Not all sympathetic delegates.

540 Cong.
900 ~~Stds~~
15-20 WHCOAging delegates

2,260 total

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Administration on Aging

Washington, D.C. 20201

February 7, 1995

Memorandum

TO: Patti Solis, Office of the First Lady

FROM: Moya Benoit Thompson, Special Assistant for Legislation and Public Affairs, Administration on Aging

SUBJECT: WHITE HOUSE CONFERENCE ON AGING AND FIRST LADY'S POSSIBLE PARTICIPATION

I am writing at the suggestion of the Office of Public Liaison to provide you with information on the upcoming White House Conference on Aging and to extend an invitation, on behalf of its Executive Director Bob Blancato and the Assistant Secretary for Aging, Fernando M. Torres-Gil, for the First Lady to participate.

The 1995 White House Conference on Aging was officially announced by President Clinton on February 14, 1994 and will be held on May 2-5, 1995 at the Washington Hilton Hotel. It will be a gathering of 2,259 delegates from across the nation, most of whom have been appointed by Governors and Members of Congress and through major aging organizations and veterans groups. The purpose of the White House Conference on Aging is to develop national aging policy to carry the nation into the 21st Century, and to provide a platform for public awareness of the continuing contributions of older Americans.

The conference will be focused on key issues that have been foremost in the minds of older Americans across the nation, collected from the hundreds of pre-conference events that have taken place throughout the country to date. Those issues include health care including long term care, economic security, housing and support services, and quality of life options.

Because the First Lady has embarked upon a campaign to bring public awareness to the issue of breast cancer among older women and the Medicare benefit for mammography screening, the White House Conference on Aging has been suggested as a possible site for a major kickoff event or a plenary session in which the First Lady could take the lead. The President will be addressing the plenary session on the morning of May 3, and there will be other

opportunities throughout the entire Conference for an event or a kick off to occur and the White House Conference on Aging staff would be happy to accommodate the First Lady's schedule were she to agree.

In addition, we have done some research into the possibility of having space for on-site mammogram screening to take place during the key days of the White House Conference on Aging. There is that possibility within the hotel to do such a thing, or perhaps we could also think about a mobile screening unit.

Your consideration of asking the First Lady to consider this request would be greatly appreciated. We think that the White House Conference on Aging would be a tremendous forum for such an appearance by the First Lady, and thank you for your attention to this matter. I can be reached at 401-4541 should you require any additional information or have any questions.

Attachments:

White House Conference on Aging Fact Sheet

2123195

Delegates to White House Conference on Aging

INTERNAL OFFICE	NAME	AFFILIATION	SPONSOR	Y/N
Chief of Staff	Weinstein, Evelyn	Director, Long Term Care Ombudservice, Nassau County, NY	Harold Ickes	Y
Domestic Policy	Wisor, Norma	Arkansas	Carol Rasco for POTUS	Y
Domestic Policy	Emory, Virginia Olga (leg affairs gov)	Dartmouth Medical School		
Domestic Policy	Cowell, Victoria Brannan (pres to HHS)	Baptist Senior Adult Ministries	Senator Mikulski	
First Lady	Fleming, Dr. Arthur or designee			Y
First Lady	Grossman, Helene (Norma Asmer?)	Leader in Gerontology		Y
First Lady (maybe taken care of)	Pynoos, Jon	National Long Term Care Resource and Policy Center for Housing and Supportive Services	First Lady	
Intergov't Affairs	Mayor Daly of Chicago	(D-IL)	(In person or represented)	
Intergov't Affairs	Butterworth, Robert	Attorney General (D-FL)	(In person or represented)	
Intergov't Affairs	Campbell, Jane	President, National Conference of State Legislatures (D-OH)	(In person or represented)	
Intergov't Affairs	Phelps, Rick	County Executive (D-WI)	(In person or represented)	
Intergov't Affairs	Lacayo, Carmella	President/CEO, National Association for the Hispanic Elderly	(In person or represented)	
Intergov't Affairs	Allocation	National League of Cities	(In person or represented)	
Intergov't Affairs	Mayor Archer of Detroit	(D-MI)	(In person or represented)	
Intergov't Affairs	Harshberger, Scott	Attorney General (D-MA)	(In person or represented)	
Intergov't Affairs	Davis, Tim	County Executive, (D-OH)	(In person or represented)	

OVP	**Peace, Nancy**	Director, Human Services Planning	VPOTUS	
OVP	**Shipp, Lynn Williams**	President, Solutions Inc.	VPOTUS	
OVP	**Taylor, Viston**	Director, Hospice of Chatanooga	VPOTUS	
OVP	**Houston, Peggy**	President, Tennessee Federation for Aging	VPOTUS	
Political Affairs	**Macko, Anne Variano**	Cleveland AFL-CIO		
Political Affairs	**Tolkin, Marvin**		Reta Lewis	
Political Affairs	**Honjiyo, George**	Hawaii State Legislature		
Political Affairs	**Wellington, Lois**	President, Congress of CAlifornia Seniors	California State Senator Lockyer	
Political Affairs	**Cohen, Daniel**	Assemblymember, California Senior Legislature	California State Senator Lockyer	
~~Elsewhere~~ Political Affairs	**~~Barela, Robert~~**	New Mexico AARP		
Political Affairs	**Sandoval, Tony**	Washington State Local Government		
Political Affairs	**Carlstrom, Helen**	Involved with Health Care Reform		
Political Affairs	**Clay, Geraldine Hart**	Advisory Council to the Commission on Aging	California State Senator Lockyer	
Political Affairs	**Saucedo, Martha**	State LULAC	California State Senator Lockyer	
Political Affairs	**Brenner, Lucy**	Office of Disability Determinations, Florida	Reta Lewis	
Political Affairs	**Greene, Dr. Charles**	Los Angeles County Commissioner	California State Senator Lockyer	
Political Affairs	**Kakekaru, Clara**	(Long Term Health Care)		
Political Affairs	**Vaughan, Norman D.**	Mount Vaughn Antarctic Expedition.		
Political Affairs	**Kaplan, Leon**	California Commission on aging	California State Senator Lockyer	
Pres. Personnel	**Evans, Mari-Lynn**	CEO, Evening Star Productions		

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	Pres. Personnel	**Goen, Bill (Alternate)**	Lifespring Mental Health Services, Salem, Indiana	U.S. Rep. Lee Hamilton	
P	Pres. Personnel	**Nottingham, Jack**	Rosalynn Carter Institute		
	Pres. Personnel	**Roses, Dr. Allen**	Dana Alliance for Brain Initiatives		
	Pres. Personnel	**Buckle, Wayne**	Federation of Government Employees	John Sturdiant, Pres. of AFL-CIO	
	Pres. Personnel	**Amodeo, Vincent**	Prof. St. Josephs College, CT	DLC (Trustee David Roth)	
P	Pres. Personnel	**Henry, Sherrye**	Women's Campaign Fund	Peg Clark	
	Pres. Personel	**Foley, Eileen**	Mayor of Portmouth, NH		
P	Pres. Personnel	**Gilgoff, Karen**	AFSCME Retiree Program	Gerald McEntree, Int'l President of AFSCME	
	Pres. Personnel	**Rodriquez-Dox, Louis**	Manager, Retirees Dep't. of the National Benefit and Pension Fund	Dennis Rivera, Pres. of the National HHS Employees Union	
	Pres. Personnel	**Boggs, John R.**	National Eduction Assoc.	U.S. Rep. Dan Schaefer	
	Presidental Personnel	**Malone, Cecil**	Arkansas AARP Director	(Recommendation fr/ Sue Smith)	
	Presidentl. Personnel	**Tilsen, Eleanor**	Director, National Benefit and Pension Fund	Dennis Rivera, Pres. of the National HHS Employees Union	
M->25 6Ps					
P	Pub. Liaisn	**English, Bill**	Michigan		
P	Pub. Liaisn	**Walker, Dorothy**	Michigan		
	Pub. Liaisn	**Poritore, Charlie**	Florida		
P	Pub. Liaisn	**Worley, Ken**	Missouri		
	Pub. Liaisn	**Thornburgh, Lucille**	Tennessee		
	Pub. Liaisn	**Roberson, Deffie**	Washington D.C.		
	Pub. Liaisn	**Mitchell, Maria**	Maryland		
P	Pub. Liaisn	**McTaggart, Herbert**	Ohio		

Pub. Liaisn	Sanders, Charles	Texas		
Pub. Liaisn	Weed, Charles	Iowa		
Pub. Liaisn	William, Walter	Missouri		
Pub. Liaisn	Miller, Betty	Maryland		
Pub. Liaisn	Shook, Marin	Nevada		
Pub. Liaisn	Spiecher, Ann	Michigan		
Pub. Liaisn	Tate, Carolyn	California		
Pub. Liaisn	Schlossberg, Dr. Nancy	Maryland		
Pub. Liaisn	Lee, Julia	California		
Pub. Liaisn	Dodds, William	Washington D.C.		
Pub. Liaisn	Perkins, Frederick	California		
Pub. Liaisn	Cooper, Bette	Virginia		
Pub. Liaisn	Clark, Charlie	Ohio		
Pub. Liaisn	Turner, John E.	Michigan		
Pub. Liaisn	Vladeck, Fredda	Maryland		
Pub. Liaisn	Blankenship, Elmer	Indiana		
Pub. Liaisn	Gross, Dorothea	Washington D.C.		
Pub. Liaisn	Palmer, Arthur	New Hampshire		
Pub. Liaisn	Fox, Dorinda	Virginia		
Pub. Liaisn	Cato, Judy	Maryland		
Pub. Liaisn	Barker, Hillian	Georgia		
Pub. Liaisn	Braman, Ed	Virginia		
Pub. Liaisn	Guenther, Harry	Florida		
Pub. Liaisn	Amorose, Samuel	Pennsylvania		
Pub. Liaisn	Hennum, Lars	Washington		
Pub. Liaisn	Burns, Patrick	Virginia		

P P P

Hamlin, Helen New York
Alexander, Frank Iowa
Gunther, Dick Calif.

