Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

THE OLDER AMERICANS ACT

I. Overview of the Older Americans Act

The Older Americans Act (OAA)is the major source of federal support for planning, advocating, and delivering services for older persons. It serves older persons regardless of income level, but specifies special targeting to those in the greatest economic and social need. With the exception of Title V, it is administered by the Administration on Aging (AoA) of the Department of Health and Human Services.

The Older Americans Act (OAA) became law in 1965, the same year as passage of Medicare and Medicaid. These programs have grown considerably since their inception. This growth has accompanied the development of an "aging network" of state, sub-state, and private agencies planning for and delivering services authorized under the OAA. Today, these services are funded in the amount of $1.3 billion annually.

The OAA sets forth an ambitious set of goals in the areas of income security, health care, community services, employment, housing, and research, among others. Major contributions have been made in the areas covered under the OAA's two principal operating titles: social and nutritional services (Title III) and older worker community employment opportunities (Title V).

Title III: Grants for State and Community Programs on Aging

This provision supports the state and area agencies on aging. In addition to those subtitles described below, Title III also funds disease prevention and health promotion activities and provides targeted funds expressly for services for the frail elderly.

Title III-B: Supportive Services and Senior Centers. Priority services include **access** activities, such as transportation, outreach, information and assistance, and case management; **in-home services**, such as homemaker and home health aide, visiting and telephone reassurance, chore maintenance, and supportive services for families of victims of Alzheimer's and related diseases; and **legal assistance**. Area agencies may also use Title III-B funds for the operation and capital expenses of senior centers. Other allowable uses include home repair and modification, employment counseling, and crime prevention.

Title III-C: Nutrition Services. This subtitle provides funding for congregate meals and home-delivered meals, or "meals on wheels." In 1993, nearly 135 million congregate meals were provided to 2.5 million people in senior centers, churches, and other community locations. Nearly 106 million home-delivered meals were served to 825,000 disabled homebound elderly persons in 1993. About half the beneficiaries of the meals programs are low income. Meals program participants contributed $150 million in voluntary payments in 1993. Total funding in fiscal year 1993 was almost $453 million.

Title IV: Training, Research, and Discretionary Projects and Programs

This title supports a wide range of demonstration projects, as well as training

and research. For example, AARP's Legal Hotline program currently receives partial funding under this title. The Assistant Secretary for Aging awards these funds.

Title V: Senior Community Services Employment Program (SCSEP)

This subsidizes part-time community service jobs for unemployed, low-income persons 55 years of age or older. SCSEP is the only direct job creation program for older persons. The program is funded by the Department of Labor, which awarded grants to 10 national organizations. SCSEP supported 65,200 jobs in the 1992-93 program year and placed over a quarter of its clients in private sector, unsubsidized jobs.

Title VI: Grants for Native Americans

Providing supportive and nutrition services for older Native Americans and Native Hawaiians, the Assistant Secretary for Aging awards funds from this title directly to tribal and Native Hawaiian organizations.

Title VII: Vulnerable Elder Rights Protection Activities

Services include long-term care ombudsman programs; programs to prevent elder abuse, neglect, and exploitation; elder rights and legal assistance; and outreach, counseling, and assistance programs to help individuals access and receive public and private insurance benefits.

II. Overview of Major Issues and Policy Considerations

The principal policy issues under the OAA have long centered on the delivery of services, eligibility for services, and the financing of services.

Delivery of Services. The major service delivery development under the OAA has been the creation of the aging network. Initially, the OAA led to the establishment of the U.S. Administration on Aging in Washington and the state units on aging, which were responsible for dispensing modest amounts of grant money to community groups for services. Major amendments in 1972 mandated the establishment of sub-state area agencies on aging throughout the country now numbering nearly 700. The creation of these agencies and modestly growing budget increases under the OAA led, in turn, to the involvement of thousands of service providers or so-called vendor agencies. The "aging network" thus consists of agencies extending from the federal government down to the state, sub-state, and community level. It has proven to be an important presence not only in social service delivery but also in advocacy activity on behalf of older persons at each of these different levels. The popularity of OAA services and the presence of the aging network were instrumental in preventing the OAA from being consolidated in a social services block grant during the early years of the Reagan Administration.

Eligibility for Services. Under the OAA, all persons over the age of 60 are formally eligible for services. No means-test to determine the income and assets of recipients has ever been imposed, except in the Title V employment program. However, because the OAA expenditures are limited by fixed appropriation levels (unlike open-ended "entitlement" programs, such as Social Security and Medicare), there has never been money sufficient to help all of those who might wish to be served. Several administrative tools have been put in place to deal with this dilemma. For nearly twenty years, OAA benefits have been "targeted" within a mandated funding formula to different groups within the overall older population: the socially and economically disadvantaged, members of minority groups, rural

elders, and, more recently, functionally impaired elders.

Financing of Services. Because the need for services is growing and federal appropriations for the OAA are not, states are trying to come up with ways to stretch resources. One way has been to solicit contributions from program participants. At meal sites and elsewhere, this is done on a voluntary basis. The federal government and states are also actively considering adding a "cost-sharing" provision to the OAA, whereby service recipients would pay for a portion of the service costs on a sliding scale based on their self-declared income. This method is widely used in the Medicaid 'waiver' and state-only community-based care programs, but has not yet been permitted under the OAA.

III. Assessment Of The Current Situation

Brief Background History. The OAA has gone through four fairly distinct stages since in its enactment: (1) fragile beginnings; (2) explosive growth; (3) program consolidation; and (4) partial integration into the arena of home and community-based services. During the OAA's first five years, appropriations were extremely modest, and by the time of the White House Conference on Aging in 1971, there was some talk of actually rescinding it. However, in the wake of that White House conference, expenditure grew rapidly, rising from $20 million in 1971, to $212 million in 1973, to $551 million in 1977, and to $951 million in 1981. During this same period, area agencies on aging also expanded nationwide. Consolidation occurred during the 1980s, with the network being more established and its operations more focussed and localized.

The fourth phase, beginning in the late 1980s, has seen the involvement of

aging network agencies in service delivery emphasizing community-based long-term care. The growth in the very old population has forced greater attention of functional limitations and cognitive impairments, problems that increase with very advanced age. Today, the aging network is more focused than ever on these issues, and a growing number of network agencies are also administering Medicaid and state-only dollars used to fund community-based long-term care services. For the OAA and the network, the change in service emphasis is subtle but nonetheless important. Whereas 20 years ago, the principal program under the OAA was based on assisting older persons living in their own homes access the community. Today, the emphasis is on allowing older persons to remain in their own homes rather than be placed in more expensive and less desirable institutional settings.

Review of Resources. Materials about the OAA and the aging network can be found from those network agencies themselves; indeed, these agencies themselves are to serve as resources. Two principal trade associations of network agencies are the National Association of State Units on Aging (NASUA) and the National Association of Area Agencies on Aging (N4A). Different provider interests also have national organizations, such as the National Association of Meal Programs. Area agencies are to serve as "focal points" and resource centers in their respective planning and service areas.

III. Projections For The Future

Assessment of Resources to Meet Expected Needs. In light of the 1994 Congressional elections, the OAA and the aging network may be facing a turbulent future. Efforts to consolidate a number of social programs and create a small number of block grants may include or impact upon the OAA. If so-called

"functional block grants" are established, a population-based law such as the OAA could, in theory, virtually disappear, with its components being placed into generic services programs such as transportation, legal assistance, home care, and nutrition. However, the creation of an "aging services block grant" could lead to expansion of the OAA, as authorizations were placed in a more broadened "OAA" function.

What does seem certain is that the OAA will continue to concentrate efforts on behalf of the seriously impaired elderly. Such a focus would not be intended to deny the needs of concerns of younger and healthier older Americans, but would be placing limited resources where they are seen as the most essential. Programs designed for the more able old will increasingly need to generate support from their local communities and from the private sector.

Opportunities for Future Public and Private Programs. For the foreseeable future, the government role in aging and other social arenas will not be an expansive one, and there will be a continuing emphasis on targeting benefits where they are deemed to be most critical. The OAA has grown over the years and has provided a broad range of services to many older persons. The presence and resilience of an "aging network" has been noteworthy as cutbacks have occurred in numerous other program areas. Indeed, advocates for other vulnerable populations--children and the mentally ill, for example--have openly envied the aging network and have occasionally attempted to create such networks in their own arenas, but only with limited success. In fact, one doubts that even an OAA or an aging network would be created from inception today, but the capacity that has grown over the years has made the network both a durable presence in the world of social services.

Because the prospects for expanded public programs are dim (and the problems they address continue to grow), there will be renewed emphasis on support from the private sector, from individual older persons, and from their families. These trends stem, in part, from the increased number of economically secure elderly because of a new emphasis on self-reliance in American political discourse. We can be sure that many of these elders will be asked to cover more of their own needs, whether it be for OAA-like services or for health care. Cost-sharing in the form of higher premiums, co-payments, deductibles, user fees, and contributions seem certain to be part of the future. How extensive they are and how deeply they cut are matters to be watched with great care.

BACKGROUND PAPER FOR DELEGATES

MEDICARE

I. Overview of Major Issues and Policy Considerations

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

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

II. Assessment of the Current Situation

Medicare serves those most in need of medical care--the elderly and disabled.

It remains one of the most popular federal programs, changing little in its first 29 years. But this important program also carries a substantial price tag. Spending in 1995 will total about $176 billion for 36 million enrollees, 90 percent of whom are aged 65 and above. Altogether, these expenditures account for over 18 percent of total spending on health services in the U.S., making the program of interest well beyond the concerns of beneficiaries alone.

