2002, Congress created approximately 34,000 new vouchers; in FY2003, Congress created no new vouchers. The voucher program currently serves approximately 1.5 million households, of which about 17 percent are elderly.

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 two of the programs (Section 504 grants and Section 515 loan) have been 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 $7,500. The combination loan and grant may total no more than $27,500.

Section 509 authorizes payments to Section 502 borrowers who need structural repairs on newly constructed dwellings.

Under the Section 514 program, USDA is authorized to make direct loans for the construction of housing and related facilities for farm workers. The loans are repayable in 33 years and bear an interest rate of 1 percent. Applicants must be unable to obtain financing from other sources that would enable the housing to be affordable by the target population.

Individual farm owners, associations of farmers, local broad-based nonprofit organizations, federally recognized Indian Tribes, and agencies or political subdivisions of local or State governments may be eligible for loans from the Department of Agriculture to provide housing and related facilities for domestic farm labor. Applicants, who own farms or who represent farm owners, must show

that the farming operations have a demonstrated need for farm labor housing and applicants must agree to own and operate the property on a nonprofit basis. Except for State and local public agencies or political subdivisions, the applicants must be unable to provide the housing from their own resources and unable to obtain the credit from other sources on terms and conditions that they could reasonably be expected to fulfill. The applicants must be unable to obtain credit on terms that would enable them to provide housing to farm workers at rental rates that would be affordable to the workers. The Department of Agriculture State Director may make exceptions to the "credit elsewhere" test when (1) there is a need in the area for housing for migrant farm workers and the applicant will provide such housing and (2) there is no State or local body or no nonprofit organization that, within a reasonable period of time, is willing and able to provide the housing.

Applicants must have sufficient initial operating capital to pay the initial operating expenses. It must be demonstrated that, after the loan is made, income will be sufficient to pay operating expenses, make capital improvements, make payments on the loan, and accumulate reserves.

Under the Section 515 program, USDA is authorized to make direct loans for the construction of rural rental and cooperative housing. When the program was created in 1962, only the elderly were eligible for occupancy in Section 515 housing. Amendments in 1966 removed the age restrictions and made low- and moderate-income families eligible for tenancy in Section 515 rental housing. Amendments in 1977 authorized Section 515 loans to be used for congregate housing for the elderly and handicapped.

Loans under section 515 are made to individuals, corporations, associations, trusts, partnerships, or public agencies. The loans are made at a 1 percent interest rate and are repayable in 50 years. Except for public agencies, all borrowers must demonstrate that financial assistance from other sources will not enable the borrower to provide the housing at terms that are affordable to the target population.

Under the Section 516 program, USDA is authorized to make grants of up to 90 percent of the development cost to nonprofit organizations and public bodies seeking to construct housing and related facilities for farm laborers. The grants are used in tandem with Section 514 loans.

Section 521 established the interest subsidy program under which eligible low- and moderate-income purchasers of single-family homes (under Section 515 or Section 514) may obtain loans with interest rates subsidized to as low as 1 percent.

In 1974, Section 521 was amended to authorize USDA to make rental assistance payments to owners of rental housing (Sections 515 or 514) to enable eligible tenants to pay no more than 25 percent of their income in rent. Under current law, rent payments by eligible families may equal the greater of (1) 30 percent of monthly adjusted family income, (2) 10 percent of monthly income, or (3) for welfare recipients, the portion of the family's welfare payment that is designated for housing costs. Monthly adjusted income is adjusted income divided by 12.

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

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

Sites financed through Section 523 may only be sold to families who are building homes by the mutual self-help method. The homes are usually financed through the Section 502 program.

Section 524 authorizes site loans for the purchase and development of land to be subdivided into building sites and sold on a nonprofit basis to low- and moderate-income families or to organizations developing rental or cooperative housing.

Sites financed through Section 524 have no restrictions on the methods by which the homes are financed or constructed. The interest rate on Section 524 site loan is the Treasury cost of funds.

Under the Section 533 program, USDA is authorized to make grants to nonprofit groups and State or local agencies for the rehabilitation of rural housing. Grant funds may be used for several purposes: (1) rehabilitating single family housing in rural areas which is owned by low- and very low-income families, (2) rehabilitating rural rental properties, and (3) rehabilitating rural cooperative housing which is structured to enable the cooperatives to remain affordable to low- and very low-income occupants. The grants were made for the first time in fiscal year 1986.

Applicants must have a staff or governing body with either (1) the proven ability to perform 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 pop-

ulation. Such projects would be candidates for the Section 515 program.

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

7. Federal Housing Administration

The Federal Housing Administration (FHA) is an agency of the Department of Housing and Urban Development(HUD) which administers programs that insure mortgages on individual home purchases and loans on multifamily rental buildings. The loans are made by private lenders and FHA insures the lenders against loss if the borrowers default. The FHA program is particularly important to those who are building or rehabilitating apartment buildings. The elderly are often the occupants of such buildings.

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

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

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

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

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

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

An assisted living facility may be free-standing, or part of a complex that includes a nursing home, an intermediate care facility, a board and care facility or any combination of the above. The law also authorizes FHA to refinance existing assisted living facilities.

8. Low Income Housing Tax Credit

The Low Income Housing Tax Credit program (LIHTC), a 1986 provision in the Federal tax code, is the major engine for subsidizing the production of privately owned rental housing affordable to lower income households, including a significant number of elderly households. This $4.1 billion a year program (estimated tax expenditure for FY2003) is administered at the state level by housing finance agencies (HFAs) that have a given amount of tax credits to distribute each year based on their state's population. HFAs award the tax credits to developers on a competitive basis according to the state's housing and community development priorities. Although estimates vary, at least 1.1 million new and rehabilitated units have probably received support over the program's 16-year history. Public Law 106–554 (signed in December, 2000) increased the housing tax credit program by 40 percent, and about 120,000 units are now being added each year. A survey in 2001 by the National Council of State Housing Agencies found 16 percent of the tax credit units were targeted for the elderly, with some states allocating a majority of their credits for senior housing (for example, Wisconsin, 68 percent; Idaho, 61 percent; Maine, 55 percent, and New Mexico, 53 percent). The survey also found that other tax credit units were targeted for assisted living facilities and for housing for disabled people.

The amount of tax credits awarded to developers is based on the amount they agree to spend to build or rehabilitate the rental units. Most developers sell their tax credits to investors who use them to reduce their Federal income taxes 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. Although the rents that may be charged are limited by a formula, tenants with particularly low incomes often pay more than the 30 percent of income maximum used by HUD as a general standard for "affordable housing". In many cases, the tax credits do not provide enough financial support by themselves to make the rental project economically viable. This is particularly the case where HFAs negotiate agreements with developers 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 housing vouchers. 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. In July 2001, the General Accounting Office (GAO) released a study, Costs and Characteristics of Federal Housing Assistance (GAO–01–901R), that compared the

total per-unit cost of five production programs, including housing tax credits and housing vouchers. The GAO found that the Federal cost of housing tax credit units, as a percentage of the Federal cost of a unit from a housing voucher, was 150 percent in the first year, and 119 percent when costs were averaged over a 30-year cycle. However, the GAO said a number of other factors must be weighed against the lower costs of vouchers. For example, there are additional services that can more readily be provided for special populations, such as the frail elderly, with project-based assistance (housing tax credits, HOPE VI, Section 202, 811, and 515) than with tenant-based assistance (vouchers). In addition, tax credits and other production programs can be used as part of strategies to revitalize economically distressed communities. In addition, vouchers may not always be a viable option even for the non-frail elderly since 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. Nevertheless, advocates say that too few tax credit units reach those who are most in need of help, extremely low-income households those with incomes at or below 30 percent of the local area median income.

Another important question is how many of the new tax credit units now being built are actually net additions to the supply of affordable rental housing. An unknown but increasing number of tax credits are currently being used to preserve Section 8 projects that might otherwise be lost to low income use. An increasing number of HOPE VI public housing projects are also using LIHTCs a program that, thus far, has torn down more units than it has built or renovated.

B. PRESERVATION OF AFFORDABLE RENTAL HOUSING

1. Introduction

It has been estimated that approximately 1.6 million units of housing for low-income families are subsidized through project-based Section 8 contracts. The elderly constitute almost 60 percent of these units. Projects with these contracts generally also have Federal mortgage insurance through FHA and/or were financed with HUD-subsidized below-market interest rate loans. These Section 8 projects, mostly constructed in the 1970's and 1980's, generally were under contract to remain affordable to low-income families and individuals for 20 years or more.

Over the past several years, Congress has faced two major issues regarding these properties. First, many have fallen into physical and/or financial disrepair, while at the same time receiving inflated HUD subsidies and FHA mortgage insurance. Landlord neglect,

waste, fraud or abuse have been blamed for the poor state of Section 8 projects in some cases. Many of these properties are at risk of default or condemnation. Also, if HUD were to renew these contracts under their current terms, they would continue "overpaying" for these units. If the buildings default or HUD doesn't renew the contracts, the units are lost as affordable housing.

The second issue Congress faces is the loss of these properties from the affordable housing stock due to opt-outs. The projects typically had multi-year use restrictions that required their owners to maintain them as affordable housing and prevented them from raising rents to market levels. The contracts for most of the 1.6 million project-based Section 8 units will expire over the next 10 years. If owners choose to opt-out of the program at the end of their contract, rather than to renew their contract, the rents for these units will likely increase to market rates and will no longer be affordable for low-income families. The National Housing Trust estimates that approximately 324,000 units of housing that currently target low income seniors almost exclusively are at risk of opting out and becoming unaffordable. Although the seniors living in these units would be provided with vouchers, it may be difficult for them to use their vouchers in tight rental markets and a limited supply of units with accessible features for the disabled elderly.

2. Portfolio Re-Engineering Program

Title V of the VA-HUD Appropriations Act for fiscal year 1998 (P.L. 105–65) created the latest restructuring plan for Section 8 contracts, called Mark-to-Market. The goal of Mark-to-Market is to reduce the subsidy paid to these properties while leaving them physically and financially viable as well as affordable to low-income households. 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 where rents are adjusted down to market level and, if necessary, a second mortgage is provided to lower operating costs. If properties are in an advanced state of deterioration where rehabilitation would be too costly, the properties would be demolished or sold. Tenants in projects that do not have renewed contracts would be eligible for voucher assistance and would receive reasonable moving expenses.

Mark-to-Market was scheduled to expire at the end of FY2001. P.L. 107–116, signed into law on January 10, 2002, extended the program through FY2006. As of June 2002, 2,159 projects have entered restructuring and 1,383 had reached completion.

C. HOMEOWNERSHIP AND THE ELDERLY

While most of the attention on homeownership issues focuses on young families, there are a significant number of homeownership issues that are of interest to the elderly. (For purposes of this discussion, "elderly households" can be thought of as beginning at about age 55 the "young elderly" and increasing to the more senior elderly.) As house prices in many areas have continued to outpace inflation, more of the elderly have been asked and have felt obligated to help their children or grandchildren accumulate funds necessary for the purchase of a first home even when their own long-term retirement needs may be inadequate. Thus, some of the elderly have an interest in current and proposed government programs to help young people buy a first home.

In addition, a debt-free home has been shown to be an important part of retirement security. The elderly have a high homeownership rate (Table X) and this gives those with accumulated equity increased options for meeting their varied financial needs. However, many elderly are or will be living on fixed incomes, and there are difficult issues associated with rising housing expenses. There are also issues having to do with changing physical needs of elderly homeowners, such as the inability to climb stairs, do yard work, or get by in the suburbs without an automobile. While surveys continue to show that most elderly homeowners wish to remain in their home as they age, many are still interested in government programs that help maintain strong housing markets and make it easy to sell if and when they choose to do so, including the tax laws.

Increasing the Homewnership Rate.—There has been strong political support since the mid–1990's by both Democratic and Republican Administrations and many in Congress for efforts to increase the homeownership rate of lower-income and minority households. Homeownership is thought to give families a stake in their neighborhood and a chance to accumulate wealth. The Federal Reserve's *2001 Survey of Consumer Finances* reports that the median net worth of homeowners was nearly $172,000, while that for renters was just below $5,000.

Increased enforcement of fair housing laws and the Community Reinvestment Act have made mortgage credit more available to lower-income and minority households than in previous times, and falling mortgage rates have helped make homeownership more affordable for under represented groups. Table X shows there have been gains in all age groups over the past 10 years. However, Table Y shows there is still a major gap between the homeownership rate for blacks and Hispanics (less than 50 percent) when compared with those of whites (about 75 percent). Single person households and unmarried households with children (largely female-headed households) also have relatively low homeownership rates. In contrast, the elderly have the highest rates of all groups, about 80 percent.

Table X. Homeownership Rates by Age: 1993 and 2003

(Percent)

Age Groups	1993	2nd Quarter 2003
Under age 35	38.0	41.9
35 to 44	65.8	67.8
45 to 54	75.2	76.3
55 to 64	79.6	81.6
65 and older	77.3	80.2

Source: U.S. Census Bureau.

Help for homebuyers is currently available from a number of existing Federal programs, including the $1 billion a year Mortgage Revenue Bond program, which lowers the mortgage rate for certain moderate-income buyers and often provides downpayment and closing cost help. The address, telephone number, and web sites of most state Housing Finance Agencies that administer this Federal program can be found at the National Council of State Housing Agency's internet site www.ncsha.org. The Federal Housing Administration (FHA) and the Veterans Administration (VA) mortgage insurance programs encourage private lenders to make loans to those who have little money for a downpayment or who have blemished credit records. An estimated 700,000 lower income and minority households have been helped annually in recent years to buy a first home under the basic FHA mortgage insurance program. The FHA also 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. However, there is far more demand for these homes than there is supply. As discussed earlier in this chapter, HUD now has programs that allow some households in the Section 8 rental assistance program to use their monthly rental assistance payments to either accumulate a downpayment for the purchase of a home or to use the monthly rental payments to pay for mortgage payments on a home.