Sara Ehrman

Pub. Liaisn	Banks, Noreen	Washington D.C.		
P Pub. Liaisn	Morrison, Del	Illinois		
P Pub. Liaisn	O'Connell, Mike	Michigan		
Pub. Liaisn	McLean, Jerry	Florida		
P Pub. Liaisn	Aquilar, Fidel	Colorado		
P Pub. Liaisn	Komer, Odessa	Michigan		
P Pub. Liaisn	Johns, Ruby	Ohio		
Pub. Liaisn	Fithian, Bill	Virginia		
Pub. Liaisn	McKenna, Theresa	Virginia		
Pub. Liaisn	McCall, Bud	Indiana		
Pub. Liaisn	Howard, Lloyd	Florida		
Public Liaison(?)	Buckles, Lisa	Therapeutic Recreation and Volunteer Department, MetroHealth Center for Skilled Nursing Care, Cleveland		
Public Liaison	Gorin, Stephen	Plymouth State College, NH	Mike Lux	
P Public Liaison	Solomont, Alan D.	A*D*S	Bruce Reed, Mike Lux	
Public Liaison	Delegate Allocation	National Committee to Preserve Social Security and Medicare		
P Public Liaison	Wilbert, Herb	Michigan		
1(2) Random	Towner, Gilbert	National Indian Council on Aging	National Indian Council on Aging	
Random	Psiharis, John Lux	Executive Director, Greek-American Community Services	Brown George's Office	
DFC Random	Mercer, Susan	University of Arkansas	ASU	
Random E	Woods, Patricia	National Indian Council on Aging	National Indian Council on Aging	
Random	Braff, Sylvia	(college graduate from New York)	[illegible]	
DFC Random	Bortz, Dr. Walter	(Author) Standford U. Medical Center	[illegible]	
Random	Wright, James T.	Henderson State University, AR	[illegible]	

DPC	Random	Hyatt, Laura put to HHS	Director, American Subacute Care Association	U.S.S. Barbara Boxer (CA)	
DPC	Random	Chernoff, Ronni	American Dietetic Association	ASK JEREMY	
P	Random	Wiley, Diana	Psycotherapist and Clinical Sexologist	Potus	
	Veterans Affairs	Secretary Brown's 20 recommendatns	(5 from HHS Sperling get ~~8~~ from WH)		

kickoff formally speak Fs health things

3/9/95

White House Conference on Aging Mtg

2,200+ delegates
300 observers

• C-Span will cover whole Conf

May 18 - Dr B weekly Hpo menopause Press

May 2 Tues

10:00 Kickoff in Rose Garden — people from listening sessions

speakout begins 7 pm
12:30 pm - AOA+ HHS Older Americans Month Kickoff

May 3 Wed

plenary 9-11 POTUS — Dr. B - breast cancer
HHS — health expo event
HUD — w/Conf members
VA — CIA technology will be on
Dr Fleming — display

work groups

Univ of Md. mammogram unit - mobile van

May 4 Thurs

declarative plenary session
11-12 pm

May 5 Fri

closing session 11-12

kick off event on Mon 1
listening session on Thurs 4

more detailed ~~for~~ briefing for press

~~Date~~ April 10th week for PSA / breast cancer listening session

Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

PROMOTION & PREVENTION

I. Overview of Major Issues and Policy Considerations

For people of all ages, health promotion is a path to feeling good now and preventing health problems in the future. While each generation experiences unique risks, an integrated intergenerational approach to health promotion and disease prevention can yield universal results.

Older Adults

For older women at high risk for osteoporotic hip fractures, health promotion, in the form of exercise programs, nutrition counseling and medication management, can make the difference between nursing home dependence and independent living.

For retirees coping with arthritis, health promotion, in the form of a chronic disease self-management program, can make the difference between just "getting by" and lives filled with purpose and meaning.

For older people with life-threatening illness, health promotion, in the form of shared medical decision-making and knowledgeable consumers of medical and health care services, can make the difference between wasted medical care that adds no value to life and effective care that adds quality to both living and dying.

Infants, Young Children, Youth, and Young Adults

Illness prevention and health promotion programs (e.g., immunizations) are the foundations of a healthy start in life for infants and young children. For youths and young adults, health promotion and illness prevention contribute substantially to their own healthy aging. Health promotion can encourage avoidance of at-risk behaviors such as alcohol consumption, cigarette smoking, substance use/abuse, obesity, and inactivity that often lead to poor health in later life.

Years of innovative programming in a wide variety of settings have shown that older people have the interest and ability to better control their health and their health care through health promotion. Research shows that the payback is substantial: better health, reduced health care costs, and improved quality of life.

Policies that encourage prevention and health promotion for all generations are substantial investments in the health of our society. For children and younger generations -- who are the older Americans of the future -- such initiatives help ensure that they will enter later years with sound basic health, possibly avoiding some of the conditions that put today's elderly at risk.

However, considering that health promotion can benefit **all** populations, health promotion for older adults continues to be underfunded, under-researched, and unavailable to large segments of the population, especially minority elders and those living in inner cities and rural areas.

Clear, compassionate and enlightened national policies are needed to:

- Shift some of the bias of our health care system from illness care toward

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Encourage all older adults, young adults, and families live tl
ınd fulfilling lives possible.

"universal access"

essment of the Current Situation

Promotion Is Wide-Ranging

Health promotion is planned action to maintain or improve physical, mental
ıritual health. Programs for older adults have been around since the late
Early programs focused primarily on promoting good health through diet
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. Examples of health promotion programs that work across generations:

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on: Pap tests, mammograms, glaucoma screening, blood pressure screening, nutrition screening and assessment, bone density testing.

"universal access"

health management, particularly for vulnerable populations, including older adults, infants and children, youths, and young parents..

- Increase universal access to and participation in programs that both improve quality of life and reduce overall costs.
- Strengthen and protect the older adult's role in making medical decisions.
- Encourage all older adults, young adults, and families live the most healthful and fulfilling lives possible.

II. Assessment of the Current Situation

Health Promotion Is Wide-Ranging

Health promotion is planned action to maintain or improve physical, mental and spiritual health. Programs for older adults have been around since the late 1970's. Early programs focused primarily on promoting good health through diet and exercise and other "wellness" activities. As interest grew and more older adults were reached, the definition has expanded to include a much broader range of activities: prevention, early detection, consumer empowerment, chronic disease management, and wellness. For children, youths, and young adults, health promotion activities are in many cases similar or identical to those for older persons. Examples of health promotion programs that work across generations:

Prevention: Flu shots, injury prevention, smoking cessation, proper nutrition and exercise, regular checkups, incontinence counseling.

Detection: Pap tests, mammograms, glaucoma screening, blood pressure screening, nutrition screening and assessment, bone density testing.

Consumer Empowerment:	Medical self-care education; workshops on medical consumerism (creating the knowledgeable consumer) and shared medical decision-making, access to information.
Chronic Disease Management:	Education on managing chronic conditions such as arthritis, hypertension, heart disease, osteoporosis, diabetes, etc.; mental health counseling; medication management seminars, self-help groups and caregiver support.
Wellness:	Fitness (including aerobic exercise and strength training), nutrition programs, stress management, mental wellness programs (coping with loss).

The best practices are those that promote dignity and independence, and build knowledge and skills to help individuals to make informed choices about health issues.

Health Promotion is Widespread

The settings and resources for health promotion for older adults are diverse and varied. Settings include:

Aging Network:	State and Area Agencies on Aging, senior centers, congregate meal sites
Health Network:	Hospitals, HMOs, insurance companies, public health departments
Private Sector:	Employers, unions, private health clubs, non-profit health organizations

Community-based:	Congregations, universities and colleges, recreation departments, community centers, YMCAs, etc.
Voluntary groups:	American Association of Retired Persons, National Council of Senior Citizens, American Red Cross, etc.

While the number of organizations offering health promotion resources to older adults has increased significantly in the last ten years, most older adults, especially elders in rural or inner-city settings, and minority populations, still do not have easy access to good resources or programs.

Health Promotion Leads to Improved Health

Research has shown that health promotion can help to postpone premature deaths (mortality), reduce disease and disability (morbidity), and improve the ability to live independently (functional health status).

Postponed mortality. Breast cancer deaths could be decreased by as much as 30 percent if older women had regular breast examinations and mammograms and received follow-up treatment. Screening for cervical cancer could also reduce premature deaths for older women, yet many older women do not have the recommended regular Pap tests.

Reduced morbidity. The focus of health promotion for many older adults is on postponing or reducing the impact of existing chronic disease. Programs that identify, treat, or manage underlying conditions, such as hypertension in the elderly, can reduce the incidence of disabling strokes. The same lessons hold true for chronic illness with onset earlier in life, such as diabetes.

Improved functional health status. Functional health status is measured by an individual's ability to live independently. Poor functional health usually results from the impact of one or more chronic conditions, injury, or sensory impairment, such as vision or hearing loss. Moderate exercise, quitting smoking, and avoiding obesity can help people stay mobile as they age.

Why Health Promotion Makes Good Economic Sense

While the main goal of health promotion is to promote healthy lives, well-designed programs also reduce the need for clinical services and lower the cost of health care. Health promotion programs reduce health care costs in three ways:

1. *Preventing health problems in the first place.* For example, hip fractures cost the nation over $2 billion each year. Prevention programs aimed at improving bone density, increasing muscle strength, reducing the risk of falls all effectively reduce costs.

2. *Effective management of chronic illness.* For example, evaluation of arthritis self-management courses shows that people who participate in such programs can reduce physician visits by up to forty percent. Diseases that can strike people of any age such as diabetes or kidney dysfunction, can similarly be managed through self-education and nutrition programs.

3. *Active involvement in health care decisions through medical self-care and informed medical decision-making.* For example, retiree self-care programs have shown decreases in hospital stays, doctor visits and health care claims. And, after involvement in informed medical decision-making programs, older men with

enlarged prostates choose surgery 40-60 percent less often.

Health Promotion and an Enhanced Quality of Life

Quality of life is an important issue for all older adults, whether they reside in their family home or in a nursing home. A feeling of control and independence, the ability to participate in desired activities, and a sense of self-worth -- all quality of life measures -- reflect each older person's overall level of health.