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

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

Strong opposition to a public program by groups such as the American Medical Association meant that most of the attention was devoted to allaying fears about government control. Consequently, the rules established to govern Medicare did little to disrupt or change the way that health care was practiced or financed in the United States. And Medicare statutes specifically assured free choice of provider and no interference in the routine practice of medicine. Payment rates were designed to resemble those in the private sector, both in the mechanics and the level of payment. Physician and other provider groups that participated in the new program at least would not be put at a disadvantage.

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

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

Since 1980, Medicare has been, each year, a major focus of budget reduction efforts. While many of these changes have concentrated on reducing payments to providers, some reductions have also affected beneficiaries. Most recently, as part of the 1993 budget reduction efforts, Medicare was cut by $56 billion. Thus far, these cuts have put off the projected exhaustion of the Part A Trust Fund for more than 10 years by major cost-cutting efforts and an increase in the wage base subject to taxation. In the early 1980s, the demise of the Part A Trust Fund was predicted for 1990. Policy changes have successfully pushed back that date. Nonetheless, current projections put the date of trust fund exhaustion at 2004.

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

There are several reasons to expect the rate of growth of Medicare to be higher than that in the private sector over time. Both technology and the aging of the population will affect the rate of growth of Medicare expenditures, placing special demands on this program. As more people live into their 80s and 90s, the costs of Medicare will rise disproportionately. Further, improvements in technology which make procedures safer and more effective are likely to be more heavily used

by the frail for whom riskier procedures were not advisable in the past. For example, cataract, hip replacement and heart by-pass surgeries are areas where major advances have occurred and all are procedures disproportionately used by the elderly. CT scans, MRIs and other advanced imaging techniques also make care safer and more accessible for the elderly and disabled. Finally, it is important to keep in mind where we are starting from in terms of Medicare versus the private sector. In the 1990s, as employers have become more serious about costs of health care, that sector is now slowing--but it is still above payment levels in Medicare.

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

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

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

likely leads to a less efficient health care system overall as well.

Expansion of these various benefits would, however, be very expensive. For example, during the health care reform debate last year, a limited expansion of Medicare to include prescription drugs would have cost over $14 billion per year once fully implemented. It is more likely, in the present environment of fiscal restraint, to expect proposals for further reducing coverage or requiring beneficiaries to pay a greater share of the costs of their care.

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

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

Thus, there are few easy solutions to the problem of seeking a balance between protections for older Americans for their acute care costs and relief for the

federal budget from what is viewed as an enormous spending burden.

III. Projections for the Future

The Medicare program will face unprecendented challenges in the future. Current projections by the actuaries suggest that the trust fund for Part A of Medicare will be depleted by the year 2001. Although that date may slip in the next trustees' report, Medicare needs to be seriously addressed within the next two or three years. And even if ways are found to slow the rate of growth of spending on health care, the increase in the number of beneficiaries as the baby boom generation approaches retirement age will lead to further pressures after the year 2010.

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

Even if the most conservative of these numbers is the eventual target, and

even though such changes will not actually lower the absolute dollars spent each year, they will of necessity have a major effect on some part of the program. Each year Medicare grows for a number of reasons: the number of people eligible for the program rises, the proportion of beneficiaries who are sick or frail--and thus more expensive to serve--also rises, and health care inflation and the introduction of new technology also contribute to costs. While most analysts of the program could agree that improved efficiencies and moderate limits on payments to providers could likely save considerable amounts of money for the program, that will be enough to achieve the savings that some have in mind.

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

A third option is to require that beneficiaries pay more of the costs of their care, usually through higher deductibles and copayments. For example, an increase in the Part B premium could be required--either across the board or targeted only on those with higher incomes. Deductibles or cost sharing requirements could be raised. The Part B deductible, which is now just $100, is one likely candidate for an increase. Home health services, which now have no copayment required, are

often listed as an area for adding cost sharing. The problem is that some of these changes would substantially increase the already high out-of-pocket burdens on the elderly. And some, such as home health copayments, would fall especially hard on the most vulnerable older Americans. Implicitly, proposals to give vouchers to beneficiaries with very strict limits on adjustments for higher costs over time are often another way to pass on higher costs to beneficiaries who would have to supplement the vouchers with additional funds in order to find viable insurance.

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

Finally, if we are serious about major, long term reductions in spending of the magnitude discussed above, we would have to find ways to rein in the use of new technology and reduce the growth in service use in addition to any other

changes. One strategy might be to restrict what services are covered or under what circumstances they will be reimbursed. This could either be done by the government or by managed care systems if we require all Medicare patients to go into such arrangements. While putting Medicare patients into HMOs has some appeal since it leaves the hard decisions to the private sector, it also has a number of disadvantages as well. Thus far, Medicare's experience with HMOs does not suggest real savings, largely because these organizations have attracted healthy patients and Medicare has often paid HMOs too much for them.

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

BACKGROUND PAPER FOR DELEGATES

MEDICAID

I. Overview of Major Issues and Policy Considerations

Designed initially to provide health benefits for welfare recipients, Medicaid's role has steadily expanded over the past three decades. It now serves as this nation's primary health insurance program for low-income families and finances acute and long-term care for low-income elderly and disabled people. Shouldering different responsibilities for each of these vulnerable population groups, Medicaid plays three essential roles for elderly people. First, Medicaid makes Medicare work for low-income elderly people by paying the premium and cost-sharing requirements under Medicare. Second, Medicaid provides coverage of medical benefits that Medicare does not cover, such as prescription drugs. Third, Medicaid stands alone as virtually the only public source of financial assistance for long-term care.

An integral part of the U.S. health system, Medicaid provided coverage for 32 million Americans, including almost 4 million elderly people, in 1993. At a cost of $125 billion, Medicaid has become a major budgetary commitment for both the federal and state governments. Medicaid spending represents a small (6 percent) but growing fraction of total federal outlays of $1.5 trillion in FY 94. In comparison, Medicare accounted for $160 billion, or 11 percent of federal outlays. Medicaid is, however, one of the largest single items in state budgets, accounting for 13 percent of state spending in 1993.

The Medicaid program, however, is at a crucial point in its history and the program's current role for elderly beneficiaries may be threatened as the Congress looks to Medicare and Medicaid to achieve significant reductions in federal spending. Efforts to reduce the federal budget deficit will create enormous pressure to limit federal Medicaid spending. Over the next 5 years, Federal Medicaid spending is projected by CBO to grow between 10 and 11 percent per year. The recent escalation in Medicaid costs combined with calls to reduce public spending have fueled discussions of major restructuring of this program. Proposals for reform typically include placing limits on federal financial obligations and increasing state flexibility in program design and operation. If enacted these reforms could substantially alter the structure, operation, and financing of Medicaid with major implications for the elderly people it serves.

II. Assessment of the Current Situation

Authorized under Title XIX of the Social Security Act in 1965, as companion legislation to Medicare, Medicaid is a means-tested entitlement program that is jointly financed by the federal and state governments. States run the program within federal guidelines. Because the states have made very different decisions related to coverage and spending, Medicaid is really 51 separate programs (the 50 states and D.C.). There is substantial variation across the states in who is covered, what benefits are offered, how services are delivered, and how much is spent for care. The federal government pays 50 to 79 percent of the costs, depending on a state's per capita income.

Increasingly called upon by policy makers to fill gaps in private sector coverage, Medicaid covered 16.1 million low-income children, 7.4 million low-

income adults, 4.9 million blind and disabled persons and 3.7 million elderly persons in 1993. Because the populations served by Medicaid are quite different in their health needs, there is substantial variation in use of services and Medicaid spending across groups. Although low-income families account for the majority (73 percent) of beneficiaries, they account for about one quarter (27 percent) of overall spending. In contrast, the elderly comprise only 12 percent of Medicaid's beneficiaries, but 28 percent of total expenditures. The disabled account for the remaining 16 percent of Medicaid beneficiaries and comprise the largest share (31 percent) of Medicaid spending. Disproportionate share hospital (DSH) payments, intended to assist hospitals serving a high volume of indigent patients, account for 14 percent of Medicaid spending.

The higher level of Medicaid spending per beneficiary associated with the elderly ($8,500) -- about eight times greater than spending for children ($1,100) and five times greater than spending for low-income adults ($1,800) -- is primarily related to their more intensive use of services, primarily nursing home care. Of the $31 billion Medicaid spent in 1993 on the elderly, almost three-quarters (73 percent) went to long-term care services.

Eligibility

Elderly people can become eligible for Medicaid in three ways. First, elderly people who are poor enough to qualify for cash assistance under the federal Supplemental Security Income (SSI) program are generally eligible for Medicaid. The link to this federal program provides a nationwide floor of eligibility for the elderly and disabled at about 75 percent of the federal poverty level, or $5,663 for a single elderly person in 1995. In 1993, 1.6 million elderly beneficiaries qualified

for Medicaid assistance through SSI eligibility. These "categorical" beneficiaries are entitled to coverage of acute and long-term care services. This includes Medicare premiums, cost-sharing, and additional services covered under state Medicaid programs such as prescription drugs, hearing and vision care, and dental care.

A second pathway to eligiblity is known as "spend-down." These medically-needy persons have incomes above cash welfare assistance levels, but incur expenses for health care services that exceed a defined level of income and assets. Thirty-six states offer medically needy programs, which are optional under Medicaid. Many elderly people who require nursing home assistance are able to qualify for Medicaid because the high cost of nursing home care depletes their financial resources.