The Administration proposed several homeownership initiatives in the 107th Congress to help lower-income and minority homebuyers buy a home. The American Dream Downpayment Act would have authorized $200 million a year to help about 40,000 families with downpayment and closing costs. Proposed as a set-aside under the existing HOME block grant, families could receive grants of up to $5,000 each. The approved FY2003 HUD budget contained $75 million for this program. The popular Habitat for Humanity program, where area residents and potential buyers help build modest homes, received $4.2 million in FY2003 as a set-aside within HUD's Community Development Block Grant program.

The Administration also proposed in the 107th Congress to create a single-family housing tax credit for developers who build moderately prices homes for sale in lower income areas census tracts with median incomes of 80 percent or less of the area median income. Homebuyers could not have incomes above 80 percent of the local area median income. In many large cities, there are thousands of dilapidated and boarded-up homes. While there is reportedly a demand for affordable homes to purchase, the economics do not support the rehabilitation and sale of these often boarded-

up units or the building of new units in these areas if done on an individual basis. However, with the proposed tax credit to builders, which could be as much as 50 percent of the qualifying cost of the unit, supporters of these bills believe that multi-block community development efforts could create homeownership opportunities for many moderate income buyers and help turn around distressed neighborhoods. There were also bills before the 107th Congress that would have modified the existing Mortgage Revenue Bond program to make more tax-exempt bond revenue available for this first-time homebuyer program.

Table Y. Homeownership Rates, by Household Type, 1993 and 2003

(Percent)

Household Type	1993	2nd Quarter 2003
Nationwide	64.1	68.0
White (Non-Hispanic)	70.2	75.2
Black (Non-Hispanic)	42.0	47.3
Hispanic	39.4	46.2
Married Couples with Children	73.7	79.3
Married Couples w/o Children	82.9	87.0
Other Families with Children	35.5	43.0
Other Families w/o Children	63.9	66.6
Single Person Household	47.1	52.1

Source: U.S. Census Bureau.

Neither the housing tax credit nor the Mortgage Revenue Bond proposals were adopted during the 107th Congress.

Mortgage Delinquencies and Foreclosures.—As efforts to increase the homeownership rate of lower income households have proceeded in recent years, many buyers have purchased homes with very low downpayments and very little savings set aside to carry them through economic setbacks. While most of these buyers have benefited from their purchase, a significant minority have had serious financial problems and some have lost their homes in foreclosures. There were an estimated 400,000 foreclosures during 2002 and the FHA mortgage insurance program had a near record 11.45 percent of its borrowers at least 30 days past due in the 4th quarter of 2002. Predatory lending, which involves home mortgages, mortgage refinancing, home equity loans, and home repair loans with unjustifiably high interest rates and excessive fees, has hurt lower-income and minority owners most, with the elderly frequently targeted. These practices can strip away home equity that has been accumulated over a lifetime. While there were anti-predatory lending bills before the 107th Congress, none were adopted. HUD funds a national network of counseling agencies that can provide advice on those behind in their mortgage payments or facing foreclosures, credit issues, discrimination in home purchasing or mortgage loans, and predatory lending (1–800–569–4287).

Financial Challenges and Options for Elderly Homeowners.—Many elderly homeowners have benefited significantly from the rise in house prices and have substantial equity in their homes. (See the discussion on Home Equity Conversion programs below.) About two-thirds of homeowners are mortgage-free by age 55 and nearly 78 percent of those age 65 and older own their home free of debt (Table Z). But not all homeowners have done as well as oth-

ers. Owners in some cities and in less desirable neighborhoods saw little if any increases in values. The Federal Reserve's *Survey of Consumer Finances* reports of 1998 and 2001 found that the median value of the residences of non-white or Hispanic families actually declined by a small amount over this 3 year period, from $92,500 to $92,000, while homes owned by white, non-Hispanics increased substantially, from $108,800 to $130,000. Some owners have used their home equity for educational purposes, home expansions and upgrades, and to start small businesses. Others have lost home equity through predatory lending and home repair scams, while still others have exhausted the equity in their homes through over-use of conventional home equity loans for vacations, boats, and other consumption uses.

Even elderly homeowners whose home values have increased significantly over the years can nevertheless have financial worries. As Table Z shows, household incomes of the elderly fall significantly for those age 55 and above, while many expenses, such as for utilities, maintenance, repairs, insurance, and other requirements can increase. See the section below, Housing Cost Burdens of the Elderly.

Table Z. Income and Housing Expenditures, 2001

Item	All Consumer Units	Under Age 55	55 and Over	65 and Over
Income Before Taxes	$47,507	$52,568	$37,185	$27,528
Average Value of Owned Home	$103,975	$91,989	$128,236	$129,037
Housing Tenure				
Homeowners	66%	59%	80%	80%
with mortgage	40%	46%	27%	18%
no mortgage	26%	13%	53%	62%
Renters	34%	41%	20%	20%
Average Annual Housing Expenditures				
Owned Dwelling	$4,979	$5,461	$4,001	$3,258
Mortgage	$2,862	$3,523	$1,523	$849
Property Taxes	$1,233	$1,161	$1,379	$1,343
Maintenance, Repairs, Insurance, etc.	$884	$777	$1,099	$1,066

Source: 2001 Annual Consumer Expenditure Survey. Department of Labor. Bureau of Labor Statistics.

Physical Challenges for Aging Homeowners.—As the population ages, there are likely to be calls for more focused and better funded programs at HUD to assist the elderly. These are likely to include efforts to help the elderly remain in their homes by making physical improvements easier to obtain and more affordable for those with limited incomes. These include items such as flashing lights for doorbells and phones, grab bars, hallway rails, and ramps, and the widening of doorways for wheelchairs. There may be more efforts to help lower income elderly homeowners convert a part of a large home into an income-earning apartment, perhaps to be rented to another elderly person. (Some communities already have such programs—see discussion below.) But there are other more profound challenges as the population ages. For example, many of the frail elderly homeowners live in low-density suburban areas with little if any public transportation. When these elderly have to give up driving, many will find it difficult to maintain their independence. Some housing advocates are calling for Federal housing policy to be more closely integrated with transportation policy and other social service needs of lower-income and elderly households.

For the fortunate elderly who have accumulated considerable home equity, this wealth will increase their options—such as down-sizing to more maintenance-free retirement communities or to assisted-living facilities.

Homeownership Tax Provisions.—The largest government housing programs are for homeowners who use the tax deductions allowed for mortgage interest and property tax paid. Upper-middle and high 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 2003 to be $92.0 billion: $69.9 billion for the mortgage interest deduction and $22.1 billion for the deduction of property taxes. These provisions are of little or no value to those in the bottom half of the income distribution because it is more beneficial for these taxpayers to take the standard deduction. Nearly 75 percent of taxpayers use the standard deduction. The mortgage interest and property tax deductions are also of little value to most elderly homeowners since most own their home without a mortgage, and without mortgage interest to deduct, it is usually better to take the standard deduction.

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 (P.L. 105–34) made major changes to the treatment of gains from the sale of a home, replacing the rollover and the $125,000 exclusion. Now, a taxpayer who is single can exclude up to $250,000 of gain from the sale of a principal residence and up to $500,000 for joint returns. There is no rollover of gains into another house required and the new provision is not restricted to those over age 55. The exclusion of gains 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. 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, many homeowners no longer need to save a lifetime of financial documents on home purchases, sales, and spending on home 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 made before age 59 and one-half do 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, are 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 or grandchild. This penalty-free withdrawal is limited to $10,000 minus 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. As noted earlier, 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.

HOME EQUITY CONVERSION

As noted in Table Z, 80 percent of the elderly (age 65 and over) own their own homes, and 62 percent own their homes free of any mortgage debt. These homes have an average value of nearly $130,000. 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.

Three reverse mortgage products are available to consumers in the U.S. at the present time, the Home Equity Conversion Mortgage Program (HECM), the Home Keeper reverse mortgage, and the Cash Account Plan. The HECM and Home Keeper products are available in every state, while the Cash Account Plan is offered in 24 states.

(A) THE HOME EQUITY CONVERSION MORTGAGE PROGRAM (HECM)

The Housing and Community Development Act of 1987 (P.L. 100–242) authorized the Home Equity Conversion Mortgage Program (HECM) in the Department of Housing and Urban Development (HUD) as a demonstration program. It was the first nation-

wide home equity conversion program which offers the possibility of lifetime occupancy to elderly homeowners. The borrowers (or their spouses) must be elderly homeowners (at least 62 years of age) who own and occupy their 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 its use for 1- to 4- family residences if the owner occupies one of the units.

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.

Reverse mortgages made under HECM account for about 90 percent of the reverse mortgages made nationwide. About 79,000 loans have been endorsed under the program since its founding. Lenders originated a record 18,097 HECM loans during FY2003, a 39 percent increase over the 13,049 loans closed in FY2002. The Federal National Mortgage Association (Fannie Mae) has been purchasing the home equity conversion mortgages originated under the program.

(B) THE HOME KEEPER MORTGAGE

Since November 1996, Fannie Mae has also been using its own reverse mortgage product the "Home Keeper Mortgage." This is the first conventional reverse mortgage that is available on a nationwide basis.

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.

(C) THE CASH ACCOUNT PLAN

Financial Freedom Senior Funding Corp., of Irvine, CA, offers the "Cash Account Plan" as a proprietary reverse mortgage product. Financial Freedom is a subsidiary of Lehman Brothers Bank, FSB. According to its web site, Financial Freedom is the largest originator of reverse mortgages in the United States. It originated $1 billion of home value in reverse mortgages in 2002 and has made more than 30,000 reverse mortgage loans totaling more than $5 billion in home value. Financial Freedom is now the largest servicer of reverse mortgages with a servicing portfolio of approximately 32,000 loans.

The Cash Account Plan is available to seniors 62 years or older who own homes with a minimum value of $75,000. It provides an open-end line of credit that is available for as long as the borrower occupies the home. The senior can draw on the line of credit in full or part at any time; the minimum draw is $500. The unused portion of the line of credit grows by 5 percent annually. Eligible home types include owner-occupied single-family detached, manufactured, condominium, Planned Unit Development units, or 1- to 4-unit residences if one unit is owner-occupied. Borrowers are required to have obtain counseling from an independent counselor prior to obtaining the loans.

A monthly servicing fee is automatically added to the loan, except that no servicing fee is permitted in Illinois and Maryland. The interest rate charged to the borrower is equal to the current 6-month London Interbank Offered Rate (LIBOR) plus 5 percentage points. The rate is adjusted semi-annually, but the interest rate may never rise more than 6 percentage points above the initial rate.

The Cash Account Plan is available in two forms: the Standard Option and the Zero Point Option. Under the Standard Option, a borrower pays a loan origination fee that is equal to 2 percent on the first $500,000 of loan balance, 1.5 percent on the next $500,000, and 1 percent on the balance in excess of $1 million. The borrower obtains an open-ended line of credit and the minimum draw is $500.

Under the Zero Point Option, the borrower pays no loan origination fee. Closing costs, including third party costs and excluding

state and local taxes, will not exceed $3,500. At closing the borrower is required to take a draw on the line of credit, and the minimum draw at closing is 75 percent of the line of credit. Subsequent draws have a minimum of $500. Full prepayment is permitted and there are no prepayment penalties, but partial prepayment on the initial draw is not permitted for the first 5 years.

The Cash Account Plan is currently available in 24 states: Arizona, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, Nevada, New Jersey, New York, Ohio, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington, and Wyoming.

(D) 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.

(E) 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.

(F) RECENT PROBLEMS WITH REVERSE MORTGAGES

In the 1990's, Homefirst, a subsidiary of Transamerica Corporation, offered a reverse mortgage plan in many parts of the country. The so-called "Lifetime" plan had several features: (1) interest would accrue on the loan; (2) the homeowner was charged a "contingent interest fee" under which Homefirst would earn a 50 percent share of the appreciation in the value of the home; (3) the borrower had to pay a "maturity fee" of 2 percent of the value of the property at the time the loan is paid off; (4); the borrower would receive monthly loan advances for a specified number of years, depending on the home value and the age of the borrower; and (5) borrowers less than 93 years old had to purchase a deferred annuity which would begin lifetime monthly annuity payments once the borrower received the last loan advance. Metropolitan Life Insurance Company provided the annuity. In 1999, Homefirst was purchased by Financial Freedom Senior Funding Corporation, a subsidiary of Lehman Brothers.

By the late 1990's, there were several complaints regarding the reverse mortgages from Homefirst. An extreme example is illustrated by the case of a New York woman. She took out a reverse mortgage and received loan advances until she died after receiving 32 monthly payments. When her home was sold a few months later, Financial Freedom (Homefirst) demanded more than $765,000 as repayment under the terms of the reverse mortgage. The monthly payments she had received during the life of the loan totaled about $58,000. There was a huge mismatch between the benefits she received under the mortgage and the amount that her heirs had to pay to Financial Freedom.

As a result of this case and similar (though maybe not as dramatic) cases, a number of lawsuits were filed against Transamerica HomeFirst, Inc., Transamerica Corporation, Metropolitan Life Insurance Company, and Financial Freedom Senior Funding Corporation. The cases have been combined before a single judge in

the Superior Court of California in San Mateo County under Judicial Council Coordination Proceeding No. 4061.