The implications for health promotion are apparent: even modest changes or improvement in one's environment and sense of control may result in significant gains in quality of life. In health promotion research, self-reported quality of life is often the measure that shows the greatest gains.

III. Projections for the Future

Four certainties must be kept in mind when planning for the health and well-being of our older population:

1. The Senior Boom. The sheer numbers of older adults in our country and the trend toward an ever-increasing senior boom will mean that the health concerns of this age group will dominate our health care system for years to come.

2. The Chronic Care Boom. As adults grow older, chronic conditions such as arthritis, high blood pressure, osteoporosis, and heart disease become more prevalent. More than four out of five people aged 65+ have at least one chronic condition. Multiple conditions are commonplace, especially among older women.

The health concerns for most older adults, therefore, focus less on cure and more on maintenance, management, and coping.

3. The Health Care Bust. Our current health care system is well-equipped to deal with acute care needs, but less equipped to help seniors with their chronic care concerns. In some cases, the health care system makes heroic efforts to sustain people near the end of life, but does relatively little for them when they are coping daily with chronic conditions. A better investment of time and money should be made to improving one's quality of life.

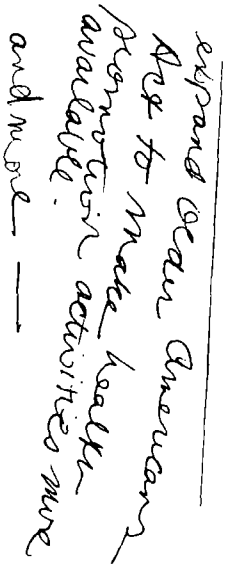
4. Promoting Health is a Critical Investment in an Aging Society. Measures taken today to promote child and young adult health will yield enormous dividends in the future. Health promotion and disease prevention should be embraced as strategies to increase the well-being and health of Americans of all ages.

Because well-designed health promotion programs improve health, prevent health problems, reduce health care costs, and help people cope with chronic conditions, they are a good societal investment and should be extended to all Americans.

Clearly, the greatest responsibility for personal health rests with the individual. However, without a sense of empowerment and access to resources, many individuals are unable to take advantage of the benefits of health promotion. The government's role in health promotion includes four main areas:

1. Dissemination. Through continued funding of programs such as Title III-F

ıe Older Americans Act, health promotion activities can continue to be
ed to older adults on a local level. Guidelines for such programs need
e expanded to embrace the broader definition of heal
ıding chronic illness management, medical self-c
umerism, and shared medical decision-making. Special e
ɜ to make health promotion available to all older Americ
-risk and underserved populations, including minority, ru
disabled elders. Additionally, coordination betwee
inistrations on Aging and Children, Youth and Families,
the Centers for Disease Control and Prevention, an
ıutes of Health could yield new avenues to promote health
ɜntion among all ages using existing structures.



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minated. The government's role should include ensuring that all older
access to good information about their medical conditions and their
care.

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attention as research on the outcomes of medical procedures. In
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ɜd to identify risk factors for disability and to determine if interventions
n to be effective in younger persons are equally effective in reducing

expand older Americans
Act to make health
promotion activities more
available.
and more —

of the Older Americans Act, health promotion activities can continue to be offered to older adults on a local level. Guidelines for such programs need to be expanded to embrace the broader definition of health promotion, including chronic illness management, medical self-care, medical consumerism, and shared medical decision-making. Special efforts must be made to make health promotion available to all older Americans, especially high-risk and underserved populations, including minority, rural, inner city, and disabled elders. Additionally, coordination between the federal Administrations on Aging and Children, Youth and Families, in conjunction with the Centers for Disease Control and Prevention, and the National Institutes of Health could yield new avenues to promote health and prevention among all ages using existing structures.

Good, sound information about health, health care and medical choices needs to be disseminated. The government's role should include ensuring that all older adults have access to good information about their medical conditions and their options for care.

2. *Research.* The medical research agenda in aging must be expanded to include evaluation of what older adults can do for themselves. Research focused on the effectiveness of health promotion programs should receive the same attention as research on the outcomes of medical procedures. In addition, more basic research is needed to determine what influences older adults and young people to change their health behaviors. Research is also needed to identify risk factors for disability and to determine if interventions known to be effective in younger persons are equally effective in reducing

risk in older people.

3. *Reimbursement.* Restrictions on Medicare and other health insurance plans often prohibit the reimbursement of health improvement programs even after cost-effectiveness has been proven. Regulatory flexibility is needed to allow both experimentation and implementation of programs that both improve health and reduce costs.

4. *Environment.* Clean air and water, crime prevention, safe highways, protected food supplies, safe places to walk, run, or relax are all needed to promote the health of Americans.

Beyond the issues of financing, delivery, and direction of health promotion for older adults lies the greater issue of rediscovering and supporting the potential of age. For younger persons, the greater issue is maximizing potential for a long and healthy life and understanding the role individuals play in their own healthy aging. The goal of health promotion is not solely to save some money here or to prolong a life there. Rather, the purpose of health promotion is to help each person reach his or her potential as an individual and as a member of society during each stage of life.

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

ACCESS TO QUALITY CARE

I. Overview of Major Issues and Policy Considerations

Access to quality care including both community and institutional long-term care must serve as the foundation for any discussion of comprehensive health care for Medicare beneficiaries. This paper discusses issues concerning access to quality care with a focus on the barriers impeding both access and quality. Policies that reduce these barriers and increase the accessibility and the quality of care for the aging population in the United States should be considered.

The traditional barriers to access to care for the elderly include structural barriers such as:

- cost or co-payment problems,
- transportation difficulties,
- appointment scheduling problems, and

attitudinal barriers such as:

- ageism that redirects scarce resources away from the elderly in need,
- ageism that incorrectly attributes health problems to advancing age.

Cost or co-payment problems

At present, approximately 93% of people out of the work force and over age 65 are covered by Medicare, the federal insurance program for hospital (Part A) and physician and related services (Part B) for Social Security beneficiaries. Although this high coverage rate is encouraging for access, Medicare neither covers all health care (custodial long-term care is one glaring omission) nor

provides first dollar coverage for the services it does cover (except in certain HMOs). In 1990, the last year of available figures, it was estimated that the average Medicare enrollee had an out-of-pocket liability of slightly more than $1,000.00 for health care. Others have estimated that older people are now spending a greater proportion of their income on health care than at any time since before the implementation of Medicare. Therefore, while the coverage rates for Medicare should be praised, the costs and co-payments are not and may again be a barrier to access to quality health care.

Transportation difficulties

Problems concerning transportation also can present barriers which may impede access. Admittedly, self-reports of the frequency with which older people forego seeing a doctor because of transportation difficulties were only about 3% in a 1985 study.

Appointment scheduling problems

Difficulties concerning scheduling of appointments and delays in waiting rooms are also considered to be traditional barriers to access. However, given the strong supply of physicians and nurse practitioners in the U.S., only 3% of the elderly reported scheduling problems as a barrier to access in a 1985 study.

Ageism that redirects scarce resources away from the elderly

During times of abundant resources, there is enough for all. However, during times of scarcity or unwillingness among the payers of health care (which seems to be the case for health care during the last decade of the twentieth century), some mechanism for rationing the scarce resources is required. Rationing health care

based on the ability to pay is always decried but unfortunately is nearly always present as well. People willing to pay a premium and/or willing to pay cash are often able to get health care services immediately, with the exception of some transplant organs which are regulated and restricted. Rationing on the basis of age of the recipient has also been proposed and generally decried. But some rationing on the basis of age does exist. Rationing on the basis of the cost of the health service itself has also been proposed. Some procedures—such as bone marrow treatments—are simply very costly at this time, and many third-party insurers attempt to avoid authorizing these procedures. All these forms of rationing—by ability to pay, by age, by cost of the procedure—need to be examined explicitly. Perhaps in an ideal world rationing would not be necessary; in the United States at this time rationing does exist. The challenge is to be explicit and fair in the approach, while maximizing access to quality health care. In this context intergenerational interdependence must be recognized and respected.

Ageism that incorrectly attributes health problems to advancing age

Both older people themselves and health care providers unfortunately can hold the ageist belief that health problems can be due to advancing age. Pathologies cause disease, advancing age does not. Advancing age may restrict the body's normal mechanism to overcome disease and advancing age may restrict the reserve capacity of the person to respond to external or pathological threats, but advancing age does not cause disease or health problems. Diseases cause health problems, and state-of-the-art medical treatments can be brought to bear on diseases in people and patients of any age. Certainly some of the probabilities of a favorable outcome may be reduced in an older person (in all likelihood because of the diminished reserve capacity), but treatment is always an option. Nevertheless,

one in eight—12%—of people over age 70 in Massachusetts reported that sometime during the previous year they did not seek medical care when they really thought they should just because they figured the health problem was really due to their age. When one out of eight fails to make the initial contact because of an attitude that is essentially agist, the best medical care in the world can not be effective.

Let us consider another example of attitudinal barriers to access, namely the case of urinary incontinence (UI). UI affects up to one-third of community living elders and slightly more than half of the institutionalized elderly. Clinical experts have judged that current medical treatments could cure or ameliorate the symptoms of approximately one third of those with UI. But in order to receive these current medical treatments, the patient and the physician must talk about the problem. A recent study undertaken by a team of researchers in Massachusetts suggests that such discussions do not occur often enough. Of 1,140 randomly selected respondents aged 65 years and older in two counties in Massachusetts, approximately one in four reported that they leaked or actually lost control of their urine sometime during the previous 12 months, while one in ten reported that they lose control of their urine at least once a week. The length of time these elders reported they had UI varied; about half (48%) reported they had their problem for a year or less, one-quarter (25%) had UI for about two years, a little less than one-quarter (22%) had UI for three to ten years, and 5% reported they had UI for more than ten years. When asked if they had ever discussed their UI with a doctor or nurse, less than half (47%) reported they ever had. Of the 53% who had discussed UI with their doctor or nurse, most had a discussion with the last six months (62%) but nearly one in five (18%) last talked with their doctor or nurse about UI two or more years ago.