A third group of Medicaid beneficiaries are eligible through the Qualified Medicare Beneficiary (QMB) program. Enacted as part of the Medicare Catastrophic Coverage Act of 1988, the QMB program provides poor elderly and disabled Medicare beneficiaries assistance with Medicare premiums and cost-sharing requirements, but not the full range of Medicaid benefits. Elderly people with incomes between 100 and 120 percent of poverty are also eligible for Medicaid assistance with Medicare premiums only. A total of 2.1 million elderly Medicaid beneficiaries qualified for coverage through the medically needy and QMB provisions.

Despite the protection that Medicaid would provide, less than one third of the poor elderly have Medicaid to supplement Medicare and less than half (42 percent) of elderly people eligible for QMB assistance actually participate in the program.

Enrollment barriers, lack of awareness and understanding of the program, limited outreach activities by federal and state governments, and reluctance to apply for help from a welfare program all contribute to low levels of participation.

In addition, Medicaid's protection does not generally reach the near-poor elderly. Less than 10 percent of elderly with incomes between 100 and 200 percent of the federal poverty level, have Medicaid. As a result, despite greater health care needs, the poor and near-poor elderly are much more likely than those with higher incomes to rely solely on the Medicare program and be at greater risk for uncovered health expenses.

Payments for Acute Care Services

Although almost all elderly people have Medicare to cover basic medical services, including hospital and physician care. However, gaps in Medicare's coverage and its financial obligations for the Part B premium and cost-sharing requirements can limit access to care and place severe financial burdens on low-income elderly people. In 1995, Medicare's cost-sharing requirements include a hospital deductible of $716 per stay, a deductible of $100 per year for Part B services, and 20 percent cost sharing for physician and other medical services. Medicare's Part B premium for 1995 is $533.20 per year.

Because low-income elderly people are less likely to have access to or be able to afford private "Medigap" coverage or retiree health benefits that are typically found among higher income elderly, they are more vulnerable to Medicare's gaps in coverage. Moreover, low-income elderly people may be unable to afford uncovered Medicare services, such as prescription drugs, vision and hearing services, and dental care. Low-income elderly are more likely than their higher-income counterparts to have poorer health status and suffer from chronic conditions, such as diabetes and hypertension. Management of these conditions in an appropriate manner often requires ongoing medical treatment, including prescription drugs and regular monitoring. By covering Medicare's financial requirements, Medicaid makes it possible for low-income elderly to

participate in Medicare.

Payments for Long-Term Care Services

Medicaid is essentially the only public financing program for long-term care services for elderly people who have physical and cognitive limitations that impede their ability to live independently. In 1993, over $100 billion was spent on long-term care, with $75 billion spent on nursing home care and $33 billion on care in the community. Medicaid pays for half of institutional care and about twenty percent of community-based long-term care. Private payments, primarily out-of-pocket spending by the elderly and their families, comprise most of the remainder. Private insurance covers less than 1 percent of total nursing home expenditures.

Less than 5 percent of elderly people have private long-term care insurance. The relatively low penetration of private long-term care policies among the elderly is attributable to two factors. First, premiums can be extremely costly for people who are already 65 and older living on fixed incomes, ranging from $650 to $4200 per year depending on the age when purchased. Second, many elderly people are prohibited from purchasing private long-term care insurance because of a pre-existing condition or disability.

Medicare was not designed to be a long-term care program and provides only minimal long-term care services. Medicare covers less than 10 percent of total nursing home expenditures. It now accounts for over one-third of total home health expenditures, largely as a result of increased use of the home health benefit. Custodial or personal care services are generally not covered by Medicare. Medicaid fills these gaps.

Medicaid plays a fundamental role for institutionalized elderly people. Often in nursing homes due to severe physical or cognitive limitations, nursing home residents tend to be over 80, female, and without a spouse in the community. Most have few choices available to them, and the need for continuous care and monitoring makes remaining in the community unaffordable and impractical.

Nursing home care is expensive, with annual costs ranging from $30,000 to $50,000 or higher in some areas of the country. Regardless of whom it affects, nursing home care is a

catastrophic expense that is likely to impoverish most middle and lower-income persons. Although Medicaid plays an essential role in helping elderly people pay for care, it is a means-tested program. Unlike insurance, it provides assistance only when financial resources are exhausted. An elderly person must deplete almost all of their assets and apply all of their income, except for a small personal allowance, toward the cost of nursing home care before Medicaid will pay for services.

Medicaid's coverage of people in nursing homes is one of its most important and controversial roles. Because the means-tested program is almost always the sole alternative to spending personal funds for nursing home care, some higher-income persons receive assistance by transferring their resources to establish eligibility. Although this situation has attracted a great deal of attention, the magnitude of this phenomenon is not well documented. In the absence of adequate private financing alternatives, setting appropriate limits on Medicaid's ability to help individuals and families with long-term care will continue to be a source of tension in program policy and spending.

Medicaid has increasingly played an important role in covering community-based services for the elderly population with disabilities. Medicaid pays for skilled home health care in all states and 22 states have elected to cover the optional benefit of personal care in the home. Through home and community-based waivers, states have been able to tailor programs to more appropriately meet the health and social needs of their elderly and disabled populations. Many states have implemented innovative programs to deliver coordinated community services to foster independence and provide an alternative to nursing home care, but most programs are small in scope and serve only a small number of frail elderly. In 1993, Medicaid spent $2.8 billion on these innovative programs under home and community-based waivers.

Finding ways to stimulate the development of home and community-based alternatives will continue to be a pressing challenge in Medicaid. Although the share devoted to home and community-based services has been steadily increasing, Medicaid spending on long-term care continues to be directed primarily toward nursing home care. Of total Medicaid long-term care spending in 1993, $6.8 billion (15 percent) went toward community-based care, with most states spending between 5 and 25 percent. Four states--Oregon, Vermont, Wyoming, and West

Virginia--spend over 25 percent of Medicaid long-term care dollars on community-based services, but they are the exception, rather than the rule. Despite the desire among the public and policy makers to expand community-based services, these alternatives are not always available or viable for some elderly people and consequently nursing home care is needed.

III. Future Issues

The major issue facing Medicaid is how to continue to provide coverage for acute and long-term care for the low-income and vulnerable populations who rely on this program in the face of intense pressure to limit public spending. Medicare and Medicaid will be viewed as key sources of federal budgetary savings, particularly if Social Security and defense spending are excluded from consideration. It will be difficult to achieve significant levels of savings within the Medicaid program without affecting long-term care benefits for the elderly who account for 28 percent of Medicaid spending.

The drive to limit public spending is likely to force difficult choices in the Medicaid program between covering low-income children, the disabled, and elderly people. Faced with the prospect of large budget cuts at the federal level, states will be under severe fiscal pressure to limit expenditures under Medicaid. Some states might, for example, restrict eligibility, reduce covered services, or lower provider payments. They may be forced to make choices that adversely affect the elderly, such as eliminating the optional Medically Needy program, scaling back coverage of prescription drugs, reducing the availability of community-based long-term care, or tightening eligibility requirements for nursing home care.

At the federal level, policy makers are likely to examine a range of options to control federal obligations under Medicaid, including strategies such as caps on spending growth and block grants. Depending on how they are structured, these alternatives could have substantial implications for Medicaid's ability to provide coverage to currently eligible populations, as well as shift more fiscal pressure to the states. In addition, because current Medicaid programs differ so dramatically across states, a uniform national approach to spending reductions could exacerbate longstanding inequities in the levels of federal financing across states.

Establishing a federal block grant to the states for all or part of Medicaid could end the

OK to discuss block grants? Many states

entitlement nature of Medicaid for low-income families and elderly and disabled people and erode federal protections for these vulnerable groups. It would result in a massive program restructuring and shift historical responsibility for the elderly served by Medicaid away from the federal government. Under a block grant, states would receive less federal funds over time, but have increased flexibility to design and operate their programs. This alternative would eliminate the matching incentives for states to spend money under Medicaid. States would have greater latitude to determine which population groups and what services to cover, but would not receive additional federal support by spending more state dollars. Moreover, unless maintenance-of-effort rules were established and mandated, states would not be required to maintain current levels of spending.

Although states have expressed a desire for more flexibility in operating their Medicaid programs with regard to both acute and long-term care, it is not clear that greater leeway would enable states to achieve the cost-savings necessary to offset the reduction in federal funds without cutting back on eligibility or services. A block grant that combines both acute care for the nonelderly population and long-term care for the elderly and disabled is likely to cause substantial conflict as groups with diverse needs compete for scarce dollars. States will increasingly face difficult choices between covering poor children for basic health insurance and covering elderly and disabled people whose more intensive acute and long-term care needs are more expensive on a per capita basis.

Another important issue regarding the restructuring of Medicaid is the role of managed care. This approach has been viewed as holding the potential for cost savings, although its ability to accomplish substantial savings in the Medicaid program remains unclear. To date, this approach has focused primarily on women and children in low-income families, a population group that is relatively healthy and low-cost. Experience with managed care for the elderly population is limited. However, the higher proportion of Medicaid dollars going towards care for elderly and disabled beneficiaries means that states are increasingly likely to explore managed care for these population groups. Setting appropriate capitation rates is difficult because little is known about risk-adjustment for older persons with high rates of chronic illness and disabilities. Managed care plans have limited experience providing care to these populations and coordination of care for beneficiaries who are eligible under both Medicaid and Medicare presents

administrative difficulties.

The separate financing streams for acute and long-term care will continue to lead to cost-shifting between the Medicare and Medicaid programs and create stumbling blocks for efforts to improve care coordination and delivery for elderly people. As long as the federal/state Medicaid program has primary responsibility for long term care and the federal Medicare program is the primary payer for acute care services for the elderly, services will remain poorly coordinated. Financial incentives to churn frail elderly patients back and forth between hospitals and nursing homes will continue and adversely affect the delivery of appropriate levels of care.