The Action asserts a number of claims against the defendants in connection with the marketing and making of "Lifetime" reverse mortgage loans nationally. In general, the plaintiffs contend that they and all borrowers generally were misled about the nature and effect of their loans' terms, including the existence and amount of certain charges and fees, and the risks inherent in the loans. More specifically, the plaintiffs have alleged that three terms of the loans are unfair or were improperly concealed or misrepresented: (1) a "Contingent Interest" fee which requires the borrower to pay HomeFirst one-half of any appreciation in the value of the property which occurs during the loan's term; (2) a "Life Annuity" issued by Metropolitan Life, which borrowers purchased from loan proceeds at the start of the loan; and (3) a "Maturity Fee" of 2 percent of the appreciated value of the property at the time the loan is paid off.

A proposed settlement has been reached under which a settlement sum of $8 million would be paid. Transamerica HomeFirst, Inc., Transamerica Corporation and Financial Freedom Senior Funding Corporation, collectively, would pay $6,750,000; and Metropolitan Life Insurance Company would separately pay $1,250,000.

After expenses, about $5,280,000 would be available for distribution to the 1,588 members of the class or their estates. The defendant firms would deny all allegations that they misled or defrauded elderly homeowners by persuading them to sign up for predatory mortgages carrying excessive fees and abusive terms.

An appeal has been filed in the case, and an appellate hearing is scheduled in March 2004.

As noted above, the reverse mortgages currently offered by Financial Freedom, under its Cash Account Plan, does not offer the three objectionable terms noted in the suits. But the cases do indicate the importance of financial counseling prior to obtaining reverse mortgages.

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 the elderly. 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.

The Fair Housing Act provisions regarding familial status do not apply with respect to "housing for older persons," a term that has three alternative definitions. "Housing for older persons" is defined as housing that is (1) provided under any state or Federal housing program for the elderly, (2) "intended for and solely occupied by persons 62 years of age or older," or (3) "intended and operated for occupancy by persons 55 years of age or older."

Under the last category of housing for the elderly, there are three additional requirements that must be met in order for the housing to meet the statutory definition of housing for older persons. First, at least 80 percent of the occupied units must be occupied by at least one person who is 55 years of age or older. Second, the housing facility or community must publish and adhere to policies and procedures that demonstrate that it is intended to be housing for the elderly. Third, the housing facility must comply with HUD rules for the verification of occupancy. Despite the complexity of these requirements, an individual who believes in good faith that his or her housing facility qualifies for the familial status exemption will not be held liable for money damages, even if the facility does not in fact qualify as housing for older persons.

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

Statistics on the number of homeless people in the Nation and their characteristics are difficult to obtain and largely unavailable, although some studies are available. 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 1 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 1996, the National Survey of Homeless Assistance Providers and Clients (NSHAPC) was conducted. NSHAPC indicated that approximately 6 percent of homeless services' clients are between 55

and 64 years old, and another 2 percent are 65 years of age or older, although some studies have estimated that as much as 19 percent of the homeless population is elderly. Studies have shown, not surprisingly, that older homeless persons are more likely to suffer from a variety of health problems, including chronic disease, functional disabilities, and high blood pressure, than are other homeless persons.

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.

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 FY2002, they were funded at roughly $1.6 billion; in FY2003 they were funded at roughly $1.5 billion. In addition to the targeted homeless programs, assistance is potentially available to homeless people through non-targeted 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 in 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. For the Homeless Assistance Grants program, Congress appropriated approximately $1.1 billion in both FY2002 and FY2003.

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 programs 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 FY2003 are as follows: Health Care for Homeless Veterans—$46 million; Homeless Providers Grants and Per Diem Program—$50 million; Domiciliary Care for Homeless Veterans—$47 million; Compensated Work Therapy/Therapeutic Residence Program—$8 million; Loan Guaranty Transitional Housing for Homeless Veterans—$10 million; and HUD VA Supported Housing—$5 million.

G. HOUSING COST BURDENS OF THE ELDERLY

As noted above, while the incomes of many elderly fall sharply, many of their housing expenses do not (Table Z). The 2003 annual report, The State of the Nation's Housing, by Harvard's Joint Center of Housing Studies, found that "A staggering three in ten U.S. households have affordability problems. Fully 14.3 million households are severely cost-burdened (spending more than 50 percent of their incomes on housing), and another 17.3 million are moderately cost-burdened (spending 30–50 percent of their incomes on housing). Of the 21.4 million lowest-income households (in the bottom income quintile), 9.1 million were age 65 and over. Of these 9.1 million, 2.1 million (23 percent) were moderately burdened and nearly 3.7 million (40 percent) were severely burdened lowest." Rising housing costs have become a serious financial burden for many low- and moderate- income elderly because many have relatively fixed incomes. Figures from the Department of Labor's 2001 Consumer Expenditure Survey show that households (renters and owners) headed by those age 65 and over spent $9,354 or nearly 34 percent of their income on housing. This category includes not only the cost of shelter itself, but utilities and household operations, housekeeping supplies, and household furnishings. For the "shelter"only category, the percentage spent falls to 17.5 percent.

The 2003 Harvard report found that for the first time ever, more homeowners are cost-burdened than renters. As the value of the

homes of many elderly increase, local property taxes take an increasingly larger percentage of their income. While the percentage of income spent on mortgage interest drops sharply for homeowners age 65 and over (since nearly 78 percent have paid their mortgage in full), other housing costs remain high. Even though household income falls significantly for those age 65 and over, $27,528 compared to the average household income of $47,507 in 2001, the amount of property taxes paid by homeowners age 65 and above is higher than that paid by the average owner, $1,343 versus $1,233. With much lower incomes, elderly homeowners spend a larger percentage of their income on property taxes: 4.3 percent versus 3.1 percent for the average household.

Government programs to improve "economically distressed" neighborhoods in cental cities and in some older suburban areas, as well the gentrification of areas that have become increasingly desirable, can cause concern among elderly owners on fixed-incomes as the cost of living in these upgraded areas increase. Some local governments have programs that limit or defer property taxes for lower-income elderly owners (so-called "circuit breaker" provisions), but not all.

The National Low Income Housing Coalition, a housing advocacy group for low income renters, puts out their annual "Out of Reach" survey that estimates the "Housing Wage" that a person working full time would have to earn to be able to afford a basic two-bedroom apartment while paying no more than 30 percent of income in rent. Their 2003 survey estimated a national Housing Wage of $15.21 an hour or $31,637 a year. They found that "Renter households in 40 states—home to almost 90 percent of all renter households in the Nation—face a Housing Wage of more than twice the prevailing minimum wage." They point out that many people working in the service sector earn much less than is required to rent a basic apartment, and as a result, many renter households pay much more than 30 percent of their income for rent. They do not break their data down by age but HUD's Annual Housing Survey for 2001 shows there were about 4.3 million renter households whose head was 65 years old or more. The National Low Income Housing Coalition survey showed only about 23 percent of the very-low income elderly households receive government housing assistance—551,000 lived in public housing units and another 446,000 elderly households received a government rent subsidy. A number of the low-income elderly with inadequate savings and pensions, including Social Security payments, work at low-wage service jobs to supplement their incomes.

State and local governments can use funds from the HUD's HOME ($2 billion in fiscal year 2003) and Community Development Block Grant ($4.9 billion in fiscal year 2003) programs to assist the elderly in areas such as energy conservation and home maintenance, but there are many competing demands on these programs. HUD data for 2001 show that about 156,000 elderly homeowners received a low-interest loan or grant to make major repairs.

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 in the winter and heat stress in the summer. Hypothermia, the potentially lethal lowering of body temperature, is estimated to cause the deaths of nearly 25,000 elderly people each year. The Center for Environmental Physiology in Washington, DC. reports that most of these deaths occur after extended 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 aim to ease the energy cost burden for low-income individuals: The Low-Income Home Energy Assistance Program (LIHEAP) and the Weatherization Assistance Program (WAP). Both LIHEAP and WAP give priority to elderly and disabled citizens to assure that they 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 gap between existing Federal resources allotted and the needs of the population these programs were intended to serve. In FY1983, 31 percent of the total households estimated to have incomes at or below the Federal maximum income eligibility standards (or just under half of the total households estimated to have incomes at or below stricter state eligibility rules) received heating assistance through LIHEAP. In FY2001 about 16 percent of federally eligible households and 22 percent of state-eligible households received LIHEAP heating or winter crisis assistance.

The *LIHEAP Home Energy Notebook for FY2001* shows that in FY2001 the average household had energy expenditures of $1,537 compared to$1,311 for low-income households (those at or below 150 percent of Federal poverty guidelines or 60 percent of state median income, whichever is greater) and $1,301 for LIHEAP recipient households. Although these data indicate that both LIHEAP-recipient households and low-income households spent less on energy than the average house did, these expenditures represented a greater portion of their incomes than for all households. In FY2001 LIHEAP-recipient households expended more than 17 percent, and low-income households expended 14 percent, of their total household income on energy costs; in comparison all households expended 7 percent of total income on energy expenditures in that same year.

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 arrearage and threats of shut-offs increased to 4.3 million households in 2001.

An estimated 4.8 million households received LIHEAP heating assistance, winter crisis aid, or both in FY2001 compared to 3.9 million in FY2000; in FY1983 about 6.8 million households received LIHEAP assistance with heating costs. (These numbers are HHS estimates of total unduplicated households served.) In each of these years a much smaller number of additional (or the same) households received summer cooling, summer crisis, or weatherization assistance. Data from the March 2001 Current Population Survey (CPS) indicates an estimated 37 percent of LIHEAP-recipient households included at least one member who was 60 years or older; the March 1983 CPS data indicated an estimated 40 percent of LIHEAP-eligible households included a member 60 years of age or older.

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 for low-income households. These programs were administered by the Office of Economic Opportunity and its now-defunct successor agency, the Community Services Administration (CSA) on an annual budget of approximately $200 million or less. However, between 1979 and 1980 the price of home heating oil doubled. As a result, Congress sharply expanded aid for energy by appropriating $1.6 billion for energy assistance (P.L. 96–126). Of this amount, $400 million went to CSA for the continuation of its crisis-intervention programs; the Department of Health, Education and Welfare (predecessor to HHS) received the remaining $1.2 billion with instructions to spend $400

million for a special one-time energy allowance to Supplemental Security Income (SSI) recipients and $800 million for block grants to States to provide supplemental energy allowances.

For the following fiscal year, as part of the crude oil windfall profit tax legislation, Congress passed the Home Energy Assistance Act of 1980 (P.L. 96–233); this act established the Low Income Energy Assistance Program (LIEAP) on a 1-year only basis. Administered solely by HHS it received a $1.85 billion appropriation. For FY1982 Congress extended and renamed this program the Low Income Home Energy Assistance Program or LIHEAP (Title XXVI of the Omnibus Budget Reconciliation Act of 1981 (OBRA, P.L. 97–35). LIHEAP has subsequently been reauthorized and amended by the Human Services Reauthorization Acts of 1984, 1986, 1990, the National Institutes of Health Revitalization Act of 1993, the Human Services Amendments of 1994, and the Human Services Reauthorization Act of 1998. LIHEAP's authorization is currently set to expire at the end of FY2004.

LIHEAP is one of the seven block grants originally authorized by OBRA. It is administered by the Office of Community Services within the Administration for Children and Families at 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, Puerto Rico, numerous Indian tribes and tribal organizations, and several U.S. territories. State grantees (including the District of Columbia) receive a percentage share of the annual Federal regular funds appropriation; (grants to Indian tribes are taken from their State's allocation and funds for Puerto Rico and other territories are from a special set-aside of these regular funds). The percentage share for each State has in most years been set by a formula established in LIHEAP's predecessor program for FY1981; that formula included some factors that gave special weight to states with high heating costs as well as greater numbers of low-income households. However, in 1984 Congress amended the LIHEAP statute to provide that in FY1986 and succeeding years, whenever Congress appropriates regular funds above $1.975 billion, a different formula takes effect. Under this different formula grants are to be allocated largely on the basis of home energy expenditures (heating or cooling) by low-income households. (A funding level that triggered this different formula was last appropriated in FY1986.)

The annual Federal regular fund LIHEAP allotments may be supplemented with contingency/emergency funds. These funds are appropriated by Congress but may only be released at the discretion of HHS and the President and to meet additional home energy assistance needs resulting from a natural disaster or other emergency. States may also use other sources to supplement Federal LIHEAP funds as well. These include : 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; Federal dollars carried over from the previous fiscal year (up to 10 percent of state allotment); funds that are authorized to be transferred from other Federal block grants; Federal payments for grantees that successfully "leverage" non-Federal resources and;

competitive Federal grants for grantees that establish a program to increase efficiency of energy usage among low-income families and reduce their vulnerability to homelessness.

Financial assistance is provided to eligible households, directly or through vendors. Some States also make payments in other ways, such as through vouchers or direct payments to landlords. These funds may be used to help meet home heating and cooling costs, assist with an energy-related crisis, provide low-cost weatherization (limited to 15 percent of allotment or up to 25 percent if grantee receives a Federal waiver) or to offer other services that reduce the need for energy assistance (limited to 5 percent of the allotment).

Flexibility is allowed in the use of the grants but states are required to target their assistance to households with the lowest incomes that pay a high proportion of their income for home energy. Federal rules also require that homeowners and renters be treated equitably and that a maximum of 10 percent of the grant may be used for administrative costs. Finally, States establish their own benefit structures and eligibility rules within broad Federal guidelines. The maximum Federal income eligibility level for a household is 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 grantees, but not below 110 percent of the Federal poverty level. Automatic eligibility may also 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.

The LIHEAP statute does place certain other 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. 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.