Access to quality health care requires an encounter between patient and doctor, and a discussion about the important health conditions. Encounters occur as evidenced by the fact that nearly nine out of ten people 65 years of age or older report at least one doctor visit during the previous year. However, the Massachusetts data cited previously seem to indicate that the appropriate discussions within the encounter do not always occur.

What role or responsibility does the health care provider share in initiating discussions about sensitive topics such as UI during an encounter? Among primary care physicians, urologists, and gynecologists responding to a survey in the same Massachusetts UI project, almost one-fourth of the physicians (23%) reported that **no** elderly outpatients had volunteered during an encounter in the last month that they had UI. In fact, 97% of these physicians reported that only one in ten or fewer outpatients 65 years of age or older volunteered during the last month that they were having problems with UI. Did these doctors therefore initiate discussions about UI? The proportion of patients with whom physicians reported initiating questions about UI tended to be large among urologists and gynecologists (about three out of four of these doctors reported asking about three-quarters or more of their patients about UI) but distressingly small among primary care physicians (only one third of primary care physicians reported initiating such discussions with three-quarters or more patients, while 41% of these primary care physicians reported initiating such discussions with one in ten patients (including none).

Even if current treatments can cure or alleviate up to one-third of the existing UI problems, patients and physicians need to take steps to initiate appropriate discussions during their health care encounters in order to trigger the treatments.

Additional factors influencing the attitudinal barriers to access

Sociodemographic factors seem to play an additional role in creating these attitudinal barriers to access. Results of one study suggest that characteristics such as age, sex, income, education level, living arrangement, perceived health status, functional level, and morale are all related to perceived barriers to accessing health care. For example, older people with lower self-perceived health status were more likely to attribute their health problems to age and were also more likely to report perceived cost and transportation barriers. Reporting transportation barriers was also found to be associated with being female, living alone, and having less education. What are the underlying mechanisms that might explain these findings?

We live in a society in which stereotypes, perceptions, and fears play an instrumental role in shaping behavior, a society in which information can be a powerful tool for survival. The impact of these factors cannot be ignored when searching for the root causes of barriers to access to care for the aging. The elderly as a group typically have been subject to negative stereotypes. These negative stereotypes not only affect the way that members of society view the elderly, but also affect the way that elderly individuals view themselves and each other. These views in turn shape the behavior of the elderly and affect how their behavior is received by others. The potential influence of negative stereotypes of the elderly on access to quality health care is sobering.

Cultural stereotypes of facilities may also play a role in access to quality care. Consider for example the possible consequences of a negative stereotype of nursing homes. The concept of nursing homes potentially brings to mind the stereotypical image of an immense, institutional facility where people are left to be forgotten and die. If an elderly person is at all influenced by this negative

stereotype, he or she might delay or fail to seek treatment out of fear that he or she might be placed in this perceived negative setting. It would be impossible in this paper to discuss all of the examples of stereotypes which factor into the construction of barriers to access, however, even these few examples demonstrate the potential magnitude of this pervasive problem.

There are many fears associated with aspects of aging, fear of getting older, fear of pain, fear of losing one's mental capacity, fear of dependence, fear of financial loss, as well as more general concepts such as fear of change and fear of the unknown, just to name a few examples. All these fears, combined with negative cultural stereotypes and attitudes, coalesce to create and perpetuate the attitudinal barriers to access to care for the aging. No one is immune to these influences, not doctors, not family members, not even policy makers. The continuing power of these factors is based largely in ignorance. Without sufficient alternative sources of information which contradict extreme stereotypes, individuals have no incentive to test and restructure views and behavior. To refer back to the nursing home stereotype as an example, if an elderly person were to be exposed to alternative information which contradicts the negative nursing home stereotype, the fear of being placed in a nursing home might be lessened, thereby freeing the individual to seek needed treatment. Obviously, information alone is not going to rid society of all the pervasive fears and stereotypes. The solution needs to be multidimensional. However, increased exposure to information is an essential step in combatting the controlling influence of these constructs as barriers to access to care for the aging.

Quality concerns

Assuming that elderly individuals manage to overcome the structural and attitudinal barriers to access and actually obtain medical care, the focus then shifts to the quality of care that these individuals receive once they enter the system. Traditionally, the conventional wisdom has been that the main barriers to quality care for the aging revolve around undercare. As a result, physician and health care providers in general respond to quality problems with a "more is better" mentality. Unfortunately, this approach has created a health care delivery system which is polarized in terms of quality, with problems related to undercare at one end of the spectrum and problems related to overcare at the other end. How do issues of undercare and overcare present barriers to quality?

Undercare. One of the major barriers to quality is a lack of communication and coordination among caregivers concerning the health and treatment status of individuals. This deficit creates a climate in which the needs of aging patients can fall through the cracks of the health care delivery system. A second related factor involves a lack of central access to medical information on patients. Without access to medical records and patient history and status information, care providers are forced either to order and wait for duplicative tests and procedures or to make uninformed decisions concerning the appropriate treatments. Furthermore, collection of patient encounter data for Medicare beneficiaries in managed care organizations is not mandatory. This creates a significant obstacle to monitoring, accessing, and improving the quality of care provided to older adults. A third related factor involving undercare is a lack of focus on effective transitioning of patients between acute and long-term care facilities and from care facilities into the home. This problem results in inconsistency in the quality of care patients receive

ows for the possibility that progress made in one setting could be negated her. The emphasis in typical fragmented care seems all too often to be on nt for the moment, without sufficient coordination of treatments between s and across time. These barriers to quality brought about by a lack of dated information, communication, and coordination ap ns inherent in a health care system which fosters a ch to care.

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Severe quality problems for the elderly enrolled in several HMOs

Overcare. The barriers to quality care which revolve around undercare valid hazards for elderly patients. However, it is essential to remember that nvolving overcare require attention as well. Although barriers to quality ng overcare produce different problems than barriers involving undercare, f the mechanisms at the source of these barriers are the same. For example, c of communication and coordination among care givers concerning the and treatment status of patients also plays an instrumental role in cting overcare related barriers to quality. One possible ramification of this might be the use of duplicate or incompatible treatment approaches. The central access to patient information also factors into barriers related to e by allowing for potential problems such as polypharmacy.

he quality of care that aging patients receive is also affected by the lack of

several quality problems for the elderly enrolled in several HMOs

and allows for the possibility that progress made in one setting could be negated in another. The emphasis in typical fragmented care seems all too often to be on treatment for the moment, without sufficient coordination of treatments between settings and across time. These barriers to quality brought about by a lack of consolidated information, communication, and coordination appear to be basic problems inherent in a health care system which fosters a highly segmented approach to care.

In addition, as a growing number of older and other Americans obtain health care services through managed care plans, more attention will be needed to the quality and quantity of care provided. Recent preliminary research has revealed severe quality care problems for the elderly enrolled in several HMO's.

Overcare. The barriers to quality care which revolve around undercare present valid hazards for elderly patients. However, it is essential to remember that issues involving overcare require attention as well. Although barriers to quality involving overcare produce different problems than barriers involving undercare, many of the mechanisms at the source of these barriers are the same. For example, the lack of communication and coordination among care givers concerning the health and treatment status of patients also plays an instrumental role in constructing overcare related barriers to quality. One possible ramification of this deficit might be the use of duplicate or incompatible treatment approaches. The lack of central access to patient information also factors into barriers related to overcare by allowing for potential problems such as polypharmacy.

The quality of care that aging patients receive is also affected by the lack of

alternative types and levels of care options currently available. This lack of alternatives can lead to overutilization of inappropriately comprehensive care facilities such as nursing homes and hospitals. Overutilization of these facilities is in no one's best interest because it can result in multiple and or unnecessary treatments for aging patients and can unnecessarily waste scant resources in the process.

Overutilization can also result from family members' unwillingness or inability to provide the support needed to care for their elders. Elderly individuals, facing a lack of family support, may attempt to compensate for this lack of support by unnecessarily utilizing care facilities. These examples convey that overcare barriers to quality require as much attention as undercare barriers when addressing ways to increase quality levels.

Iatrogenic problems. In a discussion of the barriers to quality care there is yet another dimension of overcare that merits attention, namely iatrogenic disease, illness, or conditions. Iatrogenic problems can be defined as illness resulting from diagnostic procedures, treatment measures, and injurious occurrences that are not due to the natural progression of the patient's condition. Examples of potential iatrogenic illness include preventable decubitus ulcers (bed sores), predictable adverse drug reactions, urinary tract infections from catheters, injuries incurred from some falls, and hospital-triggered acute confusion states. The elderly are subject to increased risk of developing iatrogenic problems because their frailty and reduced reserve capacity may make them more susceptible to complications. Iatrogenic illness in a university hospital setting affected 36% of 815 consecutively admitted patients in a general medical service. Factors such as age, drug exposure,

and length of stay were all found to be related to onset of iatrogenic illness. The same underlying factors identified as barriers to quality care create a climate in which iatrogenic illness thrive. Without adequate communication, coordination, and access to information care providers run the risk of over responding to patients needs concerning some aspects of care and neglecting patients needs with regard to other aspects.

Conclusions

These factors combine to place the elderly in a tenuous position. That is, often elderly patients are most in need of quality care due to the complexity and multiplicity of their care needs, yet they are often the least equipped to assert their rights to that care. Add to that a possible lack of family support and you have a sub-population of frail elderly patients with complex care needs left to navigate a confusing health care system alone.

The following are approaches that attempt to get at the root causes of barriers to access to quality care.Approaches to improve access to quality care include:

- automate and coordinate patient records across time and across providers,
- use care managers to facilitate a seamless continuum of care for frail elders,
- educate elders, the general public, and health providers to overcome negative stereotypes of both elders and some care systems for elders.

The key to combatting barriers to access to quality care for the aging successfully seems to revolve around taking measures to create a seamless continuum of care. One of the first problems that needs to be addressed in order

to facilitate creation of this continuum is the lack of central access to information concerning patient history and medical status. Although the technology exists for automated patient records, in general, care facilities are still relying upon hand written patients charts, with their demonstrated inefficiencies. One study found:

- A patient [hospital] medical record is unavailable for 30 percent of all clinical encounters.