Medicaid's role for the elderly could also be affected by changes to Medicare. If federal policy makers increase beneficiary financial requirements under Medicare, Medicaid assistance will be especially critical to assure that low-income elderly do not face severe financial burdens or suffer reduced access to care. However, Medicaid financing of Medicare gap-filling assistance could be in jeopardy if the Medicaid program is restructured or spending is reduced.

In the midst of ongoing budgetary discussions surrounding Medicaid and its restructuring, it is important not to lose sight of the vital role that Medicaid plays and recognize that serious gaps in coverage of long-term care have yet to be addressed. Medicaid has proven to be a critical program in serving the nation's poorest populations. For the elderly, its importance cannot be overstated. However, Medicaid is under increasing fiscal pressure as the federal and state governments reexamine their roles and responsibilities in financing and delivering care for vulnerable populations. Cuts in Medicaid spending, program restructuring, and changes to Medicare benefits all put millions of elderly Americans at risk.

BACKGROUND PAPER FOR DELEGATES

MEDICARE

I. Overview of Major Issues and Policy Considerations

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

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

II. Assessment of the Current Situation

Medicare serves those most in need of medical care--the elderly and disabled.

It remains one of the most popular federal programs, changing little in its first 29 years. But this important program also carries a substantial price tag. Spending in 1995 will total about $176 billion for 36 million enrollees, 90 percent of whom are aged 65 and above. Altogether, these expenditures account for over 18 percent of total spending on health services in the U.S., making the program of interest well beyond the concerns of beneficiaries alone.

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

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

Strong opposition to a public program by groups such as the American Medical Association meant that most of the attention was devoted to allaying fears about government control. Consequently, the rules established to govern Medicare did little to disrupt or change the way that health care was practiced or financed in the United States. And Medicare statutes specifically assured free choice of provider and no interference in the routine practice of medicine. Payment rates were designed to resemble those in the private sector, both in the mechanics and the level of payment. Physician and other provider groups that participated in the new program at least would not be put at a disadvantage.

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

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

Since 1980, Medicare has been, each year, a major focus of budget reduction efforts. While many of these changes have concentrated on reducing payments to providers, some reductions have also affected beneficiaries. Most recently, as part of the 1993 budget reduction efforts, Medicare was cut by $56 billion. Thus far, these cuts have put off the projected exhaustion of the Part A Trust Fund for more than 10 years by major cost-cutting efforts and an increase in the wage base subject to taxation. In the early 1980s, the demise of the Part A Trust Fund was predicted for 1990. Policy changes have successfully pushed back that date. Nonetheless, current projections put the date of trust fund exhaustion at 2004.

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

There are several reasons to expect the rate of growth of Medicare to be higher than that in the private sector over time. Both technology and the aging of the population will affect the rate of growth of Medicare expenditures, placing special demands on this program. As more people live into their 80s and 90s, the costs of Medicare will rise disproportionately. Further, improvements in technology which make procedures safer and more effective are likely to be more heavily used

by the frail for whom riskier procedures were not advisable in the past. For example, cataract, hip replacement and heart by-pass surgeries are areas where major advances have occurred and all are procedures disproportionately used by the elderly. CT scans, MRIs and other advanced imaging techniques also make care safer and more accessible for the elderly and disabled. Finally, it is important to keep in mind where we are starting from in terms of Medicare versus the private sector. In the 1990s, as employers have become more serious about costs of health care, that sector is now slowing--but it is still above payment levels in Medicare.

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

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

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

likely leads to a less efficient health care system overall as well.

Expansion of these various benefits would, however, be very expensive. For example, during the health care reform debate last year, a limited expansion of Medicare to include prescription drugs would have cost over $14 billion per year once fully implemented. It is more likely, in the present environment of fiscal restraint, to expect proposals for further reducing coverage or requiring beneficiaries to pay a greater share of the costs of their care.

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

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

Thus, there are few easy solutions to the problem of seeking a balance between protections for older Americans for their acute care costs and relief for the

federal budget from what is viewed as an enormous spending burden.

III. Projections for the Future

The Medicare program will face unprecendented challenges in the future. Current projections by the actuaries suggest that the trust fund for Part A of Medicare will be depleted by the year 2002. Although that date may slip in the next trustees' report, Medicare needs to be seriously addressed within the next two or three years. And even if ways are found to slow the rate of growth of spending on health care, the increase in the number of beneficiaries as the baby boom generation approaches retirement age will lead to further pressures after the year 2010.

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

Even if the most conservative of these numbers is the eventual target, and

even though such changes will not actually lower the absolute dollars spent each year, they will of necessity have a major effect on some part of the program. Each year Medicare grows for a number of reasons: the number of people eligible for the program rises, the proportion of beneficiaries who are sick or frail--and thus more expensive to serve--also rises, and health care inflation and the introduction of new technology also contribute to costs. While most analysts of the program could agree that improved efficiencies and moderate limits on payments to providers could likely save considerable amounts of money for the program, that will not be enough to achieve the savings that some have in mind.

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

A third option is to require that beneficiaries pay more of the costs of their care, usually through higher deductibles and copayments. For example, an increase in the Part B premium could be required--either across the board or targeted only on those with higher incomes. Deductibles or cost sharing requirements could be raised. The Part B deductible, which is now just $100, is one likely candidate for an increase. Home health services, which now have no copayment required, are

often listed as an area for adding cost sharing. The problem is that some of these changes would substantially increase the already high out-of-pocket burdens on the elderly. And some, such as home health copayments, would fall especially hard on the most vulnerable older Americans. Implicitly, proposals to give vouchers to beneficiaries with very strict limits on adjustments for higher costs over time are often another way to pass on higher costs to beneficiaries who would have to supplement the vouchers with additional funds in order to find viable insurance.

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

Finally, if we are serious about major, long term reductions in spending of the magnitude discussed above, we would have to find ways to rein in the use of new technology and reduce the growth in service use in addition to any other

changes. One strategy might be to restrict what services are covered or under what circumstances they will be reimbursed. This could either be done by the government or by managed care systems if we require all Medicare patients to go into such arrangements. While putting Medicare patients into HMOs has some appeal since it leaves the hard decisions to the private sector, it also has a number of disadvantages as well. Thus far, Medicare's experience with HMOs does not suggest real savings, largely because these organizations have attracted healthy patients and Medicare has often paid HMOs too much for them.

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

Trust fund?

Topics for Resolutions

Assuring Comprehensive Health Care Including Long-term Care

LTC Standards - non-forfeiture & inflation protection

1. Promotion/Prevention
1.1 Assuming personal responsibility for the state of one's health
1.2 Prevention/wellness throughout one's lifespan

2. Access to Quality Care
2.1 Maintaining personal choice and autonomy
2.2 Ensuring quality care, services, and treatment
2.3 Ensuring the availability of appropriate care, services, and treatment

3. Continuum of Care Integrating Community and Social Services
3.1 Ensuring the availability of a broad spectrum of services
3.2 Financing and providing long-term care and services
3.3 Support for caregivers

4. Medicare/Medicaid/Older Americans Act
4.1 Ensuring the future of the Medicare program
4.2 Preserving the nature of Medicaid
4.3 Providing health care coverage that addresses basic needs, prevention and chronic concerns
4.4 Providing services in a full range of locations that includes institutional care, home care/foster home care, and community based services
4.5 Allowing for a consumer-centered approach that provides choices for appropriate care
4.6 Developing alternative options for funding long-term care
4.7 Preserving the integrity of the Older Americans Act
4.8 Preserving advocacy functions under the Older Americans Act

5. Research and Education
5.1 Increased funding for research in the areas of long-term care, systems research, diseases of the elderly and special populations
5.2 Provider training in knowledge, sensitivity, and ethnic diversity
5.3 Promoting geriatric and gerontological education

Promoting Economic Security

6. Employment
6.1 Encouraging individual economic responsibility
6.2 Expanding training and employment opportunities for older workers
6.3 Removing barriers to keeping the older worker employed

7. Social Security

7.1 Keeping Social Security sound, now and for the future

7.2 Addressing special populations under Social Security

8. Other retirement income and resources, including pension reform

8.1 Providing oversight and ensuring pension solvency, portability and earlier vestment

8.2 Increased opportunities for development of individual retirement programs

9. Poverty and hunger

9.1 Expanding the coverage of existing food programs

9.2 Expanding SSI eligibility and raising the level of cash payments

9.3 Expanding programs to assess and address malnutrition

10. Tax policy

10.1 Advocating property, sales, and income tax relief for low-income persons

10.2 Enacting retirement benefit credits for caregivers who do not work, work part-time or intermittently

11. Discrimination

11.1 Educating the public about ageism and discrimination

11.2 Enforcing laws against age discrimination

Maximizing Housing and Support Service Options

12. Range of options

12.1 Designing housing to maximize independence

12.2 Revising life safety codes, zoning codes and regulations to permit alternative housing and living arrangements

13. Affordability/financing/tax policies

13.1 Expanding Federal and State housing programs

13.2 Increasing the availability of housing options through partnerships with the finance industry

13.3 Developing and maintaining efforts to reduce the impact of high energy costs on low-income older people

14. Linking support services to housing

14.1 Encouraging policies that support and reward the development of suitable and safe communities

14.2 Promoting innovative strategies to encourage new models of supportive housing, particularly housing which facilitates long-term care services