PROGRAM DATA

The *LIHEAP Report to Congress for FY2001,* indicates (based on State-reported data) that in FY2001 4.4 million households received regular heating cost assistance and 1.4 million received winter/year-round crisis aid. In addition, cooling aid was provided to an estimated 250,000 households, summer crisis aid to 87,000 households, and weatherization assistance to 97,000. These data do not reflect an unduplicated count of households, but rather are a State-reported count of households that received each category of assistance.

This same report shows that the average heating/winter crisis assistance benefit in FY2001 was $364, although this amount varied significantly between States. This combined benefit represented a

34 percent increase from the average FY2000 benefit of $271. This increase, however, only partially offset the rise in average home heating expenditures for LIHEAP recipient households. Between FY2000 and FY2001 these home heating expenditures increased nationally by about 45 percent; FY2001 LIHEAP heating benefits offset 68 percent of costs compared to 73 percent for FY2000. The average cooling benefit for FY2001 was $219 and the average FY2001 summer crisis benefit was $188. The percentage of federally eligible households assisted with LIHEAP heating/winter crisis aid was estimated at 16 percent for FY2001 compared to 13 percent of federally eligible households in FY2000.

The *LIHEAP Home Energy Notebook for FY2001* includes the following data:

> Colder FY2001 weather helped lift average residential energy expenditures for all households to $1,537 in that year compared to $1,293 in FY2000;
>
> LIHEAP recipient households increased their average residential energy expenditures by 21 percent, from $1,077 in FY2000 to $1,301 in FY2001;
>
> The most recent survey data on the kinds of home heating fuel used is from 1997. These data shows that natural gas is the most commonly used heating fuel for all households (52.7 percent), as well as for low-income households (49.2 percent), and for LIHEAP recipient households (51.3 percent). Use of electricity as a main heating source has increased for LIHEAP recipient households and reached 29.4 percent, compared to 29.2 percent for all households. Fuel oil is the main heating source for 8.6 percent of LIHEAP recipient households, compared to 9.3 percent for all households. Finally 2.3 percent of LIHEAP households used kerosene as a heating fuel compared to just 1.0 percent of all households.
>
> Average home heating expenditures for LIHEAP recipient households were estimated to be $535 for FY2001.
>
> In FY2001 average home heating expenditures represented a higher percentage of annual income for LIHEAP-recipient households (17.2 percent) and low-income households (14.0 percent) than for all households (7.0 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;
>
> In FY2001 among all households that cooled the average home cooling expenditure was $131, and for LIHEAP recipients that cooled it was $108;
>
> In FY2001 cooling expenditures represented a higher percentage of average annual income for LIHEAP recipient households that cooled (1.4 percent) than for low-income households that cooled (1.1 percent) or all households that cooled (0.5 percent).

FUNDING

There has been a 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 a program low of $900 million in fiscal year 1996. The annual regular LIHEAP appropriation for FY2001 through FY2003 has moved between $1.4 billion and $1.8 billion. However, regular LIHEAP funds have in every year since FY1994 been supplemented with separately appropriated emergency/contingency funding. Contingency funds appropriated by Congress are not always released and may be available for one or more years. In FY2001 states had access to more than $823 million in contingency funds. (Some of these funds were appropriated and/or released in FY2000 but remained available and were obligated by States in FY2001.) Accounting for these contingency dollars, total Federal LIHEAP funds reached an all-time high in FY2001 at $2.2 billion. Contingency funds released in FY2002 and FY2003 were significantly under this amount. Total FY2002 funding declined to $1.8 billion and in FY2003 was $2.0 billion.

Contingency LIHEAP funds have been utilized in recent years for both cold and hot weather emergencies. In FY2000 and FY2001 most contingency fund releases were allocated to all States for assistance to low-income households that faced significant increases in heating oil, natural gas, and propane prices due to cold weather. However, some contingency funds in FY2000 and all of the FY2002 contingency funds were released for cooling purposes to assist selected States that experienced extreme heat.

2. The Department of Energy (DOE) Weatherization Assistance Program

According to DOE, the term "weatherize" initially meant emergency and temporary measures such as caulking and weather-stripping of windows and doors and low-cost measures such as covering windows with plastic sheets. As the program evolved, it has gradually come to embrace a broader range of more permanent, cost-effective energy efficiency measures that may apply to the building envelope (e.g. insulation and windows), heating and cooling systems, electrical system, and electricity-consuming appliances.

Federal efforts to weatherize the homes of low-income persons began on an ad hoc, emergency basis after the 1973 Arab Oil Embargo. In 1975, a formal program was established at the Community Services Administration (CSA), a once-independent Federal agency that is now defunct. Title IV of the Energy Conservation and Production Act (P.L. 94–385), enacted in 1976, directed the Federal Energy Administration (FEA) to conduct a weatherization program. In October 1977, the newly formed Department of Energy (DOE) assumed responsibility for weatherization and all other FEA programs. In 1977 and 1978, DOE administered this weatherization grant program in a way that paralleled and supplemented the CSA program; DOE provided money for the purchase of equipment and materials and CSA arranged for labor. In 1979, DOE became the sole Federal agency responsible for operating a low-income weatherization assistance program. This program is currently ad-

ministered by DOE's Office of Energy Efficiency and Renewable Energy (EERE).

The Weatherization Assistance Program's (WAP's) goals are to decrease national energy use and to reduce the impact of high fuel costs on low-income households, particularly those of elderly and disabled persons. Also, the program seeks to increase employment opportunities through the installation and manufacturing of low-cost weatherization equipment and materials. The 1990 legislation that reauthorized the program also extended it to permit and encourage the use of innovative energy-saving technologies to achieve its goals.

The Weatherization Assistance Program distributes Federal funding to States by formula. Each State, in turn, has discretion to distribute its share of funding to local government weatherization agencies. There are 51 State grantees (each State and the District of Columbia), and about 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. Each State may raise its income eligibility level to 150 percent of the poverty level to conform with the LIHEAP income ceiling. States may not, however, set the income eligibility level 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 weatherization assistance. Priority is given to households with an elderly individual, aged 60 and older, or with a disabled person. In 2000, DOE issued a rule that amended the priorities for the Weatherization program. "Households with a high energy burden" and "high residential energy users" were added as new categories for priority service.

Federal regulations (10 CFR 440) 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 use. Funds made available to the States are, in turn, allocated to nonprofit agencies to purchase and install energy conserving equipment and materials, such as insulation, and to make energy-related repairs. Federal law allows a maximum average expenditure of $2,614 per household in program year 2003, unless a state-of-the-art energy audit shows that additional work on heating systems or cooling equipment would be cost-effective.

PROGRAM DATA

Since its inception through FY2003, the DOE Weatherization Program has served more than 5.2 million homes. In approximately 33 percent of the homes weatherized, at least one resident was 60 years of age or older. An estimated 105,000 homes were weatherized in fiscal year 2002 and the target is 123,000 in fiscal year 2003.

In 1993, DOE's Oak Ridge National Laboratory issued a report entitled National Impacts of the Weatherization Assistance Program in Single Family and Small Multifamily Dwellings. The report used data from the 1989 program year (April 1, 1989, through March 31, 1990) in which 198,000 single-family and small multi-

family buildings and 20,000 units in large multifamily buildings were weatherized. A representative sample of nearly 15,000 dwellings was used in the study. The report indicated that the Weatherization Program saved money, reduced energy use, and made weatherized homes a safer place to live.

The report had six key findings. First, the report estimated that the Weatherization Program saved $1.09 in energy costs for every $1 spent. Second, the average energy savings per dwelling was $1,690, while it cost $1,550 to weatherize the average home, including overhead. Third, the program was most effective in the cold weather states of the Northeast and upper Midwest, which may be due to DOE's early emphasis on heating needs rather than cooling needs. States with cold climates produced the greatest energy savings. For natural gas consumption, first-year savings yielded a 25 percent reduction in gas used for space heating and a 14 percent reduction in total electricity use.

Fourth, weatherization reduced the average low-income recipient's energy bill by $116, which was about 18 percent of the $640 average total bill for home heating.

Fifth, energy savings from weatherization reduced U.S. carbon emissions by nearly one million metric tons. Savings were the most dramatic in single-family, detached houses in cold climates.

Sixth, the average low-income household in the North was particularly hard hit by home energy costs, spending 17 percent of its income on energy. Elsewhere across the country, low-income households typically spent 12 percent of their income on energy, compared to only 3 percent for households with higher levels of income.

In 1997, DOE's Oak Ridge National Laboratory issued a report entitled Progress Report of the National Weatherization Assistance Program. This report was a "metaevaluation" analysis of 17 separate evaluations of state-level implementation of the Weatherization Program in program year 1996. Compared to the above-noted findings for program year 1989, this report found that implementation of many recommendations in the 1993 national evaluation had produced 80 percent higher average energy savings per dwelling in 1996. These savings include a 23.4 percent reduction in natural gas consumption for all end uses.

According to DOE, the Weatherization Assistance Program conducts periodic metaevaluations of program performance based on State-level program evaluations and generates national benefit/cost ratios based on the metaevaluation results. The most recent metaevaluation results were made available to program management for review in October 2002.

FUNDING

Since 1990, the DOE Weatherization Program has operated without a formal authorization of appropriations. Nevertheless, Congress has continued to appropriate funds to support the Program's activities. This includes $135.0 million in FY2000; $152.7 million in FY2001; $230.0 million in FY2002; $223.5 million in FY2003; and $228.5 million in FY2004.

CHAPTER 14

Older Americans Act of 1965

HISTORICAL DEVELOPMENT

Congress created the Older Americans Act in 1965 in response to concern by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to states for community planning and social services, research and development projects, and personnel training in the field of aging. The law also established the Administration on Aging (AoA) within the then-Department of Health. Education and Welfare (DHEW) to administer the newly created grant programs and to serve as the Federal focal point on matters concerning older persons.

Although older persons may receive services under many other Federal programs, today the Act is considered to be the major vehicle for the organization and delivery of social and nutrition services to this group. It authorizes a wide array of service programs through a nationwide network of 57 state agencies on aging and more than 655 area agencies on aging, supports the sole Federal job creation program benefiting low-income older workers, and funds training, research, and demonstration activities in the field of aging.

Prior to the creation of the Act in 1965, older persons were eligible for limited social services through some Federal programs. However, with the recognition that older persons were becoming an increasing proportion of the population and that their needs were not being formally addressed through existing programs, many groups began advocating on their behalf. Their actions led President Truman to initiate the first National Conference on Aging in 1950. Conferees called for government and voluntary agencies to accept greater responsibility for the problems and welfare of older persons. Further interest in the field of aging led President Eisenhower to create the Federal Council on Aging in1956 to coordinate the activities of the various units of the Federal Government related to aging.

The beginning of a major thrust toward legislation along the lines of the later-enacted Older Americans Act was made at the 1961 White House Conference on Aging. The Conferees called for a Federal coordinating agency in the field of aging to be set up on a statutory basis, with adequate funding for coordinating Federal

efforts in aging, as well as a Federal program of grants for community services specifically for the elderly.[1]

In response to the White House Conference on Aging recommendations, Representative John Fogarty of Rhode Island and Senator Pat McNamara of Michigan introduced legislation in 1962 to establish an independent U.S. Committee on Aging to cut across the responsibilities of many departments and agencies, and a program of grants for social services, research, and training that would benefit older persons. Because there were objections by the Administration to the creation of an independent Federal agency on aging, the legislation was not enacted. Legislation introduced the following year by Representative Fogarty and Senator McNamara modified the 1962 proposal by creating within DHEW, the Administration in Aging which was to be under the direction of a Commissioner for Aging and appointed by the President with the approval of the Senate. However, the 1963 proposal was not enacted.

The Act as introduced in 1965 basically paralleled the 1963 proposal. Sponsors emphasized how it would provide resources necessary for public and private social service providers to meet the social service needs of the elderly. The Act received wide bipartisan support and was signed into law by President Johnson on July 14, 1965. In addition to creating AoA, the Act authorized grants to states for community planning and services programs, as well as for research, demonstration, and training projects in the field of aging. In his remarks upon signing the bill, the President indicated that the legislation would provide "an orderly, intelligent, and constructive program to help us meet the new dimensions of responsibilities which lie ahead in the remaining years of this century. Under this program every state and every community can now move toward a coordinated program of services and opportunities for our older citizens."[2]

MAJOR AMENDMENTS TO THE ACT

The Act has been amended 14 times since the original legislation was enacted. The first amendments to the Act in 1967 extended authorization for the state grant program and for research, demonstration, and training programs created in 1965. In 1969, Congress added authority for a program of areawide model projects to test new and varied approaches to meet the social service needs of the elderly. The 1969 amendments also authorized the foster grandparent and retired senior volunteer programs to provide part-time volunteer opportunities for the elderly. (Authority for volunteer programs was subsequently repealed and these programs were reauthorized under the Domestic Volunteer Service Act of 1973.)

Major amendments to the Act occurred in 1972 with the creation of the national nutrition program for the elderly, and in 1973, with the establishment of substate area agencies on aging. The 1973 amendments represented a major change because for the first time

[1] U.S. Department of Health Education and Welfare, Special Staff on Aging, *The National and Its Older People, Report of the White House Conference on Aging,* Jan. 9–12, 1961, Washington, Apr. 1961.

[2] Public Papers of the Presidents of the United States, *Lyndon B. Johnson, Book II,* Washington, 1965, p. 744.

Federal law authorized the creation of local agencies whose purpose is to plan and coordinate services for older persons and to act as advocates for programs on their behalf. These amendments also created legislative authority for the community service employment program for older Americans which had previously operated as a demonstration initiative under the Economic Opportunity Act. In 1975, Congress extended the Older Americans Act through 1978 and specified certain services to receive funding priority under the state and area agency on aging program.