The average patient [hospital] record, weighing 1.5 pounds, makes finding specific information difficult and time consuming.

- 70 percent of inpatient medical records are incomplete at time of discharge.
- 11 percent of all laboratory tests are reordered since results are unavailable at time of discharge.
- At any one time, as many as 22 different people within a hospital setting may need access to an individual patient record.
- Physicians spend an estimated 38 percent of their time writing patient charts.
- Nurses spend up to 50 percent of their time writing patient charts.

Elements that will require attention when formulating plans for computerized patient records include: usability, uniformity, reliability, accessibility, confidentiality, cost effectiveness, in addition to consideration of exactly what

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FFS not incompatible w/managed care

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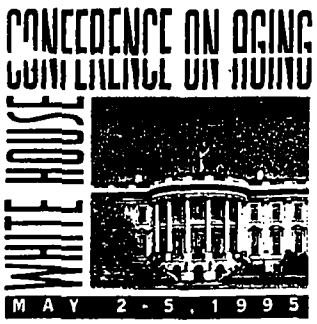
FFS not incompatible
w/ mgd care

information to include.

A second approach to creating a seamless continuum of care could involve developing the role of a care manager into the health care delivery system. Someone must be made responsible for each elderly patient to ensure that all of the patient's needs are being met, to facilitate facility transitions and family involvement, and to coordinate treatment approaches across time. It is a common belief that this type of managed care approach necessitates invoking a capitated method for financing care. However, it is important to note that the traditional fee-for-service (FFS) approach is not inherently incompatible with managed care. It merely dictates that managed care mechanisms such as a care manager/advocate need to be included on the list of services covered by FFS payments.

Third, educational efforts also could play a role in addressing access to quality care for the aging. Steps need to be taken to heighten patient/caregiver awareness of approaches to care, payment options, available resources in the community and in health care settings, and special needs and rights relating to elderly health care. Attempts at furthering the education of care providers is also warranted, with a focus on highlighting the characteristic special needs of the aging population, and on increasing understanding of the potential ramifications of various diagnostic and treatment procedures. Increasing the dissemination of health care information will also serve to undermine the influence of negative stereotypes and fears on access to quality care for the aging.



Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

CONTINUUM OF CARE INTEGRATING COMMUNITY & SOCIAL SERVICES

I. Overview of Major Issues and Policy Considerations

Maintaining Health

Older people are living longer. However, people do not want to live in pain, ill health and dependence on others. They want to be healthy enough to stay in their own homes and remain engaged with their families and communities or enjoying the lifestyle they have chosen for their retirement years.

Most people think of the goals of health care as treatment and cure of disease or repair of injuries. For older persons with chronic illness or disability, a cure or reversal of the effects of illness may not always be possible. Yet it is reasonable to pursue health care goals which will enable older persons to live where they choose, and to conduct their daily lives in their customary manner, with whatever help is needed to support their choices. Good health care can reduce mental and physical illness, pain and disability among older persons, and can reduce the differences in health and life expectancy between different ethnic and economic groups.

Effectively managing medical care in complex cases requires practitioners who are knowledgeable about age-related conditions and care. The appropriate use of prescription drugs, for example, can improve well-being of an older person, but misuse of medication can contribute to declining health, accidents and debilitating

hospitalizations. The diagnosis and treatment of mental health and alcohol problems of the elderly can result in improved health and independence of older persons and reduced health care costs. Improved nutrition and accident prevention can also reduce the need for hospital and long term care. On the other hand, the barriers of cost may prevent older persons from obtaining well-managed care, or from following prescribed courses of medication or diet.

Access to the right kinds of health care may be restricted by a lack of appropriate providers, lack of affordable transportation to care, and how much government and private insurers pay for different kinds of care.

Long Term Care

Long Term care is a set of health, personal care, social services needed by people who have lost some ability to carry out the essential activities of daily living. Long term care can be provided in a variety of locations, including a house or apartment, day center, group residential home, or nursing home. Most long term care is provided by spouses or other family members. A sometimes confusing variety of providers delivers a range of services, doing for older people the tasks they can no longer do for themselves.

One way of describing long term care is passage along a "continuum of care" over time from less intensive, less restrictive service and settings, to more intensive, more thorough care which does most things for the person.

Another concept of long term care is to offer "consumer choice" from a range of service options which could meet the individual needs. Variety, flexibility

competition in the array of services available, allows for individually-
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mily and environmental support, such as housing modification and
:. The goal envisioned in these home and community-based care systems
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current financing and policy barriers encourage higher cost nursing homes & greater dependence

and even competition in the array of services available, allows for individually-tailored care arrangements which respond to personal preferences and encourage the use of family and environmental support, such as housing modification and equipment. The goal envisioned in these home and community-based care systems is "aging in place," that is, bringing the service to the individual where they live or spend most of their time.

Most money for long term care is now spent for institutional care and often cannot be used for other arrangements in a continuum of care or for aging in place. Health care funds generally cannot be used for the most essential services needed by older persons, except in institutions. Other public funds support a fragmented and uneven assortment of community and in-home services, and other needy populations compete for the same resources. The fewest services are directed toward family caregivers, and just getting good information and advice at the right time is often difficult for spouses and relatives.

Long term care is confusing and disorganized. It is generally expensive. Its reimbursement has been biased in favor of using nursing homes and other institutions. Long term care, and health care more broadly, can make it possible for older persons and their families to remain in control and responsible for their day-to-day living, but current financing and policy barriers encourage higher cost nursing home care and greater dependence. Older persons also need the knowledge and authority to have greater control over decisions about care and treatment, especially at the end of life.

II. Assessment of the Current Situation

Between 1950 and 1990, death rates for those age 65 to 84 fell by one-third. The over age-85 population is the fastest growing in the nation, and this group is made up of the greatest users of health and long term care. Currently, while women live longer than men, the amount of time they live free of limitations on their daily activities is about the same as for men.

Among the conditions most often associated with disability and hospitalization are heart disease, falls and fractures associated with osteoporosis, stroke and high blood pressure. Between 12 and 22% of older people have mental health problems, such as depression, which affect how they take care of themselves. Nutrition-related conditions affect 85% of the elderly, and contribute to unnecessary hospital use.

At least three out of five persons needing long term care are elderly. Half of the frail elderly in need of long term care are near the poverty threshold (150% of poverty) and are most often widowed women. More than one-fifth of the over age 85 population resides in nursing homes. Two-thirds of the long term care provided in the community is provided free by spouses and other relatives or friends. Among the most disabled elderly, about half use paid help to get along at home and in the community. Studies have shown that family help is not withdrawn when formal (paid) services are provided.

Although surveys repeatedly demonstrate a preference among older persons for home and community care, most public funds (as well as private insurance) are spent on institutional care. The Urban Institute estimates that in 1993, $108 billion

was spent on long term care: $75 billion for nursing home care and $33 billion for home based care. Government spends nearly $10 in nursing homes for every $1 in home and community care.

A recent General Accounting Office (GAO) study of three leading states with case-managed home care programs showed declining public expenditures on nursing home care, and average costs for home care which were consistently lower than institutional care. Yet only a few states have been able to structure long term care to give consumers a choice between home, community-based or institutional care. Nursing homes remain the largest and growing expense in the Medicaid program nationally. Nursing home care also represents the largest out-of-pocket expenses for older citizens. There are still few alternatives.

Resources

The organization and delivery of health care to the elderly has been largely determined by the private health care industry, with the federal Medicare program playing a significant role in paying for universal access to doctor and hospital care. The cost of prescription drugs exceeds an average out-of-pocket expense of $500, which is not paid by Medicare. The high cost of drugs for some individuals can be catastrophic. ~~At the same time~~ and the misuse of prescription drugs is said to account for as many as 25% of nursing home admissions.

Long term care is the major uninsured expense for older persons. At an average annual cost in excess of $30,000, nursing home admission can be a catastrophic event for older persons of modest means, especially if a spouse remains in the community with an obligation to pay for most of the care. Of the

$59.9 billion spent on nursing home care in 1991, nursing home residents and their families paid $25.8 billion. Medicaid and Medicare spending for nursing homes amounted to $28.4 billion and $2.7 billion respectively. Private insurance paid $600 million.

Home and community care is also a major expense. Older people paid for about 12% of their home care ($1 billion). Medicare paid $4.4 billion, and Medicaid paid $1.4 billion for home **health** care.

Because most long term care consists of assistance with essential daily tasks, most necessary services are outside the scope of home health care. The most commonly needed services include:

- personal assistance with bathing, toileting, dressing, eating and transferring from bed to wheelchair;
- home modifications and adaptive equipment;
- housekeeping and chores;
- food purchase and preparation;
- arranging for social, physical and intellectual activity to maintain abilities;
- transport to medical care and services;
- monitoring health status and managing medications.

These services can be provided at home, in senior centers or day health programs, in apartment buildings, in group living arrangements, in nursing homes, or using some combination of settings, depending on individual needs.

Individual assessments and care plans are the most reliable way to define the

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for the Future

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Financing Policies in MC and MA Limit Consumer Choice

financing policies in
GMC and Md limit
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types, settings and amounts of help each consumer needs and prefers. State and Area Agencies on Aging and some community-based providers offer the assessment and care planning help in most states, at least for some low-income older persons. However, the major funders, Medicare and Medicaid, pay for few of these services outside of nursing homes, so consumer choice is limited by financing policies.

The complexity of identifying and arranging health and long term care services for frail older persons is daunting for public and private paying consumers. Some communities have organized "one-stop-shopping," or "aging resource centers" to provide information and assistance and care management for families and older persons. Such arrangements are not widely available, however, as they are dependent on the limited funding available from the Older Americans Act (less than $1 billion for all services) and special Medicaid waivers managed by states. The absence of information and advice about alternatives makes nursing home care, with its comprehensive range of care, the most convenient form of care for families in crisis; this may overcome cost and other considerations. The predictability of Medicaid for nursing home care, after private funds are expended, also makes nursing homes more attractive in some cases than home care, with its uncertain public funding base.