15. Consumer choice/decision-making/promoting independence

15.1 Ensuring that vital information for older persons to make decisions about housing choices is readily available

15.2 Utilizing older persons on community planning and housing design/policy-making boards

15.3 Maximizing transportation choices

Maximizing Options for a Quality Life

16. Resources for elders (community and social services/activities)

16.1 Expanding, coordinating and targeting necessary services

16.2 Using technology to facilitate access to service information and resources

17. Crime, personal safety and elder abuse

17.1 Preventing crimes against the elderly

17.2 Preventing elder abuse, exploitation, and neglect

17.3 Educating seniors about fraud

18. Spiritual well-being, ethics, values and roles

18.1 Encouraging development and ensuring implementation of advance directives

18.2 Meeting seniors spiritual needs

19. Image and roles of older people

19.1 Promoting positive images of aging by sensitizing society to the value of older adults

19.2 Supporting cooperation across the generations

20. Elders as resources and opportunities for volunteering

20.1 Acknowledging the contribution of older volunteers

20.2 Advocating for children

20.3 Issues related to grandparenting

21. Isolation and loneliness

21.1 Enhancing community participation

21.2 Meeting mental health needs

22. Legal issues

22.1 Setting ground rules for guardianship

22.2 Using the Americans with Disabilities Act (ADA)

Assuring Comprehensive Health Care Including Long-term Care

1. Promotion/Prevention

1.1 Assuming personal responsibility for the state of one's health

WHEREAS individuals make choices about the food that they eat, the physical activity/exercise in which they engage and the lifestyle they lead;

WHEREAS many health problems can be prevented or alleviated by changes in behavior, lifestyle, or treatment plan;

WHEREAS all individuals, including older individuals and their families and caregivers, need adequate information to make informed choices about lifestyles;

WHEREAS the level of information of health care providers and recipients impacts the efficiency and effectiveness of health care services;

WHEREAS cultural differences influence lifestyle choices; and

WHEREAS older adults are normally their own primary providers of health care.

THEREFORE BE IT RESOLVED THAT the WHCoA supports policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Ensure that all individuals, especially older adults and caregivers, have full access to educational programs, services and tools that will enable them to provide sufficient self care and know when to consult a medical expert;

Provide information to older adults about disease prevention, detection, chronic disease management and wellness programs;

Educate the community about the physical and mental conditions of older adults and evaluate the effectiveness of these programs;

Utilize traditional and non-traditional means as well as new technologies and innovative approaches to get information to older adults, their families and caregivers, including the frail elderly and individuals who are homebound;

Improve/increase geriatric/gerontology training of physicians and other health care providers; and

Ensure that approaches and materials are culturally sensitive.

1. Promotion/Prevention

1.2 Prevention/wellness throughout one's lifespan

WHEREAS preventive health care in all age groups leads to an improved quality of life, and reduces health care costs;

WHEREAS wide disparities exist in morbidity and mortality among Americans of various racial, ethnic and cultural groups;

WHEREAS education, consumer empowerment, chronic disease management, and wellness programs contribute to the prevention of illness, accidents, and disease;

WHEREAS good health habits established in childhood improve health over a lifespan and reduce overall health care costs;

WHEREAS retiree self-care programs have proven to decrease hospital stays, doctor visits, and health care claims;

WHEREAS our current health care system is adequately prepared to address acute care needs, but less equipped to assist seniors, and others, with chronic care concerns,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities

Extend health promotion programs to all Americans, especially older adults, and vulnerable populations, to improve overall well-being, prevent health problems, reduce health care costs, and help people cope with chronic conditions;

Shift the emphasis of our health system from illness care toward health management for people of all ages, particularly older adults, high risk, and underserved populations;

Increase access to and participation in health promotion and prevention programs that improve quality of life and reduce overall costs;

Utilize preventive medicine approaches and early detection methods such as flu shots, smoking cessation, Pap tests, mammograms, and glaucoma and blood pressure screening;

Encourage a wellness approach by emphasizing fitness programs, regular dental care, nutrition assessment and counseling, stress management, and other mental wellness services;

(1.2)

Disseminate culturally-sensitive, age-appropriate information and educational materials on medical self-care and prevention programs.

2. Access to Quality Care

2.1 Maintaining personal choice and autonomy

WHEREAS fear of dependence is of paramount concern to today's elders, the greatest fear being control over their lives by professionals;

WHEREAS seniors are often unaware of physicians who accept medicare assignment, thus limiting their choice of provider;

WHEREAS chiropractics, acupuncture, traditional native-american medicine and other alternative health care services are often desireable and effective options to standard medicine;

WHEREAS the current pool of health care providers does not adequately reflect all ethnic groups and therefore, limits a patient's options when attempting to choose a provider from like cultural background;

WHEREAS financial, informational and other barriers severly limit the options of households that include an elderly member with a health or mobility problem;

WHEREAS assistive technology promotes personal independence, increases quality of life, and lowers cost of care by reducing risks of secondary conditions,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Promote consumer-centered values such as choice, dignity, autonomy, right to take informed risks, and ability to maintain continuity of desired lifestyles through state and federal legislation;

Protect the individual's right to choose his or her own physician and to make other care plan decisions;

Disburse information regarding physicians and other health care providers who accept medicare;

Expand efforts to recruit cultural and ethnic minority physicians, pharmacists, and other health care professionals;

Recognize the benefit of non-traditional health care and promote their inclusion in medicaid, medicare and private health

(2.1)

insurance benefits to enhance patient participation in care-planning;

Allow older and disabled Americans to age in place by providing assistive devices and other home modifications through medicare and medicaid based on current eligibility standards.

evaluating feasibility and advisability of . . .

2. Access to Quality Care

2.2 Ensuring quality care, services and treatment

WHEREAS a major barrier to quality care is the lack of communication and coordination among health care professionals concerning patients' health status and treatment between settings and across time;

WHEREAS lack of coordination and communication results in overcare as well as undercare;

WHEREAS the elderly are subject to an increased risk of treatment-generated problems;

WHEREAS the trend toward large managed health care organizations is expanding,

WHEREAS funded programs often reward process goals rather than client-centered, performance-based outcomes;

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Develop the role of the care manager as a quality monitor of client services;

Implement quality assurance measures that include advocacy, evaluation, accountability, consumer feedback, and utilization of the communication highway;

Require federally funded programs to promote performance-based outcomes as measures of quality;

~~Require~~ Encourage quality review panels of managed care organizations to ~~include~~ consumers of all ages in addition to providers;

Thru ? federal HMO Act ?

~~Mandate~~ Encourage communication between providers of health care for the elderly in all phases of care, from prevention to acute and long-term care services.

2. Access to Quality Care

2.3 Ensuring the availability of appropriate care, services and treatment

WHEREAS over 40 million Americans of all ages lack health insurance coverage;

WHEREAS seniors as patients are ill-informed of their health care choices;

WHEREAS Americans age 65 and older are 10 times more likely to develop cancer than those under 65, yet less likely to be screened and get early treatment;

WHEREAS lack of information enhances fears and negative sterotypes, which act as barriers to care;

WHEREAS 34 insurance companies administer Medicare, which leads to regional inconsistencies in Medicare part B benefits;

WHEREAS increasing numbers of persons with life-long and early onset disabilities are living longer;

WHEREAS many persons with disabilities, regardless of age, have common health care needs that require access to the full continuum of health care services;

WHEREAS the elderly in rural areas and small communities have greatly limited acute and long-term care services relative to those in urban centers,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Set universal coverage as a near term goal;

Improve and expand information and referral services;

Increase availability of culturally sensitive educational materials to ensure awareness of and access to appropriate assistance for individuals of all ages with disabilites;

Ensure greater consistency in carriers' interpretation of national coverage policies;

(2.3)

Improve the availability of appropriate health care services to persons of all ages with disabilities;

Enhance access to care in all communities, particularly in rural areas, including: greater equity in provider payments through Medicare, other incentives to attract providers to rural communities, and expanding medical-related transportation services.

3. Continuum of Care Integrating Community and Social Services

3.1 Ensuring the availability of a broad spectrum of services

WHEREAS the current system for providing home and community based services is complex and fragmented;

WHEREAS there are a large number of home and community based service programs, each with their own complex set of rules and requirements;

WHEREAS current legislation and funding has an institutional bias and does not reflect the common preference of the elderly to remain in familiar surroundings;

WHEREAS the elderly visit multiple providers for health care services, which leads to conflicting treatments and over-medication with serious consequences;

WHEREAS up to 22% of older people have mental health problems which can lead to self-neglect;

WHEREAS more than one-third of older persons living alone and unable to perform one or more activities of daily living receive no help from any source;

WHEREAS public perception commonly undervalues the ability of the elderly to make changes and decisions in their own best interest,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Allow for individually-tailored care arrangements that respect personal preferences, inspire responsibility and cost-consciousness, and encourage the use of family and community support;

Ensure a continuum of services that begins with prevention education for healthier living and includes: case management, community based services, assisted living, adult day care, home care, senior centers, mental health services/counseling and institutional care;

Encourage rehabilitation and home and community-based care;

Develop and implement comprehensive coordinated community wellness models on the local level that rely on and promote

cooperative agreements between agencies;

Promote primary care through family doctors, nurse practitioners, physician assistants, and other medical professionals and para professionals, including those in managed care settings;

Coordinate state and local programs and services to reduce fragmentation and facilitate access to needed services from a single entry point based on standard intake and assessment data.