The 1978 amendments represented a major structural change to the Act when the separate grant programs for social services, nutrition services, and multipurpose senior center facilities were consolidated into one program under the authority of state and area agencies on aging. The intent of these amendments was to improve coordination among the various service programs under the Act. Among other changes were requirements for establishing state long-term care ombudsman programs and a new Title VI authorizing grants to Indian tribal organizations for social and nutrition services to older Indians.

The 1981 amendments made modifications to give state and area agencies on aging more flexibility in the administration of their service programs. These amendments also emphasized the transition of participants to private sector employment under the community service employment program. In 1984, Congress enacted a number of provisions, including adding responsibilities for AoA; adding provisions designed to target services on low-income minority older persons; giving more flexibility to states regarding service funds allocations; and giving priority to the needs of Alzheimer's victims and their families.

The 1987 amendments expanded certain service components of the state and area agency program to address the special needs of certain populations. Congress authorized six additional distinct authorizations of appropriations for services: in-home services for the frail elderly; long-term care ombudsman services; assistance for special needs: health education and promotion services; services to prevent abuse, neglect and exploitation of older individuals; and outreach activities for persons who may be eligible for benefits under the supplemental security income (SSI), Medicaid and food stamp programs. Among other changes were provisions designed to give special attention to the needs of older Native Americans and persons with disabilities, emphasize targeting of services to those most in need, elevate the status of AoA within the Department of Health and Human Services (DHHS), and liberalize eligibility of community service employment participants for other Federal programs.

The 1992 amendments restructured some of the Act's programs. A new Title VII, Vulnerable Elder Rights Protection Activities, was created to consolidate and expand certain programs that focus on protection of the rights of older persons. Title VII incorporated separate authorizations of appropriations for the long-term care ombudsman program; program for the prevention of elder abuse, neglect, and exploitation; elder rights and legal assistance development program; and outreach, counseling, and assistance for insurance and public benefit programs. In addition, provisions were in-

cluded to strengthen requirements related to targeting of Title III services on special population groups. Other amendments authorized programs for assistance to caregivers of the frail elderly; clarified the role of Title III agencies in working with the for-profit sector; and required improvements in AoA data collection.

The latest amendments were enacted in 2000 after 6 years of congressional debate on reauthorization. P.L. 106–501 extended the Act's programs through FY2005. These amendments authorized the National Family Caregiver Support Program under Title III; required the Secretary of the Department of Labor (DoL) to establish performance measures for the senior community service employment program; allowed states to impose cost-sharing for certain Title III services older persons receive while retaining authority for voluntary contributions by older persons toward the costs of services; expanded a state's authority to transfer funds between these programs; 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; and consolidated a number of previously separately authorized programs. In addition, the amendments require the President to convene a White House Conference on Aging by December 31, 2005.

The following provides a brief description of the Act titles.

TITLE I. DECLARATION OF OBJECTIVES

Title I of the Act sets out broad social policy objectives oriented toward improving the lives of all older Americans, including adequate income in retirement, the best possible physical and mental health, opportunity for employment, and comprehensive long-term care services, among other things.

TITLE II. ADMINISTRATION ON AGING

Title II establishes AoA as the chief Federal agency advocate for older persons and sets out the responsibilities of AoA and the Assistant Secretary for Aging. The Assistant Secretary is appointed by the President with the advice and consent of the Senate. Title II requires that AoA establish the National Eldercare Locator Service to provide nationwide information through a toll-free telephone number to identify community resources for older persons. It also requires AoA to establish the National Long-Term Care Ombudsman Resource Center, the National Center on Elder Abuse, the National Aging Information Center, and the Pension Counseling and Information Program.

TITLE III. GRANTS FOR STATE 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, older persons. It accounts for 69 percent of total OAA funds in FY2004 ($1.243 billion out of $1.8 billion). The program, which supports 56 state agencies on aging, 655 area agencies on aging, and more than 29,000 service providers, authorizes six separate service programs. States receive separate allotments of funds for supportive services and centers, family caregiver support, congregate and home-deliv-

ered nutrition services, nutrition incentive services grants, and disease prevention and health promotion 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/health promotion services 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 the family caregiver program is allotted to states based on each state's relative share of the total population of persons aged 70 years and over. Nutrition services grants are allotted to states based on a formula that takes into account the number of meals served by the nutrition projects programs the prior year.

Supportive Services.—The supportive services and senior centers program provides funds to states for a wide array of social services, as well as the activities of approximately 11,000 senior centers. Supportive services allow older persons to reside in their homes and communities and remain as independent as possible. In FY2002, the program served 7.5 million older persons who received a range of services including transportation, home care, adult day care, information and assistance, and legal assistance. Of all persons served, 28 percent had income below the poverty level, and over 20 percent were minority older persons. The most frequently provided services are transportation, information and assistance, home care services, and adult day care. In FY2002, the program provided 37 million one-way trips and 2.7 million assisted trips; 20 million hours of personal care, homemaker, and chore services; and more than 10 million hours of adult day care services.

Nutrition Services.—The Title III nutrition program is the Act's largest program; funded at $714 million in FY2004, it represents 40 percent of the Act's total funding and 57 percent of Title III funds. Data for FY2000 show that of the 250 million meals served, 57 percent were provided to frail older persons at home, and 43 percent were provided in congregate settings, such as senior centers and schools.

Meals provided must comply with the Dietary Guidelines for Americans published by the Secretary of DHHS and the Secretary of Agriculture. Projects must provide meals that meet certain dietary requirements based on the number of meals served by the project each day. That is, projects that serve one meal per day must provide to each participant a minimum of one-third of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council, National Academy of Sciences. Projects that serve two meals per day must provide a minimum of two-thirds of the dietary allowances, and projects that serve three meals per day must provide 100 percent of the dietary allowances.

Persons who are 60 years of age or older, and their spouses of any age, may participate in the nutrition program. The law also allows the following groups to receive meals: persons under 60 years

with disabilities who reside in housing facilities occupied primarily by the elderly where congregate meals are served; persons with disabilities who reside at home with, and accompany, older individuals; and volunteers who provide services during the meal hours.

Congregate and home-delivered nutrition services providers are required to offer older persons at least one meal per day five or more days per week. The law provides an exception in rural areas if the 5-day weekly frequency is not feasible and a lesser frequency has been approved by the state agency on aging. Congregate nutrition providers are required to provide at least one "hot or other appropriate meal" per day; home-delivered nutrition providers are to provide at least "one hot, cold, frozen, dried, canned, or supplemental foods," meal per day.

Data from a national evaluation of the nutrition program completed in 1997 show that, compared to the total elderly population, nutrition program participants were older and more likely to be poor, to live alone, and to be members of minority groups. Roughly half of all meal recipients were low-income and 27 percent were minorities. They were also more likely to have health and functional limitations that place them at nutritional risk. The report found the program plays an important role in participants' overall nutrition and that meals consumed by participants are their primary source of daily nutrients. The evaluation also indicated that for every Federal dollar spent, the program leverages additional other funding on average, $1.70 for congregate meals, and $3.35 for home-delivered meals.[3]

National Family Caregiver Support Program.—The National Family Caregiver Support Program was added to Title III by the 2000 amendments (P.L. 106–501). 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.

Caregivers eligible to receive services may receive information and assistance, and individual counseling, access to support groups, and caregiver training. Services that tend to be more individualized, such as 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 atten-

[3] U.S. Department of Health and Human Services. Office of the Assistant Secretary for Aging. *Serving Elders at Risk: The Older Americans Act Nutrition Programs.* National Evaluation of the Elderly Nutrition Program, 1993–1995, June 1996.

tion to low income 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 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.

According to AoA, in FY2002, states and territories conducted outreach efforts to provide information about caregiver programs to about 4 million persons; provided access assistance to 440,000 caregivers; and conducted counseling and training services for about 180,000 caregivers. The program also supported respite care services for over 76,000 caregivers and provided a variety of supplemental services such as home care and adult day care to over 56,000 caregivers.

TITLE IV. TRAINING, RESEARCH, AND DISCRETIONARY PROJECTS AND PROGRAMS

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. Over the years Title IV has supported a wide range of research and demonstration projects, including those related to income, health, housing retirement, long-term care, as well as projects on career preparation and continuing education for personnel in the field of aging.

In recent years, AoA has funded a number of national efforts that support the work of state and area agencies on aging, including the National Long-Term Care Ombudsman Resource Center, the National Center on Elder Abuse, and other National Resource Centers that focus on legal assistance, retirement needs of minority populations and the vulnerable elderly. Other recent projects have included the development of Naturally Occurring Retirement Communities (NORCs) that assist older persons to age in place by providing them with home and community services in their own residential areas, and intergenerational opportunities that link older volunteers with children with disabilities whose support system is fragile.

TITLE V. COMMUNITY SERVICE EMPLOYMENT FOR OLDER AMERICANS

The community service employment program for Older Americans has as its purpose to promote useful part-time opportunities

in community service activities for unemployed low-income persons who are 55 years or older and who have poor employment prospects. The program is the only existing job creation program for adults since the elimination of public service employment under the Comprehensive Employment and Training Act (CETA).[4] Modeled after a pilot program called Operation Mainstream, it was first funded in 1965. Operation Mainstream was designed to employ poor, chronically unemployed adults and operated primarily in rural areas. In 1967, administrative responsibility for Operation Mainstream was transferred from the Office of Economic Opportunity to the Department of Labor (DOL), but funding authority continued under the Economic Opportunity Act. In 1973, the program was given a statutory basis under Title IX of the Older American Comprehensive Services Amendments of 1973. The 1975 amendments to the Older Americans Act incorporated the program as Title IX of the Act, and the 1978 amendments redesignated the program as Title V. The program continues to be administered by DoL.

In FY2004, the community service employment program represents about 24 percent of total OAA funds ($438.7 million out of $1.8 billion). The program not only provides opportunities for part-time employment and income for older persons, but also contributes to the general welfare of communities by providing a source of labor for various community service activities. Enrollees work part-time in a variety of community service activities. The program supports 61,500 jobs and services about 92,300 persons in FY2003 (for the program year, July 1, 2003-June 30, 2004). The cost per job slot in FY2003 is $7,153.

Enrollee Benefits.—Enrollees are paid no less than 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 (52 weeks at 25 hours a week), including orientation and training. Participants work an average of 20–25 hours per week.

In addition to wages, enrollees receive physical examinations, personal and job-related counseling, and transportation for employment purposes, under certain circumstances. Participants also may receive on-the-job training. DOL regulations indicate that training should be oriented toward upgrading job skills in preparation for community service as well as unsubsidized employment. Enrollees are paid at the established rate of pay when participating in training.

Participant Eligibility.—Persons eligible to participate in the program are those who are 55 years of age or older (priority must be given to persons 60 years and older), unemployed, and who have poor employment prospects. Persons' income must not exceed 125 percent of the DHHS poverty level guidelines.

When determining eligibility for Title V benefits, non-cash income such as food stamps and compensation received in the form of food or housing, unemployment benefits, and welfare payments, are not counted as income. Wages received under Title V are count-

[4] The Rehabilitation Act authorizes a community service employment program for persons with disabilities. It has never been funded.

ed when determining eligibility for certain income-tested programs, such as the supplemental security income (SSI) program. However, Title V wages are exempted in determining eligibility and level of benefits for the food stamp program and for Federal housing programs. Enrollee wages are subject to Federal, state, and local taxes, and participants contribute to social security.

Placement of Enrollees into Unsubsidized Employment.—The 20002 amendments to the Act emphasized the role of the program regarding placement of enrollees into unsubsidized private employment in a number of ways. First, the law was changed to state 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 increased the amount of funds to be set aside by the Secretary of DoL from the total appropriation for projects that place participants in unsubsidized employment. Third, the law codifies a DoL regulation regarding placement of enrollees into unsubsidized employment: the Secretary must establish 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.

Distribution of Funds to National Organizations and States.—Funds under the program are distributed to states and to national organizations according to a set of requirements that include a 2000 hold harmless amount (funds are distributed to state agencies and national organizations at their FY2000 level of activities) and state relative population aged 55 and over and relative per capita income.

In 2002, DoL initiated a competitive grant award process for distribution of funds to national organizations. The process was effective with the release of funds for FY2003 (to be used during program year 2003–2004 July 1, 2003-June 30, 2004). Prior to that time, funds allocated for national organizations had been awarded to 10 public or non-profit private organizations and the US. Forest Service in the Department of Agriculture. The initiation of the competitive grant process resulted in distribution of funds to 13 organizations; some organizations that received funds prior to the competitive process either received some reduction in funds or did not receive funds after competition.

The following table shows the distribution of funds for program year 2003–2004.

Title V of the Older Americans Act: FY2003 Funding to National Organizations and State Sponsors

Sponsor	FY2003 amount (millions)*	Percent of total
AARP Foundation Programs	$75.0	17.0
Asociación Nacional Pro Personas Mayores	7.8	1.8
Easter Seals, Inc.	16.2	3.7
Experience Works[1]	86.2	19.5
National ABLE Network	5.5	1.2
National Asian Pacific Center on Aging	6.1	1.4
National Caucus and Center on the Black Aged inc.	15.3	3.5
National Council on the Aging	21.9	5.0
National Indian Council on Aging	6.2	1.4
Senior Services America, Inc.[2]	50.1	11.3
SER-Jobs for Progress National, Inc.	26.3	5.9
U.S. Department of Agriculture Forest Service	20.5	4.6
Mature Services, Inc.	5.5	1.2
National organization sponsors, total	$342.6	77.5%
State agencies, total,	$99.7[3]	22.5%
Total	$442.3[4]	100.0%

*Funds are for FY2003 and are used from July 1, 2003-June 30, 2004.
[1] Formerly Green Thumb, Inc.
[2] Funds for this organization were previously administered by the National Council of Senior Citizens.
[3] This amount includes funds allocated to the territories.
[4] Includes funds for Section 502(e) experimental projects to assist in transitioning enrollees into unsubsidized positions.