III. Projections for the Future

Assessment of Resources to Meet Needs

Rising cost and demand are an unavoidable demographic and economic reality. The cost of health care for all age groups is projected to pose a serious threat to our national prosperity. The increased number of older persons will require increased care. Just in the area of long term care, the cost of nursing home

care is expected to rise from a 1993 total of $75 billion to $168.2 billion in the year 2018 in constant (1993) dollars. The Brookings Institution projects that users of nursing homes will increase from 2.2 million to 3.6 million; users of home care from 5.2 million to 7.4 million.

The role of family caregivers other than spouses cannot be expected to remain as high given the necessity for women to be in the paid workforce, the decline in the number of children in each family, and the movement of families away from the communities in which their aging parents reside. The increasing reliance on paid care, and worker shortages, may contribute to a necessary rise in wages and benefits, which means an increase in overall costs of care.

Only a small percentage, perhaps 20%, of the population can be expected to afford lifetime savings or insurance premiums adequate to fully protect the family from the escalating costs of long term care. However, the current public system which requires institutionalization and poverty to qualify for help from Medicaid, exacts a harsh penalty on consumers and their spouses not found in other sectors of health insurance.

Other financing systems have been proposed to enable citizens to insure for the some of the cost of long term care at the level of their ability to pay. Citizens can then expect to pay out-of- pocket (or out of savings) for remaining, uninsured cost of the long term care services they ultimately use, based on how much they can afford, with government subsidies for the rest.

Public costs can be minimized by expanding systems of pre-admission

screening and case management in long term care, to carefully assess needs and to arrange the most consumer-centered, cost-effective services to accommodate different needs and different locations of long term care. The development of innovative services and technology can also reduce costs.

"Assisted Living" is increasingly discussed as a residential care option which costs less than nursing homes. The definition of Assisted Living remains vague - ranging from private apartments with services to maintain independence, to large "group homes" which are fairly institutional in character. Some of the most desirable models, which encourage autonomy and privacy, are priced beyond the means of most older persons. Restrictions on the amount of nursing and personal care provided often result in relatively short lengths of stay before older persons must move. Development of assisted living models which are affordable and encourage "aging in place" holds promise for the future.

Other areas for future service development include: wider availability and lower cost for housing modifications and adaptive equipment for persons with disabilities; more innovative and affordable options for 24-hour care at home; a greater variety of day time programs for disabled older persons; programs to reduce the isolation, loneliness and boredom of homebound older persons; more cost-effective approaches to health monitoring and medication management for homebound older persons, and wider availability of daily home-delivered meals.

The development of innovations in nursing home care, as well as limitations on overuse of institutions, are a necessary strategy for the future. The replacement of aging facilities creates an opportunity for new design concepts that offer greater

privacy, encourage more self-sufficiency and mobility, and maintain mental and physical well-being. At the same time, the use of some nursing homes can be redirected toward more effective and age appropriate rehabilitation in the community.

Most recommendations for the future of health care for the elderly project increases in Medicare expenditure based on the growth of the population, and presume that costs can only be reined in by improving preventive health care, the management of complex health conditions, and restraints on the costliest sectors of the health system.

In long term care, the growth of the population in need of care is the most dramatic change expected on the health horizon. Reform and adequate financing of the system of long term care will include more individualized and cost-effective service arrangements; a flexible array of provider options; care management which is aimed at responding to consumer preference in the most cost-conscious ways; mechanisms for citizens to plan and save for their future care needs; and advice and assistance to families and older persons to organize and purchase care when they need it. Close coordination and planning at the community level will be necessary to assure that there is continuity across the spectrum of services from prevention and primary care, through acute care, and into long term and terminal care.

Autonomy and self-reliance are prominent values in the emerging concepts of health and long term care. Personal responsibility is a prominent theme in the discussion of public policies. Younger citizens can only be expected to save or insure for long term care if there is a simple and financially sound way to do so.

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what long term care will look like

Demands of financing education, the increasing difficulty of home ownership, and the costs of health care for younger families are all barriers to exclusive reliance on private savings and insurance to finance care. Some combination of public and private financing may be the most feasible. Older persons with modest resources also would benefit from cost-sharing arrangements which combine private, public and personal financing of care.

Planning for future health and long term care needs on a national or personal level requires clear goals. Older persons most often express the preference for assistance to remain at home and interdependent with families and community. Older persons express the desire for privacy, self-sufficiency, affordability, simplicity, safety and comfort. Consensus about these goals is a first step toward restructuring the continuumof care services and funding to achieve what citizens want at a price we can all afford into the future.

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

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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.

Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

COMPREHENSIVE HEALTH CARE, INCLUDING LONG-TERM CARE

I. Overview of Major Issues and Policy Considerations

This year marks the 30th anniversary of the Medicare, Medicaid, and Older Americans Act programs. Together they have helped bring health and economic security to older Americans. Yet, the nation faces a dilemma—brought on in part by the success of these programs. As the life expectancy of the elderly in the U.S. has increased to be among the best in the world and as modern technology has brought new ways of both extending and improving the quality of life, the cost of caring for older people has risen. Health care and long-term care for the elderly are expensive for taxpayers and it is expensive for older people themselves. Strengthening these programs to make them work better for older Americans must be balanced against competing demands such as the need to devote resources to assuring children a healthy and productive start in life.

Public programs—primarily Medicare and Medicaid—cover 63 percent of all health care expenses of people age 65 and over. Yet, they fall short of protecting older Americans against the burden of high health care bills and assuring access to quality health care. The major gap is coverage for long term care. Prescription drugs are the major acute care service not covered by Medicare. Disease prevention and health promotion services are not covered by Medicare, except in limited circumstances. For those with moderate incomes, the costs of private

supplemental insurance and the out-of-pocket cost of deductibles, co-payments and uncovered services remain much higher for older people than for the younger population.

Increasing pressures to reduce spending on Medicare, Medicaid, and other smaller publicly-funded health programs are on the horizon. The size of these programs relative to the rest of the federal budget is already quite high. Because of the rapidly growing costs of care associated with health care spending, these programs are viewed by many as unsustainable in their present forms. Moreover, the pressure not only arises from general concerns about the federal budget overall but also the financing crisis facing Medicare in the near term and the longer term challenges of an aging baby boom generation.

Other critical challenges also command attention. Because our health care system is fragmented, there are major problems with coordination of services and continuity of the care provided. Too often care is driven by who pays rather than by what best meets needs. Consequently, people may be inappropriately kept in the hospital when what they need is long term care. Or, because drugs are not covered by insurance, people forgo taking medications, their health status worsens, and they end up using more expensive services. Such situations lead not only to inefficiencies and higher costs, but also to lower quality care for those who have complex needs.

The complex system of financing and delivering health care also leads to confusion. Few families know where to turn or what options are available when long-term care is needed for older family members or disabled children. Filing

claims and sorting out what is owed after a serious illness are onerous. Medi-Gap supplemental insurance policies can be confusing and costly. As managed care plans increasingly market to older people, the merits and quality of care of these alternative choices are often obscure. Expanding choices, fostering independence, and enabling people to make informed decisions about issues critical to their well-being are major challenges.

Finally, until quite recently research in health care often ignored the needs of older Americans. It was simply not considered a very high priority. Trials of new drugs and tests of new procedures often still do not include elderly subjects even though the elderly are high users of health care.

II. Assessment of Current Situation

Despite popular views that older Americans enjoy high incomes and standards of living, most elderly Americans have modest incomes. For example, over three-fourths of Medicare beneficiaries have incomes below $25,000 and only about 5 percent have incomes above $50,000. Out of these modest incomes, older persons must make substantial payments for health care insurance premiums and out-of-pocket spending. In 1994, it is estimated that such expenses totaled about $2500 per elderly person residing in the community, although those amounts vary substantially across families by age, presence of supplemental insurance, and income. Persons over age 80, for example, devote over 29 percent of their incomes, on average, to health care expenses.

For persons young and old with substantial long term care needs, burdens of

health care spending quickly become catastrophic. The annual cost of a nursing home exceeds $30,000 per year in most parts of the country and even modest amounts of home care services can mount up to $10,000 or $15,000 per year. These expenses are beyond the reach of most Americans if they must fully pay for them out of pocket. Moreover, many seniors who need long term care also have high acute care spending needs as well.

These high expenditures do not come about because of a lack of other sources of support. Rather, it is because the overall costs of care are very high and public and private insurance programs leave a number of gaps in coverage. For example, the elderly represent only about 12 percent of the U.S. population, but account for 36 percent of all health care spending in the U.S. These costs are spread over a number of payers of health care on behalf of older Americans. Medicare accounts for 45 percent of spending on the elderly and Medicaid and other public programs cover another 18 percent. Medicaid is also a critical part of the safety net for millions of low-income children.

Private sources of spending—a little more than a third—include supplemental insurance coverage and beneficiary out-of-pocket payments. About three-quarters of seniors have some form of private supplemental coverage. Generally, they pay for much of the costs of supplemental insurance through private insurance. The exception is older Americans fortunate enough to have good employer-subsidized employee or retiree coverage. But only 38 percent of Medicare beneficiaries have this type of supplemental insurance. Although that number has grown substantially since the 1970s, it may not expand much further as more and more employers have chosen to limit or cut back their retiree health benefits. Furthermore, supplemental

coverage does not eliminate the risks of very high health care burdens when an individual has an expensive acute care episode.

Private insurance for long term care is much less prevalent. Only about 2 million such policies have been sold in the U.S. and many of those are owned by persons under the age of 65. Many persons over age 65 with any type of health problem would find it difficult to purchase private long-term care insurance. Thus, as yet private insurance offers little in the way of protection against long term care needs.

What about the public programs that offer health care services to older Americans? Medicare is the largest and most important program. It covers nearly 98 percent of all persons over 65 residing in the U.S. Eligibility for Medicare is related to eligibility for Social Security benefits, either as workers, dependents or survivors. Once eligible, an individual is covered without charge by Part A, Hospital Insurance. This part of the program is funded by payroll tax contributions and covers hospital, home health and limited skilled nursing home services. Part B, Supplementary Medical Insurance, is voluntary and enrollees in Part B must pay a premium equivalent to a little more than 25 percent of the actuarial costs of the insurance. Most, but not all, Part A beneficiaries sign up for Part B. This part of the program covers physicians services, outpatient care, and laboratory and other ambulatory services. Medicare was intended to be an acute care program and thus it
covers almost no long term care services.