3. Continuum of Care Integrating Community and Social Services

3.2 Financing and providing long-term care and services

WHEREAS 80% of out-of-pocket catastrophic health care expenses go to nursing home costs;

WHEREAS nursing home and home care spending will reach $168.2 billion in 2018, more than double the current figure;

WHEREAS more than 5 million people will need nursing home care;

WHEREAS 3 times as many disabled elderly are likely to receive formal and informal long-term care services at home than in institutions;

WHEREAS older American Indians and Alaska Natives strongly prefer health care programs delivered by the Indian Health Service, and that system provides neither a geriatric focus nor long term care;

WHEREAS only one in five elderly persons is expected to own a private long-term care insurance policy in 2018 due to barriers which limit their desireability;

WHEREAS younger citizens will save or insure for long-term care only if there is a simple and financially sound way to do so,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Develop culturally-sensitive long-term care insurance regulations that standardize private policies to encompass home and community-based services, as well as institutional care;

Reduce the catastrophic costs of long-term care;

Pilot a community ~~based~~, long-term care, managed care project ~~that includes a voucher system~~;

Support individualized, cost-effective service arrangements through care managers;

Enhance the intergenerational appeal of private long-term care insurance through consumer protection legislation, quality assurance measures, and other incentives to buyers;

(3.2)

Stimulate personal responsibility and planning for long-term care needs;

Encourage employers to offer long-term care insurance as an employee benefit;

Change the emphasis of medicaid long-term care benefits from institutional care to preferred options such as home care, day care for adults and children, community based services and others;

Expand the strengths of the aging network in facilitating community-based long-term care through the Older Americans Act;

Allow the Indian Health Service, tribal, and urban Indian health programs to provide home and community based long-term care through Medicare and Medicaid.

3. Continuum of Care Integrating Community and Social Services

3.3 Support for caregivers

WHEREAS Americans clearly prefer home and community care over institutionalized care;

WHEREAS the lack of information regarding less costly and preferred alternatives increases the convenience of choosing institutional care;

WHEREAS informal support systems which consist of spouses, children, other relatives and friends, provide two-thirds of all long term care in the community;

WHEREAS family members are sometimes forced to leave paying jobs to care for elderly relatives;

WHEREAS the average American woman will spend 16 years caring for children and 17 years caring for an elderly relative;

WHEREAS caregivers need training in the technical aspects of geriatric care and care for disabled persons of all ages, as well as access to community services;

WHEREAS caregivers for the elderly are often elderly themselves and have few options and opportunites for respite care;
WHEREAS 4% of our nation's children are being raised by grandparents;

WHEREAS language and culture are critical to communication between older people, members of their support systems, and service providers,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Provide culturally sensitive education and support for intergenerational family caregivers through the efforts of volunteers and revenue-neutral support groups;

Ensure adequate funding and training for formal and informal providers of long-term home care services;

Provide information and referral services under Medicaid, Medicare, and the OAA through community based organizations that are sensitive to differences in language and culture;

- Expand availability and funding of respite care, including overnight and weekend services;

- Provide financial and other support services for caregiving spouses, adult children, certified volunteers and family caregivers of long-term care, and for grandparents raising grandchildren;

- Expand the Family and Medical Leave Act to encompass family caring for aging relatives and grandparents raising children.

4. Medicare/Medicaid/Older Americans Act

4.1 Ensuring the Future of the Medicare Program

WHEREAS Medicare provides near universal health insurance coverage for older people, essentially eliminating the access crisis in health care which older Americans faced up until 1965;

WHEREAS Medicare has played a critical role in providing mainstream care for the aged and disabled in the U.S., with lower administrative costs than any other health insurance program;

WHEREAS there are still gaps in coverage for preventive medicine, prescriptions, mental health services, and dental care, causing older Americans to spend 25% of their household incomes on health care, the highest of any age group;

WHEREAS the growing numbers of seniors and individuals with disabilities, increased life expectancy, and the high cost of advanced technology have been factors contributing to the rapid increase in Federal and State funds spent for health care;

WHEREAS assuring affordable quality health care for older people and addressing the Federal budget deficit and projected Medicare insolvency require making careful choices,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Encourage open and bi-partisan dialogue of critical issues and divergent views, addressing changes to Medicare in the context of change in the overall health care marketplace, to prevent cost shifting from seniors to other generations;

Continue to protect seniors, especially those on low and fixed incomes, with respect to health care affordability and access;

Analyze and carefully consider the full range of options for new revenues, as well as creative lower cost options for providing care and restructuring benefits, considering the fairness of every option and its impact on all generations;

Ensure that any savings achieved through programmatic changes be directed toward safeguarding the viability of the trust fund;

Provide objective information to the public so that it can make informed choices and rational decisions about health care.

4. Medicare/Medicaid/Older Americans Act

4.2 Preserving the nature of Medicaid

WHEREAS Medicaid is essentially the only public financing program for long-term care services for elderly people who have physical and cognitive limitations that impede their ability to live independently;

WHEREAS Medicaid pays for half of all institutional care and 20% of community-based long-term care;

WHEREAS in 1993, Medicaid covered 16.1 million low-income children;

WHEREAS there is wide variation across states in who is covered, what benefits are offered, and how much is spent for care;

WHEREAS fee payments to providers are lower than Medicare and private insurance, and already substantially limit the pool of providers who accept Medicaid;

WHEREAS the poor and near poor elderly are much more likely than those with higher incomes to rely solely on Medicare and be at greater risk for uncovered health expenses;

WHEREAS Medicaid is a safety-net for millions of vulnerable Americans of all ages including the blind, disabled, members of families with dependent children, and persons who have become impoverished by excessive medical and long-term care payments,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Maintain federal protections for vulnerable groups;

Preserve the Qualified Medicare Beneficiary program which provides assistance with premiums and cost-sharing requirements for the poor elderly and disabled;

Prevent competition for scarce dollars among intergenerational groups with diverse needs by ensuring that acute care for the nonelderly population is not combined with long-term care for the elderly and disabled in block grants to states;

Further the study and implementation of managed care as a cost saving option for health care delivery to vulnerable populations of all ages;

Stimulate the development of home and community-based, lower cost alternatives to institutional care;

Prevent the impoverishment of caregiving spouses of Medicaid recipients of home and community-based services.

Explore innovative options to expand the pool of providers.

4. Medicare/Medicaid/Older Americans Act

4.3 Providing health care coverage that addresses basic needs, prevention and chronic concerns;

WHEREAS access to health care by our nation's elderly, disabled and medically indigent has improved;

WHEREAS further cuts in fee payments to providers could reduce the pool of physicians who accept Medicare and lessen the gains in access to health care;

WHEREAS deductibles and co-payments are manageable by some but hinder access to care for others;

WHEREAS the elderly, and Americans of all ages, with means to be responsible for themselves face barriers to affordable private health care insurance;

WHEREAS many who cannot afford out of pocket expenses postpone basic preventive care, yet, preventive procedures reduce the need for higher cost acute care services;

WHEREAS baby boomers start to reach age 65 in the year 2010, when available funds will not be adequate to meet the need,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Continue to cover basic health care for the elderly and vulnerable people of all ages;

Support community rating and eliminate pre-existing conditions so that the elderly can buy private health insurance as a supplement to medicare;

Generate diverse and affordable health insurance plans which cover preventive medicine, prescriptions, vision and hearing aids, mental health services, and dental health care;

Recognize prevention as an important cost cutting measure by providing immunizations, annual Pap smears, mammograms, nutrition screening, and other proven preventive methods through Medicare and Medicaid;

Review cost cutting measures, especially differentials in payments to providers, to prevent negative effects on access to care, cost-shifting, and intergenerational conflicts;

Explore affordable health care coverage for the elderly including managed care, HMOs and other plans that encourage private sector participation and risk-sharing.

4. Medicare/Medicaid/Older Americans Act

4.4 Providing services in a full range of locations that encompasses: institutional care; home care/foster home care; community based services

WHEREAS most older Americans prefer to age in familiar surroundings;

WHEREAS institutional care is costly for both the private and public sectors, and is not an appropriate choice for all aging and disabled Americans;

WHEREAS the informal support and care which many families provide to aging members often creates great financial and emotional stress,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Continue to provide institutional care where appropriate;

Strengthen families' abilities to care for their aging members at home;

Enc. incentives
Allow older Americans and their families to choose creative alternatives to institutional care, including programs such as geriatric foster family care, adult day care, congregate housing, assisted living, respite care, and group homes;

Ensure that community based services such as nutrition/meals programs take medical, social, and cultural needs into consideration, including diabetic, low-fat, low-salt diets, and kosher meals;

Safeguard community based services as a cost-effective alternative to institutional care.

4. Medicare/Medicaid/Older Americans Act

4.5 Allowing for a consumer-centered approach that provides choices for appropriate care

What is appropriate care?

WHEREAS the American ethos values individual choice and decision-making;

WHEREAS adults are practiced in making personal decisions regarding their living arrangements, eating habits, extent of family involvement, and financial matters;

WHEREAS older people are entitled to respect for their individual autonomy and ability to make decisions;

WHEREAS Americans are ethnically and culturally diverse and individual preferences are expressed through such diversity;

WHEREAS access to information aids decision-making,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

What does this mean (?)

Employ a consumer-centered approach to health and long-term care services restructuring funding guidelines under OAA, Medicare, and Medicaid to reflect the new approach;

Encourage

~~Ensure~~ the availability of choices that offer an affordable, comprehensive range of quality mental and physical health services, and that respect cultural diversity by addressing the needs of individuals from varied backgrounds and ethnic groups;

Eliminating counseling under recession

Provide consumers with information and referral services, case management and decision counseling that enable individuals and families to make responsible choices;

Recognize and value the preferences of Americans on where they wish to live and age, and other personal concerns.