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. To be eligible for funding, a tribal organization must represent at least 50 Native American elders age 60 or older.

In FY2003, grants were awarded to 241 organizations representing 300 Indian tribal organizations and two organizations serving native Hawaiian elders. The 2000 amendments (P.L. 106–501) added a new part to Title VI authorizing caregiver support services to Native American elders. Most frequently provided services under the program are transportation, home-delivered and congregate nutrition services, and a wide range of home care services.

TITLE VII. VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES

Title VII authorizes four separate vulnerable elder rights protection activities; these are the long-term care ombudsman program; the elder abuse, neglect and exploitation prevention program; legal assistance development; and the Native American elder rights program.

Funding for ombudsman and elder abuse prevention 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 service providers, or volunteer organizations.

Most Title VII funding is directed at the long-term care ombudsman program. Of $19.4 million appropriated for FY2004, almost

three-quarters is for ombudsman activities. The purpose of the program 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.

The ombudsman program leverages funds from a number of sources, other than the Older Americans Act.[5] In FY2001 (latest data available), more than $60 million supported this program from all sources combined (Federal and non-Federal). About 55 percent of total program effort came from Older Americans Act and other Federal sources; the remainder came from state and other non-Federal sources.

In FY2001, there were 596 local and regional ombudsman programs with 1,029 staff (full-time equivalents). The program relies heavily on volunteers to carry out ombudsman responsibilities—about 14,000 volunteers assisted paid staff in FY2001. In FY2001, AoA data show that state and local ombudsman programs investigated more than 264,0000 complaints by individuals in all residential settings. Most complaints relate to resident care, resident rights, and quality of life issues.

LEGISLATIVE ACTIVITIES IN 107TH CONGRESS

Other than appropriations legislation, no major legislative amendments to the Act have occurred since the Act's reauthorization in 2000. The Act is scheduled to be reviewed for reauthorization by the 109th Congress.

The following table presents appropriations history for the Act's programs from FY1998 through FY2004. Total funding in FY2004 is $1.798 billion, a slight increase over the FY2003 level.

In FY2003, Congress transferred administrative authority for the nutrition services incentive grant program from the U.S. Department of Agriculture, where it had been since its inception, to AoA. The program retains a separate authorization of appropriation under Title III and funds are allocated to states based on their share of total meals served the prior year. In addition, for FY2004, Congress appropriated $2 million to support planning for the White House Conference on Aging which is to be convened by the President by December 2005.

[5] States receive funds under a separate allotment of funds for ombudsman activities under Title VII; in addition they may use Title III funds to support these activities.

Older Americans Act, Alzheimer's Demonstration Programs, and White House Conference on Aging, FY1998–FY2004

($ in millions)

OAA programs and Alzheimer's demonstration grants	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004
TITLE II: Administration on Aging	$14.795	$15.395	$16.461	$17.232	$20.501	$20.233	$30.618
Program Administration	(14.795)	(15.395)	(16.461)	(17.232)	(18.122)	(17.869)	(17.324)
Aging Network Support Activities	.....	.....	.....	.....	(2.379)[1]	(2.364)[1]	(13.294)[2]
TITLE III: Grants for State and Community Programs on Aging	961.798	952.339	987.617	1,151.285	1,230.293	1,240.891	1,243.059
Supportive services and centers	309.500	300.192	310.082	325.082	357.000	355.673	353.889
Family caregivers	.....	.....	.....	125.000	136.000[3]	149.025[3]	152.738[3]
Disease prevention/health promotion	16.123	16.123	16.123	21.123	21.123	21.919	21.970
Nutrition services	626.412	626.261	661.412	680.080	716.170	714.274	714.462
Congregate meals	(374.412)	(374.261)	(374.336)	(378.412)	(390.000)	(384.592)	(386.353)
Home-delivered meals	(112.000)	(112.000)	(146.970)	(152.000)	(176.500)	(180.985)	(179.917)
Nutrition services incentive program	(140.000)	(140.000)	(140.000)	(149.668)[4]	(149.670)[4]	(148.697)[5]	(148.192)
In-home services for the frail elderly	9.763	9.763	none	[6]	[6]	[6]	[6]
TITLE IV: Training, Research, and Discretionary Projects and Programs	10.000	18.000	31.162	37.678	38.280	40.258	33.509[7]
TITLE V: Community Service Employment	440.200	440.200	440.200	440.200	445.100	442.306	438.650
TITLE VI: Grants to Native Americans	18.457	18.457	18.457	23.457	31.229	33.704	32.717
Supportive and nutrition services	.....	.....	.....	.....	(25.729)	(27.495)	(26.453)
Native American caregivers,	.....	.....	.....	.....	(5.500)	(6.209)	(6.318)
TITLE VII: Vulnerable Elder Rights Protection Activities	none[8]	12.181	13.181[9]	14.181[9]	17.681[9]	18.559	19.444
Long-term care ombudsman program	none	(7.449)	[9]	[9]	[9]	[9]	(14.276)
Elder abuse prevention	none	(4.732)	[9]	[9]	[9]	[9]	(5.168)
Legal assistance	none	none	none	none	none	none	none
Native Americans elder rights program	none	none	none	none	none	none	none
Total—Older Americans Act Programs	$1,445.250	$1,456.569	$1,507.078	$1,684.033	$1,783.084	$1,771.057	$1,798.051
Alzheimer's Demonstration Grants[10]	$5.970	$5.970	$5.970	$8.962	$11.500	$13.412	$11.883
White House Conf. on Aging	none	none	none	none	none	none	$2.814[11]

[1]Includes $1.2 million for the Eldercare Locator and $1.2 million for Pension Counseling and Information Program.

[2]Includes funds for activities previously funded under Title IV: Senior Medicare Patrols; National Long-Term Care Ombudsman Resource Center; and National Center on Elder Abuse. Also includes funds for the Eldercare Locater and Pension Counseling and Information Program.

[3]Funding for Native American family caregiving is shown in Title VI.

[4]Congress originally appropriated $150 million, then rescinded $332,000 (.22 percent) pursuant to Section 1(a)(4) of P.L. 106–544.

[5]Congress transferred the program, previously funded by USDA, to AoA in FY2003.

[6]Not authorized.

[7]See footnote b. Funds shown are reduced from FY2003 level due to transfer of some funds to Title II.

[8]Funding for ombudsman and elder abuse prevention activities was included in Title III.

[9] Separate amounts not specified.

[10]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.

[11]P.L. 100–75 requires the President to convene the conference no later than Dec. 31, 2005.

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 has been superceded by appropriations bills for each of fiscal years 2001–2003, maintaining the transfer authority at the 10 percent level. Legislation proposing to permanently maintain the 10 percent transfer level has been introduced in the 108th 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 nonprofit or public organizations designated as the official antipoverty agency for a community. These community action agencies were di-

rected 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 recipi-

ents 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 2001 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 2001 fifty State survey also found that in FY2001, the total resources spent by the CSBG network in 49 States were about $9.3 billion. Of that total, almost 65 percent came from Federal programs other than CSBG; approximately 13 percent came from the States; 6 percent came from local sources; 11 percent came from private sources, including the value of volunteer time; and 6 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 (17 percent), linkages between and among programs (18 percent), nutrition programs (8 percent), education (10 percent), employment programs (11 percent), income management programs (5 percent), housing initiatives (9 percent), self-sufficiency (15 percent), health (4 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) was 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. In its survey of CSBG performance outcomes for FY2001, the National Association for State Community Services Programs reported that all 50 States and 935 CAAs were actively engaged in ROMA implementation.

OCS believes that the six national ROMA goals reflect a number of important concepts that transcend CSBG as a stand-alone 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 2003, HHS released the annual report on SSBG expenditures and recipients for 2001. This report is based on information submitted by the States to HHS. According to that report, 37 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 8 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 2001, approximately 659,754 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 serv-

ice categories receiving the greatest amount of SSBG funds in 2001 were protective services for children 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 at which 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 earlier levels of $2.38 billion and $2.8 billion has been introduced in the 107th and 108th Congresses, respectively, but has not been approved. Likewise, a bill proposing to permanently maintain the transfer authority from TANF to SSBG at 10 percent has passed the House in the 108th Congress, but has not yet been acted upon in the Senate.

(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 all 50 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 2001 CSBG grant outcomes, discussed above, provides some interesting clues. 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 10.9 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 17.8 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 17.2 percent of CSBG expenditures in fiscal year 2001; 8 percent of CSBG clients in FY2001 were older than 70, and another 9 percent were between 55 and 70 years old. CAAs served over one million retired families and individuals in FY2001.

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. The appropriated amounts for FY2002 and FY2003 mirrored the ceiling level, at $1.7 billion in both years.

(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 na-

tional 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 2003, appropriations were as follows: $645.8 million for the CSBG; $27 million for community economic development; $5.5 million for job opportunities for low-income individuals (JOLI); $7.2 million for rural community facilities; $16.9 million for national youth sports; $7.3 million for community food and nutrition and $24.8 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 might have a need for formal education extending beyond the informal, experiential environment. This possible 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 economic or 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 individual's ability to read, write, and speak in English, and compute and solve the problems at levels of proficiency necessary to function on

the job and in society, to achieve one's goals, and develop one's knowledge and potential."

The National Adult Literacy Survey (NALS), conducted in 1992 by the Department of Education 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 Department of Education will conduct a similar 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 suggest a cause for concern over the current condition of adult education and literacy. According to the Statistical Abstract of the U.S., 2002, 175 million American adults were 25 years old and over in 2000; of these, 15.8 percent (28 million) never graduated from high school (*Statistical Abstract of the U.S., 2000*, Table 210). The portion of non-graduates increases among older population groups. In contrast to the 15.8 percent average, the percent of persons 55 to 64 years old who did not graduate from high school was 18.3 percent, the rate was 26.4 percent for those 65 to 74, and 35.4 percent for those 75 years old and over. 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 educational skills of adult individuals.

2. Federal Programs

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 Department of Education makes grants to assist states and localities provide adult education and family literacy programs. Approximately 3 million adults participate in these programs on an annual basis. The FY2001 appropriation for AEFLA programs was $561 million, representing a substantial increase above the FY2000 amount of $470 million. The AEFLA appropriation increased again for FY2002 to $591 million. States and localities spend significantly more on the same programs; the amount was nearly $1.1 billion in FY1999, the most recent year published for these data.

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 equiva-

lent; or 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.

In the latest year for which detailed state enrollment data are available from all states (the 1999–2000 program year), 2.9 million adults participated in federally supported adult education and literacy programs. Of this total, 1.1 million participated in adult basic education programs, 1.1 million in English-as-a-second-language programs, and 0.7 million in adult secondary education activities. The Department of Education has estimated that as many as 90 million adults, based on the 1992 NALS survey, do not have the "reading, language, computational, or English skills" needed either for self-sufficiency or for the present or future global information economy.[1]

The Workforce Investment Act of 1998 (P.L. 105–220), including the AEFLA under Title II, was enacted by the 105th Congress. Since the AEFLA is authorized through FY2003, the 107th Congress left reauthorization of the AEFLA for the 108th Congress to consider. Regarding appropriations, the 107th Congress enacted on one annual appropriations for FY2002 for the AEFLA by means of P.L. 107–116, the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations, 2002 (signed into law by the President on January 10, 2002). The FY2002 AEFLA appropriation was $591 million. The FY2002 appropriation continued 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 FY2002 reserve, of $70 million, was used to 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. THE 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),

[1] Source: http://www.ed.gov/about/offices/list/ovae/pi/AdultEd/aefacts.html (visited December 15, 2003).

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 nonprofit organizations. These entities apply to the Corporations' State offices for funds to recruit, place, and support the senior volunteers.

(1) Retired Senior Volunteer Program

The Retired Senior Volunteer Program (RSVP) was authorized in 1969 under the Older Americans Act. In 1971, the program was transferred from the Administration on Aging to ACTION and in 1973 the program was incorporated under Title II of the Domestic Volunteer Service Act. RSVP is designed to provide a variety of volunteer opportunities for persons 55 years and older. Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, refugee assistance, drug abuse prevention, consumer education, crime prevention, and housing rehabilitation. Although volunteers do not receive hourly stipends ,as they do under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses, such as transportation costs.

In FY2001, approximately 480,000 volunteers served in 766 projects.[1] 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 75 percent , and those 85 and older accounted for 10 percent. Women made up 75 percent of the volunteers. For FY2002 $54.9 million was appropriated.

[1] Corporation for National and Community Service. *National Overview 2001 Retired and Senior Volunteer Program.* See: [http://www.seniorcorps.org/research/overview—rsvp01.html].

(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 $2.65 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.

In FY2001, approximately 30,200 individuals served as foster grandparents.[2] Fifty-five percent were white, 39 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 10 percent of the volunteers. Persons under the age of 65 accounted for 14 percent of the volunteers, those between 65 and 84 accounted for 81 percent, and those 85 and older accounted for 5 percent. Women made up 91 percent of the volunteers. For FY2002, $106.7 million was appropriated.

Of the over 275,000 children served by the foster grandparents in FY2001, 39 percent were 5 years of age or under, 46 percent were between 6 and 12 years of age, and 15 percent were 13 and older. Of the children served, 63 percent had one of five special needs. The special needs areas were learning disabilities (26 percent), significantly medically impaired (13 percent), developmentally delayed/disabled (11 percent), emotionally impaired/autistic (7 percent), and abused/neglected (7 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

[2] Corporation for National and Community Service. *National Overview 2001 Foster Grandparent Program.* See: http://www.seniorcorps.org/research/overview—fgpp01.html].