Medicaid, on the other hand, covers a broader range of acute and long term

care services, but to a more limited group of older Americans. It is a joint federal/state program and hence many of the details vary across the United States. Moreover, there are actually several types of older Medicaid beneficiaries who qualify in different ways and may receive different services. Low income seniors become eligible by qualifying for the Supplemental Security Income program. Most of these "categorical" eligibles are automatically enrolled in Medicaid and can receive all acute and long term care services offered. Even for persons with Medicare, this is likely to be an important benefit, filling in acute care services such as prescription drugs and alleviating the older person from having to pay cost sharing under Medicare or Part B premiums.

Another group which becomes eligible are those who have very high medical expenses and hence their incomes net of medical expenses are low enough to qualify them as "medically needy." These beneficiaries are often nursing home residents who rapidly spend down because of the very high costs of nursing home care. They receive help, but only after they have already spent a great deal of their incomes and assets. And, 20 states do not have a medically needy program.

A last group of eligibles are those who are in what is referred to as the Qualified Medicare Beneficiary (QMB) program. These additional enrollees in Medicaid have incomes below 100 percent of poverty (or between 100 and 120 percent of poverty for a less generous, related program). In this case they are not eligible for all Medicaid benefits, but only for relief of the premiums and cost sharing expenses that Medicare requires. This benefit, added in 1989, thus could help to fill in gaps in coverage for those with very low incomes. Participation in the QMB program remains low, however.

Medicaid has become, by default, the major public program for long term care. Since it was designed as a welfare program, individuals must spend most of their own incomes and assets before becoming eligible for any help. In turn, this has led many persons to seek ways to meet these requirements, while protecting or transfering their assets. But even more important is the poor balance between nursing home and home and community based services. One of the major gaps in health care coverage for the elderly is in the lack of home care services. Some states, like New York or Oregon, have been aggressive in offering home care services to their Medicaid beneficiaries, but these states are the exceptions and not the rule. Partly as a result of few public dollars available to support development, capacity in home care has tended to lag. In the last few years, however, there has been a rapid increase in the availability and use of such services, albeit from a very small base.

From the perspective of public costs of these various programs, aggregate spending by Medicare and Medicaid is very high. In 1995, total spending by Medicare on persons age 65 and older will be about $155 billion and on Medicaid for people age 65 and over nearly $46 billion (counting both the federal and state shares). This will constitute 12 percent of the federal budget and 2.5 percent of GDP in the U.S. These two programs are each expected to grow about 10 percent per year for the foreseeable future.

Information on the quality of health care services for older Americans is more difficult to come by. But interestingly, in recent surveys, Medicare beneficiaries report higher levels of satisfaction with their health insurance as compared to beneficiaries of all other types of insurance. Among Medicare

beneficiaries, 52 percent say they are very satisfied, as compared to only 44 percent of those with employer-provided insurance. Moreover, when considering various issues, 89 percent of Medicare beneficiaries report they are very satisfied with the overall quality of their care. The percentages drop off, however, when the question refers either to out-of-pocket costs (72 percent very satisfied) and availability of care (46 percent). Some of the concerns about availability may be capturing some of the increased reluctance by providers to take new Medicare patients. As yet, however, this problem is still an isolated one.

III. Future Directions

What will the future hold? It seems very likely that there will be increasing pressures to reduce spending on health care services for the elderly through the public sector. Indeed, there are already calls for major reductions as part of the budget balancing discussion underway in the U.S. Congress. These items are too large a part of the federal budget to ignore. This means that not only are expansions in areas such as long term care or prescription drugs unlikely in the near future, but also that some of the budget cutting efforts are likely to affect current levels and quality of services offered.

There are few easy ways to slow public spending. Payment levels to providers of health care services are already lower for both Medicare and Medicaid than those found in the private sector. Although most providers still take Medicare patients, major cutbacks in payment levels could reduce access to care over time, or affect the high quality of care that beneficiaries now generally receive. It could also threaten the financial stability of institutions that depend on Medicare revenues,

budget cuts will affect Medicare

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such as rural hospitals and specialized teaching hospitals. Payment levels under Medicaid are already so low that it would be difficult to cut them any further. Under Medicare, beneficiaries may be asked to pay more for their care in the form of higher cost sharing or premiums.

The movement to managed care that is taking place so rapidly elsewhere in the health care system will have a major impact on America's senior citizens as well. Even if Medicare and Medicaid stick with the largely fee-for-service systems they have in place for older beneficiaries, the private marketplace changes will influence the availability of care for seniors. It is very likely that expansion of managed care will be undertaken as a means for holding down the rate of growth of spending in these programs.

If done well, managed care holds a lot of promise; effective coordination and support of those with high cost illnesses could be a benefit to both patients and taxpayers. Moreover, competition among private plans to package services creatively for senior citizens might lead to some improvements in the coordination of acute and long term care services. But managed care plans have tremendous financial incentives to cover only healthier patients and to cut corners in the provision of quality care. Managed care plans have little experience meeting the special needs of elderly and disabled patients. Studies to date show that managed care costs rather than saves Medicare money—in part because the current method of paying managed care plans can not adjust appropriately for the health status of enrolled beneficiaries. Moreover, reporting requirements about the quality and quantity of care provided by managed care plans are very limited. Nor do beneficiaries have the information they need to make informed choices among

managed care plans.

Fiscal pressures make it important to set priorities. Expansion of home and community based services needs to be weighed against reducing out of pocket costs for acute care such as prescription drug benefits. Improved supplemental coverage and outreach to low-income seniors to participate in the QMB program must be evaluated against more funds for prevention and basic and applied medical research on issues important to the health of older people. The need for improvements in Medicare and Medicaid must be weighed against other national priorities.

Resolving the dilemma of assuring affordable quality care for older people and addressing the federal budget deficit and looming Medicare insolvency requires making careful choices and trade-offs. Accurate information and an informed public debate are critical. The full array of options needs to be developed, analyzed, and carefully considered. They should include new revenues such as increased income or payroll taxes, premiums, and taxes on Social Security or Medicare benefits. Increased revenue options should be analyzed by their fairness and intergenerational equity. Restructuring benefits to provide better coverage for the chronically ill and older people with modest incomes should be weighed against moderately higher Part B premiums or deductibles for all. Tighter provider payment rates for managed care plans, hospitals, and physicians should be considered in the context of acceptable differentials between public program and private insurer provider payment rates, and the need to preserve a high quality health care system for all Americans.

Most importantly, people need information and choices so that they can take

greater responsibility for decisions that affect their independence and well-being. This includes making decisions among physicians or managed care plans and selecting a home care aide or assisted living facility, as well as their role as citizens and voters expressing their views about programs which have a 30 year record of protecting their health and economic security.

Final Draft

1995 WHITE HOUSE CONFERENCE ON AGING

BACKGROUND PAPER FOR DELEGATES

THE OLDER AMERICANS ACT

last page only

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.

Karen FYI
Pl review for any probs you may have Rhy

Assuring Comprehensive Health Care Including Long-term Care
IRDS 2 Access to Quality Care

2.4 Reforming the Health Care System

1 WHEREAS the components of the health care system are so interrelated that no part can function well unless the system as a whole functions well;

2 WHEREAS the cost of health care is rapidly escalating and currently represents over 17% of the Federal budget and up to 25% of each older person's annual expenditures;

3 WHEREAS 40 million Americans are uninsured, including one-quarter of all children;

4 WHEREAS the current health care system does not adequately emphasize preventive care;

5 WHEREAS Medicare covers only 50% of all health care expenses of people age 65 and older and covers almost none of the cost of long-term care; and

6 WHEREAS the Federal budget deficit cannot be eliminated without reforming the health care system,

THEREFORE, BE IT RESOLVED by the White House Conference on Aging to support system-wide reform efforts that adhere to the following principles:

7 Americans of all ages are entitled to health security, including ~~access to~~ affordable health care and especially long-term care, while preserving choice of health care providers;

8 Cost containment is a critical component of meaningful health care reform and must not be isolated from the reform process;

9 Medicare's commitment to its beneficiaries must not be jeopardized by arbitrary cuts. Savings can be achieved in Medicare and then reinvested in expanded coverage, to include long-term care, thus making Medicare more cost effective;

10 Long-term care is to be developed with home and community based services as well as institutional services. Private long-term care insurance must include specific consumer protections and safeguards;

11 Health promotion and prevention services must be emphasized; and

12 Improved consumer information and education must accompany health care reform to ensure that quality care is not sacrificed.

prescription drugs added

M E M O R A N D U M

To: **Melanne Verveer**
Patti Solis

From: **Karen Guss**

Date: **April 12, 1995**

Re: **White House Conference on Aging**

cc: **Jennifer Klein**

Yesterday, I attended a planning meeting for the White House Conference on Aging at which a few issues that may be of interest to you were discussed.

First, the official opening of the Conference will be a two-hour plenary session on the morning of May 3, at which the President, Cabinet Secretaries, and Members of Congress will speak. The session will be carried by satellite to at least 10 locations. The downlink sites include New York, Providence, Pittsburgh, Orlando, San Diego, Los Angeles, Sacramento, Dallas and Little Rock. The seating capacities at the sites range from 400 to 2000 people. People at yesterday's meeting discussed trying to get the Cabinet and others to appear at the satellite sites on May 3 as hosts of the event, with the goal of attracting regional press. I wanted to let you know about this because someone (probably Lee Ann Inadomi) will be contacting one or both of you in an effort to get Mrs. Clinton and/or Mrs. Rodham to host at one of these sites. (As you know, Mrs. Clinton has her own WHCoA event in Washington the following day, May 4, at 8:30 a.m.).

The Conference staff brought up the Older Americans Month proclamation, and asked when it would be signed by the President. (Older Americans Month is in May). Melanne, as you may recall, when Norma Asnes came in a few weeks ago, she told us that she was interested in White House hosting an event honoring older Americans and she reacted enthusiastically to a suggestion made by a representative of the Administration on Aging that the President sign the Older Americans Month proclamation at the event. I'm unaware of the status of Norma's suggestion, but if her suggested event is going to happen and we want the proclamation signed at it, perhaps we should get involved before other plans are made.