4. Medicare/Medicaid/Older Americans Act

4.6 Developing alternative options for funding long term care

WHEREAS the population of the U.S is aging such that by 2040 almost 25% will be 65 or older, 4% will be 85 or older, and the nursing home population is projected to double;

WHEREAS the cost of long term catastrophic health care is the single largest reason for personal bankruptcy;

WHEREAS the average length of stay in nursing homes is three years and 30% of residents become impoverished after six months;

WHEREAS many individuals are either unaware of available alternatives to institutional care or unable to obtain financial assistance;

WHEREAS the Indian health delivery system is the preferred health provider of older Indians, is meeting less than 50% of existing patient need, and few tribes have home or community care program funding;

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Develop affordable private and public long-term care insurance plans that free the elderly, and their families, from the fear of impoverishment;

Ensure that long-term care insurance plans include home care and community based services as well as eliminate institutional biases;

Lead to the implementation of demonstration projects that cost effectively reduce nursing home utilization, satisfy consumers, and maintain or increase quality of care;

Educate the public about current and future funding alternatives for long term care so that they can financially prepare to meet the needs of their families;

Allow Indian health programs to have full access to federally-assisted programs affecting long-term care.

4. Medicare/Medicaid/Older Americans Act

4.7 Preserve the integrity of the Older Americans Act

WHEREAS in 1994, Older Americans Act programs provided over 230 million meals, 40 million rides, 12 million responses for information and referral, 1 million care visits, and 1 million legal counseling sessions to elders who are at risk of losing their independence;

WHEREAS programs funded under the Older Americans Act have effectively reached out to elders with the greatest social and economic needs;

WHEREAS services for the aging have changed focus over the last twenty years from assisting the able elderly with community access to concentrating on the seriously impaired elderly;

WHEREAS programs designed for the more able seniors must increasingly rely on financial support from local communities, private individuals, families and corporate sponsors;

WHEREAS the number of financially independent, self-reliant elderly continues to grow;

WHEREAS each state, territory, and local community has a unique demographic composition and related concerns;

WHEREAS the number of minority elderly and their corresponding service needs are rising exponentially,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Improve targeting on all levels to serve those with the greatest economic and physical needs;

Allow states to develop intrastate funding formulas that address unique demographic factors and increase state and local flexibility;

Provide community based services (e.g. home delivered and congregate meals, personal care, information and referral, transportation, and assisted home care) on a cost share/sliding fee basis;

Heighten the sensitivity of State Units on Aging towards the needs of minority communities;

Safeguard the Older Americans Act and ensure that aging services currently funded under the Act remain together;

Appropriate funding for the Older Americans Act at a level that reflects the continued growth of the older population.

4. Medicare/Medicaid/Older Americans Act

4.8 Preserving Advocacy Functions Under the Older Americans Act

WHEREAS the Older Americans Act has supported advocacy efforts by and on behalf of older Americans;

WHEREAS the Act has led to the establishment of advocacy services at the local level including legal services, ombudsman and elder rights programs;

WHEREAS the aging network has traditionally been a strong voice for programs that affect intergenerational populations;

WHEREAS older persons critically need protection against abuse, neglect and exploitation,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Preserve the Act's focus on protecting the rights of the most vulnerable elderly;

Expand the ombudsman program;

Continue and strengthen consumer and caregiver involvement in the delivery of Older Americans Act services;

Increase the Act's emphasis on self-directed care, encouraging the greatest degree of independence and autonomy possible.

Assuring Comprehensive Health Care Including Long-term Care

5. Research and Education

5.1 Increased funding for research in the areas of long-term care, systems research, diseases of the elderly and special populations

WHEREAS research and education have contributed to the improvement of quality of life for older Americans during the past three decades;

WHEREAS past legislation has provided funding and support for research programs that have facilitated improvements in the health and well-being of older Americans;

WHEREAS biomedical research by the National Institute on Aging and other notable institutions, has contributed significantly to the diagnosis and treatment of osteoporosis, cancer, cardiovascular disease and Alzheimer's disease;

WHEREAS quality of care and cost-effective studies have been instrumental in determining services in long-term care;

WHEREAS women, ethnic minorities, and other societal groups, such as homosexuals, have been routinely excluded in aging research,

BE IT THEREFORE RESOLVED That the WHCoA support policies that:

- Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;
- Increase federal funding for outcomes based research regarding the treatment of chronic diseases such as osteoporosis, hypertension, etc.
- Promote clinical epidemiology, and health services research, such as preventive care research, malnutrition and nutrition screening and incontinence;
- Mandate quality of care and cost-effectiveness in long-term care;
- Include women and ethnic minority populations, and homosexuals, as subjects in clinical research studies;
- Increase funding substantially for mental health, Alzheimer's and other dementias;

(5.1)

- Redirect funding to increase the budget of the National Institute on Aging significantly for studies in basic biomedical, clinical, behavioral/social, and bioethics research;

Assuring Comprehensive Health Care Including Long-term Care

5. Research and Education

5.2 Provider training in knowledge, sensitivity and ethnic diversity

WHEREAS older persons have multiple health problems that require specialized knowledge and interactive skills to be dealt with effectively;

WHEREAS older minority populations receive services from providers within diverse cultures;

WHEREAS 47% of the 1.5 million nursing home residents suffer from senile and other forms of dementia;

WHEREAS many of the health problems of the elderly can be postponed or avoided by adopting a healthy life style;

WHEREAS certified nursing assistants have the most contact with nursing home residents yet are paid the least, leading to high turnover and diminished continuity of care,

BE IT THEREFORE RESOLVED that the WHCoA support policies that:

- Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;
- Provide training, education in gerontology and personal interactive skills;
- Raise the awareness of the service needs of various ethnic groups;
- Prepare long-term care staff to deal with demented and behaviorally difficult patients;
- Train providers to teach disease prevention and health promotion skills;
- Improve salary and benefit packages for certified nursing assistants and other direct service providers to reduce staff turnover and increase continuity of care.
- Provide continuing and in-service education for health care personnel including nurses, physician assistants, other professionals, paraprofessionals, and caregivers.

Assuring Comprehensive Health Care Including Long-term Care

5. Research and Education

5.3 Promoting geriatric and gerontological education

WHEREAS the growth of the older population requires a large trained personnel

WHEREAS appropriate care is a necessity for people of all ages, and for individuals with special needs;

WHEREAS few medical and nursing schools and other health related professional schools and programs provide education in geriatrics and gerontology;

WHEREAS there is a need to integrate geriatrics and gerontology into the curricula of these schools;

WHEREAS by 2040 there will be 83 million people over 65 and 17.8 million over 85;

WHEREAS projections of personnel needs in aging predict current and future shortages of appropriately trained personnel;

WHEREAS the Department of Veterans Affairs has made a distinct contribution to the training of geriatric physicians,

BE IT THEREFORE RESOLVED, That the WHCoA support policies that:

- Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;
- Increase geriatric and gerontological training in medical and nursing schools, other health professional schools and programs, continuing education and in-service programs
- Integrate geriatrics and gerontology into the curricula of health care specialty programs;
- Increase federal funding for schools and programs to teach geriatrics and gerontology;
- Establish more VA residency programs particularly at non-affiliated rural sites;
- Promote geriatric and gerontology fellowship programs in mental retardation and developmental disabilities;
- Offer scholarships with "forgiven clauses" as an incentive to studying geriatrics and gerontology.

Promoting Economic Security

IRDS 6 Employment

6.1 Encouraging individual economic responsibility

WHEREAS individuals of all ages need to know more about handling their personal finances and understand more about the national economy to participate as citizens;

WHEREAS such learning can take place in the home, school, work place and community; and

WHEREAS financial management planning is particularly important in the pre-retirement years;

BE IT THEREFORE RESOLVED, That the 1995 White House Conference on Aging supports policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Introduce into the K-12 curriculum information on the aging process, the older population and the importance of financial management and planning across the life span;

Encourage local communities to develop workshops, seminars, etc., that educate the public on the importance and "how to" of financial planning and management;

Encourage aggressive outreach programs by public and private entities at the community level to teach financial planning and management skills to populations most at risk;

Encourage employers to provide information on and assistance with financial management and retirement planning to employees;

Encourage older persons who are skilled in financial management and planning to assist charitable and non profit community groups in teaching all ages how to implement sound financial strategies;

Promote use of existing senior service programs to assist older persons with financial management and planning.

Promoting Economic Security

IRDS 6 Employment

6.2 Expanding training and employment opportunities for older workers

WHEREAS those reaching 65 in 1990 can expect to live an additional 15 years for men and almost 20 years for women;

WHEREAS today's work force has approximately 12 million workers between the ages of 55-64 and more than 80% of those born in 1965 will reach the age of 65 in 2030, representing a significant resource to American productivity;

WHEREAS women are more likely to be confined to dead end, low paying jobs with few benefits, but will need more retirement resources to extend over their greater life expectancy;

WHEREAS women are paid 70 cents for every dollar in wages earned by men;

WHEREAS technological changes continue to occur at an increasing pace in the work place and society in general; and

WHEREAS unemployed older workers remain out of work longer than younger workers,

BE IT THEREFORE RESOLVED, That the 1995 White House Conference on Aging supports policies that:

Reward, through tax credits, private sector employers who invest in the upgrading of skill and abilities of their workers, including older workers;

Encourage labor organizations to support members in life long skill development and training, which will further enhance their competitiveness in today's work place;

Encourage labor and industry to work together to develop more flexible approaches to work that provide incentives to older workers to remain in the labor force;

Encourage post-secondary educational institutions at all levels to preserve and expand programs that provide older workers and midlife women returning to the labor force opportunities to continue their education, training and skill development;

Continue support for Title V, Older Americans Act, that provides community service employment opportunities for older persons.