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 FY2001, the number of individuals who served as senior companions was approximatley 15,500.[3] Fifty-eight percent were white, 35 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 64 percent of the volunteers, those between 75 and 84 accounted for 31 percent, and those 85 and older accounted for 5 percent. Women made up 85 percent of the volunteers. For FY2002 $44.4 million was appropriated.

Of the more than 61,000 adults served by the senior companions in FY2001, 12 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

[3] Corporation for National and Community Service. *National Overview 2001 Senior Companion Program.* See: [http://www.seniorcorps.org/research/overview—scp01.html].

economic level of the people they serve. Generally, volunteers receive a living allowance, 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 FY2001, 59.5 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 2000–2001, 4,447 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 2000–2001, approximately 48 percent were 18 through 25 years of age; 10 percent of the participants were 55 and older. For FY2002, $85.3 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.

2. Federal Response

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. Section 5310 provided $90 million in fiscal year 2003.

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 annually in the period 1979–1991, to an average of around $120 million annually for 1992–1998, to an average of almost $210 million annually for 1999–2003.

The STAA of 1982 (P.L. 97–424) established Section 5307 in its amendments to the UMTA Act. Section 5307 provides general assistance 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. In FY2002, states transferred $4.2 million of Section 5307 funds to the Section 5311 program. State and local governments also have the choice of using some of the Federal highway funds for rural transit. In fiscal year 2002, $58.2 million of flexible highway funds was transferred to Section 5311 projects.

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; in 1998, the Council was renamed the Coordinating Council on Access and Mobility. The Council is charged with coordinating related programs at the Federal level and promoting coordination at the State and local levels.

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 surface transportation programs in 1991 (the Intermodal Surface Transportation Efficiency Act of 1991 [ISTEA]; P.L. 102–240) provided a number of important changes for the elderly and disabled. Key provisions of ISTEA (which renamed UMTA the Federal Transit Administration [FTA]) included: (1) Allowing paratransit 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 home-

bound 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 FTA, the Transportation Research Board (TRB), and the American Public Transit Association (APTA). To date, TCRP has resulted in the publication of over 250 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.

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 over the levels provided in ISTEA, 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 $90 million in FY2003; for Section 5311, appropriations have risen from $120 million in FY1997 to $237 million in FY2003. 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 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.

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 19.1 million older drivers (70 years and above) in 2001. These drivers constitute about 10 percent of all drivers. In 2002 there were 57,803 drivers involved in fatal crashes of which 8.1 percent were age 70 or older, and there were 26,549 drivers killed in crashes, of which 11.8 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 breakdowns, 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 75 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
- The fatal crash rate for licensed drivers declines as licensed drivers get older, until reaching the 70 and older age group, where the rate rises sharply (though the rate for age 70 and older drivers is still lower than the rate for licensed drivers under age 45).

It does not follow, however, that because a higher percentage of elderly die in traffic accidents, that the elderly actually cause a greater number of such accidents. Some statistics suggest that the elderly, as a group, are safe drivers. They have the fewest accidents per 100,000 licensed drivers, the lowest rate of alcohol involvement, and the highest level of restraint (i.e. seatbelt) use among various age groups. According to DOT's *Traffic Safety Facts 2002 Older Population,* "Older drivers involved in fatal crashes had the lowest proportion of intoxication with blood alcohol concentrations (BAC) of 0.08 grams per deciliter (g/dl) or greater of all adult drivers. . . In two-vehicle fatal crashes involving an older and a younger driver, the vehicle driven by the older person was more than twice as likely to be the one that was struck." 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.

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 few years 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:

National Highway Traffic Safety Administration <http://www.nhtsa.dot.gov>

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 Op-

portunity 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 the 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 2002, LSC funded 170 local programs. Together they served every county in the nation, as well as the U.S. territories. These local programs provide legal assistance to individuals based on locally determined priorities that meet local community conditions and needs. Local programs hire staff, contract with local attorneys, and develop pro bono programs for the direct delivery of legal assistance to eligible clients.

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 2002 (P.L. 107–77), LSC grantees may not: engage in partisan litigation related to redistricting; attempt to influence regulatory, legislative or adjudicative action at the Federal, state or local level; attempt to influence oversight proceedings of the LSC; initiate or participate in any

class action suit; represent certain categories of aliens, except that nonFederal funds may be used to represent aliens who have been victims of domestic violence or child abuse; conduct advocacy 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. In the Velazquez ruling, the Supreme Court stated that LSC-funded attorneys can challenge welfare reform laws but only if it is part of the client's case for individual benefits. After the Supreme Court issued its decision, the LSC announced that it would no longer enforce the specific provision addressed by the Supreme Court, and in May 2002, the LSC formally eliminated it from the welfare regulations.

Grantees also are required to maintain timekeeping records and account for any nonFederal funds received. The appropriations law contains extensive audit provisions. The Corporation is prohibited from receiving nonFederal funds, and grantees are prohibited from receiving non-LSC funds, unless the source of funds is told in writing that these funds may not be used for any activities prohibited by the Legal Services Corporation Act or the appropriations law. However, grantees may use non-LSC funds to comment on proposed regulations or respond to written requests for information or testimony from Federal, state, or local agencies or legislative bodies, as long as the information is provided only to the requesting agency and the request is not solicited by the LSC grantee.

(B) OLDER AMERICANS ACT

Support for legal services under the Older Americans Act (OAA) was a subject of interest to both the Congress and the Administration on Aging (AOA) for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services

in the initial version of the OAA in 1965, but recommendations concerning legal services were made at the 1971 White House Conference on Aging. Regulations promulgated by the AOA in 1973 made legal services eligible for funding under Title III of the OAA. Subsequent reauthorizations of the OAA contained provisions relating to legal services. In 1975, amendments granted legal services priority status. The 1978 Amendments to the OAA established a funding mechanism and a program structure for legal services. The 1981 amendment required that area agencies on aging spend "an adequate proportion" of social service funding for three categories, including legal services, as well as access and in-home services, and that "some funds" be expended for each service. The 1984 amendments to the Act retained the priority, but changed the term to "legal assistance," and required that an "adequate proportion" be spent on "each" priority service. In addition, area agencies were to annually document funds expended for this assistance. The 1987 amendments specified that each State unit on aging must designate a "minimum percentage" of Title III social services funds that area agencies on aging must devote to legal assistance and the other two priority services. If an area agency expends at least the minimum percentage set by the State, it will fulfill the adequate proportion requirement. Congress intended the minimum percentage to be a floor, not a ceiling, and has encouraged area agencies to devote additional funds to each of these service areas to meet local needs.

The 1992 amendments modified the structure of the Title III program through a series of changes designed to promote services that protect the rights, autonomy, and independence of older persons. One of these changes was the shifting of some of the separate Title III service components to a newly authorized Title VII, Vulnerable Elder Rights Protection Activities. State legal assistance development services was one of the programs shifted from Title III to Title VII.

In order to be eligible for Title VII elder rights and legal assistance development funds, State agencies must establish a program that provides leadership for improving the quality and quantity of legal and advocacy assistance as part of a comprehensive elder rights system. State agencies are required to provide assistance to area agencies on aging and other entities in the State that assist older persons in understanding their rights and benefiting from services available to them. Among other things, State agencies are required to establish a focal point for elder rights policy review, analysis, and advocacy; develop statewide standards for legal service delivery, provide technical assistance to AAAs and other legal service providers, provide education and training of guardians and representative payees; and promote pro bono programs. State agencies are also required to establish a position for a State legal assistance developer who will provide leadership and coordinate legal assistance activities within the State.

The OAA also requires area agencies to contract with legal services providers experienced in delivering legal assistance and to involve the private bar in their efforts. If the legal assistance grant recipient is not a LSC grantee, coordination with LSC-funded programs is required.

Another mandate under the OAA requires State agencies on aging to establish and operate a long-term care ombudsman program to investigate and resolve complaints made by, or on behalf of, residents of long-term care facilities. The 1981 amendments to the OAA expanded the scope of the ombudsman program to include board and care facilities. The OAA requires State agencies to assure that ombudsmen will have adequate legal counsel in the implementation of the program and that legal representation will be provided. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs. The AOA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal, and protective services activities for older people and to assure coordination of these activities. State ombudsman reports and a survey by the AARP conducted in 1987 indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to the records of residents and facilities, provide consultation to ombudsmen on law and regulations affecting institutionalized persons, represent clients referred by ombudsman programs, and work with ombudsmen and others to change policies, laws, and regulations that benefit older persons in institutions.

In other initiatives under the OAA, the AOA began in 1976 to fund State legal services developer positions (attorneys, paralegals, or lay advocates) through each State unit on aging. These specialists work in each State to identify interested participants, locate funding, initiate training programs, and assist in designing projects. They work with legal services offices, bar associations, private attorneys, paralegals, elderly organizations, law firms, attorneys general, and law schools.

The 1987 amendments to OAA required that beginning in fiscal year 1989, the Assistant Secretary collect data on the funds expended on each type of service, the number of persons who receive such services, and the number of units of services provided. Today, OAA funds support over 600 legal programs for the elderly in greatest social and economic need.

In 1990, the Special Committee on Aging surveyed all State offices on aging regarding Title III funded legal assistance. Key findings of the survey include: (1) 18 percent of States contract with law school programs to provide legal assistance under Title III-B of the Act and 35 percent contract with nonattorney advocacy programs to provide counseling services; (2) a majority of States polled (34) designated less than 3 percent of their Title III-B funds to legal assistance; (3) minimum percentage of Title III-B funds allocated by area agencies on aging to legal assistance ranged from 11 percent down to 1 percent; and (4) only 65 percent of legal services developers are employed on a full-time basis and only 38 percent hold a law degree.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, either provide services directly or contract with public and nonprofit social service agencies to provide social services to individuals and families. In general, States determine

the type of social services to provide and for whom they shall be provided. Services may include legal aid. Because the Omnibus Budget Reconciliation Act of 1981 eliminated many 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 FY2001, a very small amount (0.6 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, numerous 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 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.

During 2002, legal services attorneys closed 976,519 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 FY2002, Congress appropriated $329.3 million to the LSC. Although efforts to reduce funding for the LSC that began in 1996 have now begun to reverse, there is no doubt that older persons still find it very difficult to obtain legal assistance. When the Legal Services Corporation was established in 1974, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of two legal services attorneys for every 10,000 poor people. The goal of minimum access was achieved in fiscal year 1980 with an appropriation of $300 million, and in fiscal year 1981, with $321 million. This level of funding met only an estimated 20 percent of the poor's legal needs. Currently, the LSC is not even funded to provide minimum access. In most States, there is only 1 attorney for every 10,000 poor persons. In contrast, there are approximately 28 lawyers for every 10,000 persons above the Federal poverty line. Moreover, the United States currently funds less for legal services than its counterparts in most of the other Western developed nations. For example, the annual per capita government expenditure for civil legal assistance is $2.25 in the United States compared to $32 in England.

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 indicate 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 number of grantees receiving LSC funding decreased from 325 in 1995 to 262 in 1998, to 207 in 2001, to 170 in 2002. The reduction in local programs is due to both cutbacks in funding and a LSC-initiated reconfiguration of the LSC program in which States were urged to merge, reorganize, and consolidate local programs into a more efficient regional and statewide delivery system of legal services to the poor.)

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." In April 2003, 8 new Board members appointed by President Bush were sworn into office, and 3 existing Board members appointed by President Clinton in 1993 continue to serve on the Board.

(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. From their perspective, 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.

On February 28, 2002, the House Judiciary Subcommittee on Commercial and Administrative Law held an oversight hearing on the Legal Services Corporation. The hearing covered a number of issues, including the following: Has an effective system of competition been implemented by the LSC, and how is this system working? Have Legal Services Corporation grantees been maintaining program integrity as required by regulations? What types of changes have been made by Legal Services Corporation grantees to

clean up the case-overcounting problem? What Is the Impact of the Supreme Court's decision last term in the case of Legal Services Corporation vs. Velazquez and the related follow-up case of Dobbins vs. Legal Services Corporation.

Bob Barr, House Judiciary Subcommittee chairman at the time of the 2002 hearing, commented that since its inception, the Legal Services Corporation has been plagued with problems and controversy. He stated:

"Over two decades, Congress has listened to complaints about Legal Service lawyers who were not serving the needs of the poor but rather were using taxpayer money to fund liberal political and ideological causes. In response to these complaints, in 1996 Congress passed a series of reforms and restrictions regulating the Corporation and the work of its grantees. Now, almost 6 years later, since those reforms were passed, it is time for Congress to consider seriously the question of whether these restrictions have been effectively implemented, whether there has been full and complete compliance by the grantees within the legal restrictions, and, moreover, what role the Board of Directors has played in all of this. As we meet today, Congress continues to hear complaints about the true mission of Legal Services lawyers and how the reforms are being violated or circumvented."

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 some believed went 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 little detail from the Corporation about its proposed use of the funding request, despite 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 activities. 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 included $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 was reduced to $329.3 million.

The language accompanying President Bush's FY2002 budget affirmed 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

requested the current level funding of $329.3 million for the LSC. The proposal included all restrictions on LSC-funded activities that were currently in effect.