Promoting Economic Security

IRDS 6 Employment

6.3 Removing barriers to keeping the older worker employed

WHEREAS people who are age 55+ will constitute **29%** of the population by the year 2020, **an 80% increase, while the number of those 16-54 years of age will increase only 15%**;

WHEREAS the percentage of the work force age 55+ is expected to increase from the present level of 29.3% to 39.1% by the year 2020;

WHEREAS research shows that older workers are productive and flexible and a good investment for training;

WHEREAS corporate downsizing often results in unexpectedly high costs in severance and retiree benefit health costs, loss of skilled employees, and a loss in company morale;

BE IT THEREFORE RESOLVED, That the 1995 White House Conference on Aging support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Encourage employer recognition of the value older workers bring to the work place, both in the private and public sectors and the rewards that flow to both employer and employee from developing programs geared toward older workers;

Address inequities in the availability of training and skill development opportunities for older workers;

Encourage **minorities,** midlife and older workers and to aggressively seek greater education and training;

Encourage business and industry to develop educational programs that challenge the negative stereotypes and attitudes management/supervisors often hold towards older workers;

Broaden the insurance risk pool to reflect the general community rather than a specific company, thereby minimizing additional health insurance costs to older workers and their employer;

Promote flexible work schedules providing older workers the opportunity to decrease their level of responsibility and pay

rather than quitting, or to choose part time or flex time employment;

Encourage businesses and corporations to examine the role, function and value of older workers when downsizing and restructuring plans are considered.

Promoting Economic Security
IRDS 7 Social Security
7.1 Keeping Social Security Sound Now and for the Future

WHEREAS 1995 is the 60th anniversary of Social Security, a social insurance system that benefits American families and persons of all ages by providing economic security through intergenerational support so as to preserve the dignity and independence of beneficiaries;

WHEREAS Social Security is one of our nations' most successful and popular programs; it mandates universal participation and covers 98.5% of paid workers; since inception it has reduced the poverty rate among older persons from 33% to 12% and keeps 1 million children under age 21 out of poverty;

WHEREAS Social Security benefits are an earned right, based on wage-related contributions made by both employers and employees during one's work career;

WHEREAS Social Security is self-financing, currently has a surplus of $400 billion, and does not contribute to the deficit;

WHEREAS, as a result of the 1983 bipartisan reforms, Social Security is adequately financed for the next 25 years and only modest changes will be required to assure the program's longer term solvency; and

WHEREAS , despite its overwhelming success and popularity, there is widespread public confusion and concern about Social Security's impact on the Federal deficit, its future solvency, and the willingness of the Federal Government to maintain the program's basic structure and purpose,

BE IT THEREFORE RESOLVED, That the 1995 White House Conference on Aging support policies that:

Reaffirm the covenant that the government established with the American people 60 years ago with the passage of the Social Security Act;

Act to maintain and strengthen the program's structure and purposes, its fiscal solvency and widespread public support;

Direct the Statutory Advisory Council to the Social Security Administration, which has the responsibility to recommend policy changes to assure the program's long range solvency, to develop recommendations for public consideration that solve the long term financing problem while maintaining the program's basic structure and purpose;

Task, with adequate resources, the Social Security Administration to launch a 5 year national education campaign to provide the public with accurate information on Social Security's impact on

the Federal deficit, its long term solvency, its origins and underlying principles, and its importance to all Americans.

Promoting Economic Security

IRDS 7 Social Security

7.2 Addressing special populations under Social Security

WHEREAS Social Security is a social insurance program that protects young and midlife families, who have children under age 18, from loss of income due to the death or disability of the primary wage earner, provides income for disabled workers of all ages and provides retirement income for older workers;

WHEREAS Social Security provides 90% of the income for 15% of older couples and 37% of widowed, divorced, separated or never married older women;

WHEREAS older women, especially those 85 years old and older, are most susceptible to being in poverty;

WHEREAS minorites are proportionally more likely to live in or near poverty and more likely to have shorter life spans, thus reducing their chances of receiving benefits;

WHEREAS nontraditional families do not enjoy the right of survivorship;

THEREFORE BE IT RESOLVED, That the 1995 White House Conference on Aging support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Continue Social Security's role in protecting families and survivors of beneficiaries who die or become disabled;

Direct the Social Security Administration to examine the issues of adequacey and social equity as they apply to benefits received by women and minorites;

Explore the option of providing nontraditional families the right of survivorship.

Promoting Economic Security

IRDS 8 Other retirement income and resources, including pension reform

8.1 Providing oversight and ensuring pension solvency, portability, and earlier vestment

WHEREAS 60% of the income of individuals over the age of 65 comes from sources other than Social Security;

WHEREAS only 55% of all employees are offered pension plans by their employers, and of these workers only 43% are vested and only 25% of women who participate in a private pension plan are vested;

WHEREAS many pension plans are significantly underfunded, and the Employment Retirement Income Security Act (ERISA) of 1974, which attempts to address this short fall problem, covers less than one-third of today's workforce;

WHEREAS recent job growth has been most dramatic in the small business and service sectors of the economy, where pension plans can create hardships;

WHEREAS minorities and women are more likely face discrimination in the work place and are the most likely segment of our population to work part-time or on an intermittent basis, situations in which pensions are generally not available; and

WHEREAS pension plans are seldom transferrable, require a lengthy period of employment before vesting, and tend to be governed by complex rules and eligibility requirements,

THEREFORE BE IT RESOLVED, That the 1995 White House Conference on Aging support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Strengthen voluntary pension plans for traditional workers and create private retirement programs for service, contract, part time and intermittent workers that are transferrable and independent of employer participation;

Establish a network of voluntary, tax-favored retirement savings plans based on occupation, not specific employer;

Encourage employers who offer pension plans to provide information about benefits, options, etc. and to reduce the number of years required for pension vestment;

Examine the issue of gender, race, ethnic and language discrimination in salaries, promotions and pension benefits;

Encourage senior service organizations and community service organizations to offer assistance with retirement asset management to individuals as well as to businesses.

Promoting Economic Security

IRDS 8 Other retirement income and resources, including pension reform

8.2 Increased opportunities for development of individual retirement programs

WHEREAS retirement income should be based on a combination of Social Security, pensions and asset income;

WHEREAS less than half of the workforce is vested in pension programs and only 25% of women who participate in a private pension plan are vested;

WHEREAS the average Social Security benefit equals only 42% of one's final annual earnings;

WHEREAS only 13% of workers have Individual Retirement Accounts (IRA), 2% have Keogh-type plans and 21% have tax exempt plans separate from IRAs;

WHEREAS low participation rates in individual retirement programs can be attributed to confusion over choices, a lack of information and assistance, a misunderstanding of the effects of pretax savings on take-home pay and inability to contribute because of low wages;

WHEREAS caregivers often interrupt or reduce their employment thus impacting their ability to fund an IRA;

WHEREAS one-half of marriages end in divorce, leaving women particularly vulnerable in building retirement income;
WHEREAS retired persons frequently manage assets so conservatively thus reducing income,

THEREFORE BE IT RESOLVED, That the 1995 White House Conference on Aging support policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Encourage businesses and employers to provide workers, especially service and blue collar employees, accurate information on retirement programs available to them, the tax benefits and future security such programs provide;

Increase the amount employees can put into IRAs and raise the income limits for which tax deferred deposits can be made;

Allow the establishment of an IRA for a nonworking spouse in which contributions can be made on their behalf up to the limit allowed a working spouse and that the contributor receive the deduction for the contribution;

Encourage businesses, senior and community service organizations to provide financial and investment assistance to retirees so that they can maximize earnings from their assets;

Amend the Internal Revenue code to make the IRA tax deductible based on the pension status of the IRA owner and not his or her spouse.

Promoting Economic Security
IRDS 9 Poverty and Hunger

9.1 Expanding the coverage of existing food programs

WHEREAS the 1984 President's Task Force on Food Assistance defines hunger as being "a situation in which someone cannot obtain an adequate amount of food, even if the shortage is not prolonged enough to cause health problems;"

WHEREAS hunger is likely to precede medical and psychological symptoms of malnutrition;

WHEREAS hunger is an increasing problem across all age groups, particularly among those who are poor or near poor;

WHEREAS hunger can result from food shortages due to inadequate resources, reliance on emergency food providers,lack of access to access grocery stores, loss of appetite caused by medications, and reduced ability to prepare or ingest food;

WHEREAS in 1993, 1.5 million older persons reported they had experienced food deprivation within the last 6 months;

WHEREAS 40% of those 65 years old or older who experience hunger have incomes above the poverty level;

WHEREAS 26.4 million older persons (84.6%) do not participate in food assistance programs, yet there are thousands on waiting lists for home delivered meals,

BE IT THEREFORE RESOLVED, That the 1995 White House Conference on Aging supports policies that:

Recognize the importance of interdependence among generations and among members of extended families, the responsibility of individuals to plan for changes that will occur throughout the lifespan and the unique contributions and needs of special populations, including veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities;

Promote joint public and private endeavors to develop programs and services that address the needs of hungry citizens;

Continue congregate meal sites and increase resources for home delivered meals to enable more older persons to receive weekend delivery;

Ensure the present system of voluntary contributions for meals remains a key ingredient in achieving greater cost sharing, while at the same time maintaining **sensitivity to the needs of low income older persons and** the intent of the Older Americans Act;

Use nutrition screening tools developed by the Nutrition Screening Initiative by providers of social and health care services.

BE IT FURTHER RESOLVED, That the 1995 White House Conference on Aging opposes

Cutbacks in programs that provide food and nutrition services to any age group.