The Bush Administration's FY2002 request for LSC ($329.3 million) was the same as the amount that was obligated for the program for FY2001. For FY2002, the House Appropriations Committee recommended a total of $329.3 million for LSC. This amount was the same as the FY2001 appropriation (after accounting for the 0.22 percent governmentwide rescission) and President Bush's FY2002 budget request for the program. The House Committee's recommendation also included existing provisions restricting the activities of LSC grantees. In carrying out LSC's vision of an effective and efficient statewide system of delivering legal services to the poor, grantees have been merging and reconfiguring their legal services programs to better use the Federal dollars allocated to them. The House Committee report (H.Rept. 107–139) indicated concern about the LSC overruling, without appeal, certain configurations implemented by grantees via the state planning process. The House Committee report directed LSC to review the state planning process and the concerns raised and report back to the Committee by September 4, 2001, with a proposal (including input from the stakeholders) that outlined the reconfiguration standards and the process for states to appeal LSC's decisions. On July 18, 2001, the House passed H.R. 2500, which included $329.3 million for the LSC. For FY2002, the Senate Appropriations Committee also recommended $329.3 million for LSC and included existing program prohibitions. On September 13, 2001, the Senate passed H.R. 2500, which included $329.3 million for LSC.

The Conference Committee report on H.R. 2500 included $329.3 million for LSC for FY2002. This was identical to the FY2001 appropriation for LSC (after the rescission) and the Bush Administration's FY2002 budget request for LSC. The Conference Committee report's recommendation for LSC included $310 million for basic field programs, $12.4 million for management and administration, $4.4 million for client self-help and information technology, and $2.5 million for the inspector general. The Conference Committee report also included existing provisions restricting the activities of LSC grantees. The Conference report (H.Rept. 107–278) was passed by the House on November 14, 2001, and by the Senate on November 15, 2001. H.R. 2500 was signed into law (P.L. 107–77) by President Bush on November 28, 2001.

Current LSC funding still remains below the Corporation's highest level of $400 million in FY1994 and FY1995.

(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 significant 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. According to the LSC, a substantial amount of these funds, $133 million in 2002, 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. (On March 26, 2003, the Supreme Court upheld the constitutionality of the IOLTA program by a narrow 5–4 decision. In *Brown* v. *Washington Legal Foundation,* the Supreme Court ruled that although the IOLTA program does involve a taking of private property interest in escrow accounts that was owned by the depositors for a legitimate public use, there is no violation of the Just Compensation Clause of the Constitution because the owner did not have a pecuniary loss.)

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 rec-

ommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly (also known as the Commission on Law and Aging) was established by the ABA in 1979. The mission of the Commission is to strengthen and secure the legal rights, dignity, autonomy, quality of life, and quality of care of elders. It carries out this mission through research, policy development, technical assistance, advocacy, education, and training. The Commission consists of a 15-member interdisciplinary body of experts in aging and law, including lawyers, judges, health and social services professionals, academics, and advocates. With its professional staff, the Commission examines a wide range of law-related issues, including: legal services to older persons; health and long-term care; housing needs; professional ethical issues; Social Security, Medicare, Medicaid, and other public benefit programs; planning for incapacity; guardianship; elder abuse; health care decisionmaking; pain management and end-of-life care; dispute resolution; and court-related needs of older persons with disabilities.

The Commission receives funding from a variety of sources. These include grants and contracts from the U.S. Department of Justice; U.S. Department of Health and Human Services, Administration on Aging; Robert Wood Johnson Foundation; Borchard Foundation; and the Alzheimer's Association. Approximately one-third of the Commission's funding comes from the ABA's Fund for Justice and Education, in part, from the Marie Walsh Sharpe Endowment.

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 Commission also publishes a quarterly newsletter, called BIFOCAL, which aims to generate legal resources for older persons through the joint efforts of public and private bar groups and the aging network. In addition, since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

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 note-

worthy. Moreover, in 1998, the American Bar Association published a comprehensive document entitled the "National Handbook on Laws and Programs Affecting Senior Citizens."

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.

The American Bar Association has indicated that 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 the mid–1990's, public perceptions about crime appear to be out of line with government statistics. According to an October 23, 2003 Gallup poll, 60 percent of those polled believed that crime is worse now than a year ago.[1] An October 2002 poll showed that 90 percent of Americans 65 and older believe that crime is an important issue.[2] Additionally, research done by the American Association for Retired Persons (AARP) indicated that "one-third of persons age 50 and older avoid going out at night because they are concerned about crime."[3]

The Federal Bureau of Investigation (FBI) 2002 Uniform Crime Report (UCR) figures, however, suggest that the fears of many of these Americans may be exaggerated. Five- and 10-year trend data from the 2002 (UCR) showed that in 2002 the Crime Index[4] was 4.9 percent lower than the estimate from 1998 and 16.0 percent below the 1993 estimate. 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]

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[1] The Gallup Organization, *"Pessimism About Crime Is Up, Despite Declining Crime Rate,"* October 23, 2003.

[2] The Washington Post/Kaiser Family Foundation/Harvard University, *"A Generational Look at the Public: Politics and Policy,"* October 2002.

[3] For further information see: AARP, *The Policy Book: AARP Public Policies 2001.* Chapter 13, p. 19.

[4] The FBI's Uniform Crime Report's Crime Index is composed of selected offenses used to gauge fluctuations in the volume and rate of crime reported to law enforcement. The Crime Index includes the following offenses: Part I crimes, which includes violent crimes (murder, nonnegligent manslaughter, forcible rape, robbery, and aggravated assault) and three property crimes (burglary, larceny-theft, and motor vehicle theft). See the U.S. Department of Justice, Federal Bureaus of Investigation, *"Crime in the United States 2001 & Crime in the United States 2002."*

[5] According to the Bureau of Justice Statistics, *Victim Characteristics:*

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

Continued

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 other groups due to 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.

2. Legislative Response

There were several hearings held in the 107th Congress on elder victimization. The Senate Special Committee on Aging held a hearing that focused on crimes committed against the elderly.[6] The Senate also held a hearing on financial exploitation of seniors.[7]

Several pieces of legislation were introduced in the 107th Congress, however, none of them were enacted into law. The Elder Justice Act (S. 2933) would have established an Office of Elder Justice in the Department of Justice.[8] The act would have created a director position that would have reported to the Attorney General and would have been charged with developing a program for elder justice. It would have also created a senior counsel position that would have been responsible for coordinating elder justice activities among the Office of Elder Justice and other relevant offices within DOJ. The bill was referred to the Senate Committee on Finance and no further action was taken.

The Seniors Safety Act of 2002 (S. 2240), among other things, would have required the U.S. Sentencing Commission to review and amend, if appropriate, the sentencing guidelines to include the age of the victim as one of the criteria for determining whether a sentencing enhancement is appropriate. The bill was referred to the Senate Judiciary Committee and no further action was taken.

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

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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.bjs/cvict—v.htm].

[6] U.S. Congress. Senate Special Committee on Aging.

[7] U.S. Congress. Senate Special Committee on Aging. *Identity Theft: The Nation's Fastest Growing Crime Wave Hits Seniors.* 107th Cong., 2nd Sess., July 18, 2002; and U.S. Congress. Senate Special Committee on Aging. *Financial Predators and the Elderly.* 107th Cong., 2nd Sess., May 20, 2002.

[8] The same piece of legislation, *The Elder Justice Act,* has been reintroduced in the 108th Congress (H.R. 2490).

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 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 "ceberg" 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 found that two-thirds of abusers were adult children or spouses.

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 re-

tirees (over the age of 50) have steadily risen over the past 20 years.[9] 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."[10] 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."[11] In one case, the FBI reported a fraudulent telemarketing scam wherein nearly 80 percent of the calls were directed to older consumers.[12]

Efforts have been in place to combat elderly victimization since the late 1980's. 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.[13] 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 number 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, accessibility to older victims by con artists 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

[9] For further information see: [http://research.aarp.org/econ/beyond—50—econ.html], p.22–23.
[10] See: [http://aarp.org/fraud/1fraud.htm].
[11] See: [http://www.ojp.usdoj.gov/ovc/assist/nvaa2000/academy/N–14–ELD.htm].
[12] See:[http://www.aarp.org/fraud/1fraud.htm].
[13] For additional information on TRIAD programs, visit AARP's website at [http://www.aarp.org].

he or she telephones an older person. Door-to-door salespeople hawking worthless goods are more likely to find someone at home when they ring the doorbell of a retired person. Deceptive or fraudulent mass mailings are likely to be given more attention by retired individuals with more leisure time.

2. Legislative Response

In 2002, the Senate Special Committee on Aging held hearings on identity theft and financial exploitation among the elderly; and in 2001 the House Judiciary Committee held a hearing on crime against the elderly.[14] Additionally, several pieces of legislation were introduced in the 107th Congress that would have increased penalties for fraud. The Seniors Safety Act of 2002 (S. 2240), among other things, would have amended the Federal criminal code to increase penalties for fraud that resulted in serious injury or death and would have set penalties for individuals found guilty of fraud in association with retirement arrangements. The bill also would have directed the Federal Trade Commission to establish procedures regarding telemarketing fraud. Another bill introduced in the 107th Congress, the Telemarketing Victims Protection Act (H.R. 232), would also have directed the Federal Trade Commission to establish procedures regarding telemarketing fraud. Both bills were referred to the relevant committees and no further action was taken.

Although not focused exclusively on the elderly, the Identity Theft Penalty Enhancement Act of 2002 (S. 2541), among other things, would have required a sentence of imprisonment for individuals who falsely use, transfer or possess another person's identity in the course of committing a felony. The bill was favorably reported out of the Senate Judiciary Committee on November 14, 2002.

[14] U.S. Congress. Senate Special Committee on Aging. *Identity Theft: The Nation's Fastest Growing Crime Wave Hits Seniors.* 107th Cong., 2nd Sess., July 18, 2002; U.S. Congress. Senate Special Committee on Aging. *Financial Predators and the Elderly.* 107th Cong., 2nd Sess., May 20, 2002; and U.S. Congress. House Judiciary Committee. *Crime Against the Elderly.* 107th Cong., 1st Sess., July 11, 2001.

SUPPLEMENTAL MATERIAL

LIST OF HEARINGS AND FORUMS HELD IN 2001 AND 2002

The Senate Special Committee on Aging, convened 27 hearings, 9 field hearings, and 1 forum during the 107th Congress.

HEARINGS

March 29, 2001—Healthy Aging in Rural America
April 19, 2001—Modernization of Social Security and Medicare
April 26, 2001—Assisted Living in the 21st Century: Examining Its Role in the Continuum of Care
May 3, 2001—Technology and Prescription Drug Safety
May 17, 2001—Family Caregiving and the Older American Act: Caring for the Caregiver
June 14, 2001—Saving our Seniors: Preventing Elder Abuse, Neglect, and Exploitation
June 28, 2001—Long-Term Care: Who Will Care For The Aging Baby Boomers?
July 18, 2001—Long-Term Care: States Grapple With Increasing Demands and Costs
July 26, 2001—Medicare Enforcement Actions: The Federal Government's Anti-Fraud Efforts
September 10, 2001—Swindlers, Hucksters and Snake Oil Salesman: Hype and Hope Marketing Anti-Aging Products to Seniors
September 24, 2001—Long-Term Care After Olmstead: Aging and Disability Groups Seek Common Ground
December 10, 2001—Straight Shooting on Social Security: The Trade-offs of Reform
February 6, 2002—Women and Aging: Bearing the Burden of Long-Term Care
February 27, 2002—Patients in Peril: Critical Shortages in Geriatric Care
March 4, 2002—Safeguarding Our Seniors: Protecting the Elderly From Physical and Sexual Abuse in Nursing Homes
March 14, 2002—The Economic Downturn and Its Impact on Seniors: Stretching Limited Dollars in Medicaid, Health, and Senior Services
March 21, 2002—Broken and Unsustainable: The Cost Crisis of Long-Term Care for Baby Boomers
April 10, 2002—Offering Retirement Security To The Federal Family: A New Long-Term Care Initiative
April 16, 2002—Assisted Living Reexamined: Developing Policy and Practices to Ensure Quality Care
May 20, 2002—Schemer, Scammers, and Sweetheart Deals: Financial Predators of the Elderly

May 23, 2002—Settling for Silver in the Golden Years: The Special Challenges of Women in Retirement Planning and Security
June 20, 2002—Long-Term Care Financing: Blueprints for Reform
July 9, 2002—Buyer Beware: Public Health Concerns of Counterfeit Medicine
July 18, 2002—Identity Theft: The Nation's Fastest Growing Crime Wave Hits Seniors
September 4, 2002—The Image of Aging in Media and Marketing
September 19, 2002—Disease Management and Coordinating Care: What Role Can They Plan in Improving the Quality of Life for Medicare's Most Vulnerable?
September 26, 2002—Faces of Aging: Personal Struggles to Confront the Long-Term Care Crisis

FIELD HEARINGS

May 30, 2001—The Vaccine Vacuum: What Can Be Done To Protect Seniors?, Portland, OR
August 9, 2001—Our Greatest Generation: Continuing A Lifetime of Service, Indianapolis, IN
August 27, 2001—The High Cost of Prescription Drugs, Jefferson City, MO
February 11, 2002—Emergency Preparedness For the Elderly and Disabled, New York, NY
July 2, 2002—High-Tech Medicine: Reaching Out To Seniors Through Technology, Pocatello, ID
August 8, 2002—Retirement Security and Corporate Responsibility, Indianapolis, IN
August 15, 2002—Healthy Aging and Nutrition: The Science of Living Longer, Baton Rouge, LA
August 15, 2002—Expanding And Improving Medicare: Prescription Drugs: An Oregon Perspective, Beaverton, OR
August 23, 2002—Planning For Retirement Promoting Security and Dignity of American Retirement, Boise, ID

FORUMS

May 29, 2001, May 30, 2001, May 31, 2001, and June 1, 2001—The National Family Caregiver Support Program Its Impact on Idaho

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