Finally, the AARP's radio programs were discussed. These programs reach tens of millions of seniors. It might be worthwhile for the First Lady or someone else connected to the mammography awareness campaign to appear on one of the programs.

Another option could be to tape the remarks made at the kickoff on May 1 and then broadcast them on an AARP program.

Please call me at (x65603) if you have any questions or would like me to follow up on this memo.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

10-Apr-1995 01:55pm

TO: (See Below)

FROM: Jeremy D. Benami
Domestic Policy Council

SUBJECT: Aging Meeting

Final confirmation!

Meeting is at 1:00 Tuesday room 211

I have assembled the following agenda items. Please e mail me with additions. My only suggestion is that we steer away from the big picture questions we can't answer at our pay grade and focus on what we can address - such as the items listed below!

1. Program for Opening Plenary
   - who besides POTUS is/should be invited to speak

2. Media Strategy
   - what media opportunities have been planned
   - what requests have been made
   - what opportunities exist to plug delegates for regional media
   - general brainstorming focussing in particular on speciality/aging press

3. Satellite sites
   - status report on planning, funding, etc.
   - how should we reach out to mayors, govs
   - what level admin representation should we aim for?

4. Pre-Conference rollout
   - First Lady event
   - Report on other events planned?
   - Should we look to a Cabinet pre-rollout?

5. Discussion re groups
   - what sort of outreach to and coordination with the groups pre-conference should we be doing?

I've set the meeting for an hour and a half because I think these are all topics that require some detailed discussion. I hope most

of you can come for the whole time and will understand if I try to

hold us to this agenda.

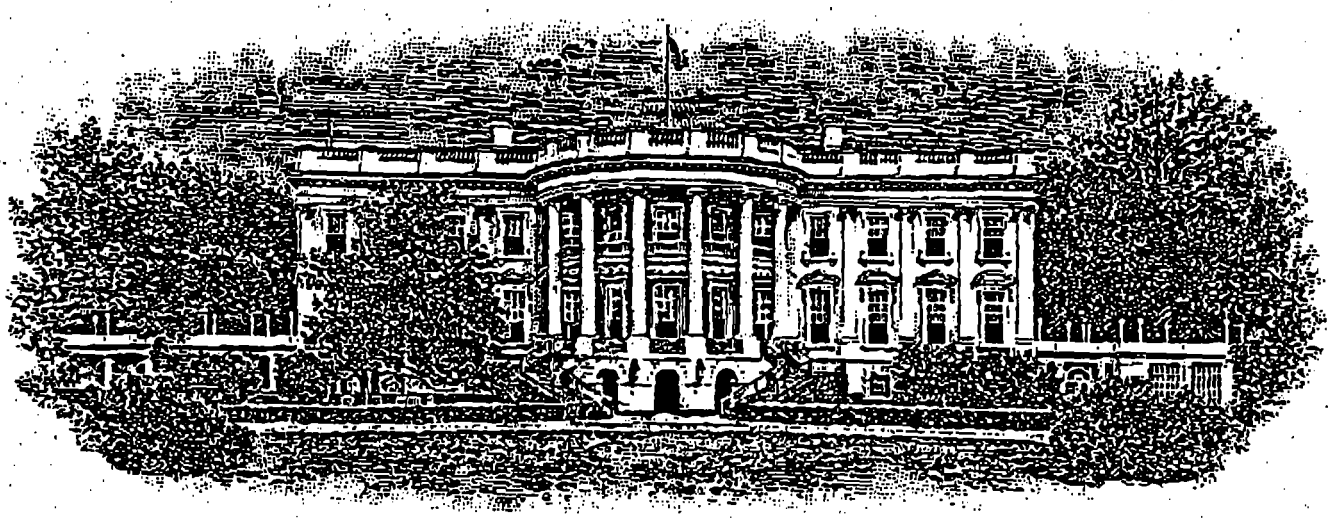
Based on this meeting, we may want a follow-up with Gearan, Sperling, (Alexis?), and other higher-ups later this week or early next to report on where we are and to revisit some of the bigger picture items.

See you tomorrow.

Distribution:

TO: LeeAnn Inadomi
TO: Julia Moffett
TO: Anna Winderbaum
TO: Marilyn Yager
TO: Mike Lux
TO: Barbara C. Chow
TO: Lorraine McHugh
TO: Christopher C. Jennings
TO: Stacey L. Rubin
TO: Jennifer L. Klein
TO: rb@ban-gate.aoa.dhhs.gov@INET

The White House



DOMESTIC POLICY

FACSIMILE TRANSMISSION COVER SHEET

TO: Jen Kline

FAX NUMBER: 6-2878

TELEPHONE NUMBER:

FROM: Jeremy

TELEPHONE NUMBER:

PAGES (INCLUDING COVER): 2

COMMENTS:

FAX to Jon K

Dear ----------,

I am delighted that you are serving as a delegate to the 1995 White House Conference on Aging.

You can take great pride in your selection for participation in this historic Conference, only the fourth in history. In your role as a delegate, you will help to shape a national aging policy for our country -- a policy that will move us into the twenty-first century.

In fact, you may have already participated in one of the more than 800 pre-White House Conference on Aging events in the fifty states and territories. The grass roots participation in the planning and development of this conference has been critically important.

This Conference is a chance to reaffirm our commitment to security, good health and productive lives for older Americans -- and for all Americans. Seniors from around the country have voiced their concerns for the well-being of their children, grandchildren and great-grandchildren. In fact, this year's conference theme says it best -- "America Now and Into the Twenty-first Century: Generations Aging Together With Independence, Opportunity and Dignity for all Americans."

Your active support and participation in the proud tradition of White House Conferences on Aging will be critical to the success of the 1995 conference. I believe we can work together to stimulate public attention to the challenges facing older Americans and future generations and to identify common goals and solutions.

Karen

White House Conference on Aging Meeting Agenda
April 6, 1995

I. THE BASICS

Date: May 2-5, 1995
Theme: America Now and Into the 21st Century: Generations Aging Together with Independence, Opportunity and Dignity
Agenda: 1) Assuring Comprehensive Health Care incl. Long Term Care
2) Promoting Economic Security
3) Maximizing Housing and Support Service options
4) Maximizing Options for a Quality of Life
POTUS: Addressing Plenary Session on May 3; other requests pending (Seniors Focus Group, "Senior Speak Out")
Chair: Senator David Pryor
Participants: 2250 delegates from 50 states (chosen by Govs. and Members)
Satellites: Providence, RI; East Rutherford, NJ; Pittsburg, PA; Orlando, FL; Dallas, TX; Little Rock, AR; Los Angeles, CA; San Diego

II. MESSAGE

-Standard "Fighting for Seniors; Protecting"?
-How best to tap into "Future" message?
-Set the groundwork on 4/12--Social Security event

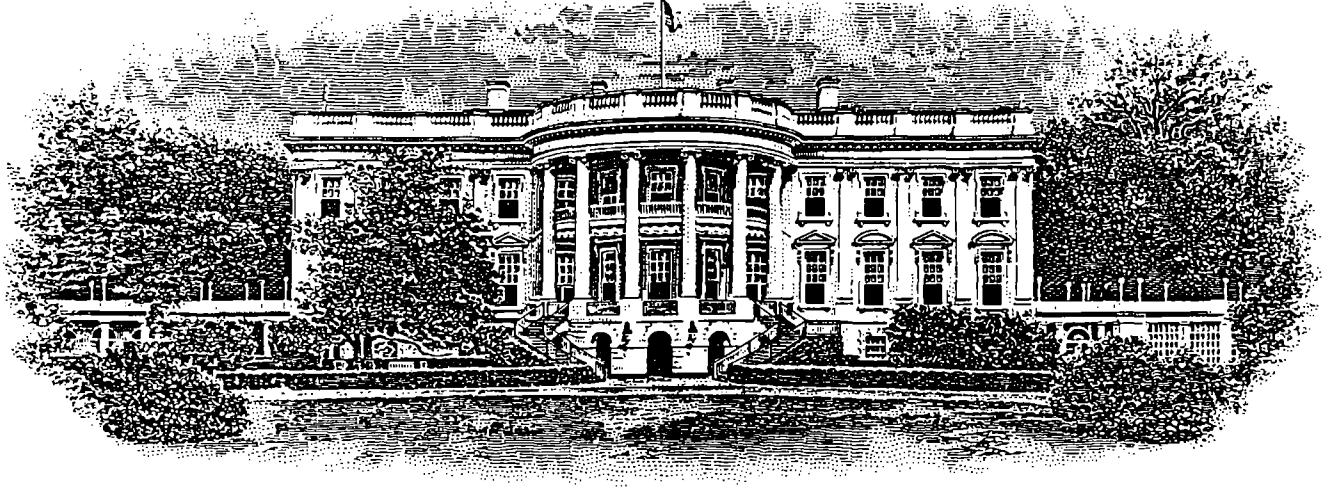
(Important to keep in mind that at the past conferences in 1961, 1971 and 1981, delegates developed and voted on policy recommendations which precipitated landmark legislative initiatives such as Medicare, Medicaid, the Older Americans Act and reforms to Social Security.)

III. POLITICAL CONTEXT

-Late April/early May Senate Finance Hearing on Medicare Trust Fund
Shalala, Rubin, Vladeck invited to testify
-Tie-in to 30th anniversary of House passage of Medicare; the House is throwing a big birthday event

IV. ROLL-OUT

-POTUS Press/Events
-Other Principles
-Cabinet Press/Events
-Intergovernmental Press/Events (All states are hosting WHCOA activities)
-Public Liaison/Aging Groups; Baby Boomers; Generation X
-Congressional Participation/Outreach
-Media Affairs



1995 WHITE HOUSE CONFERENCE ON AGING
FACT SHEET

The fourth White House Conference on Aging (WHCoA) -- and the last of this century -- will be held May 2-5, 1995, in Washington, D.C. President Clinton called for the Conference on February 17, 1994. The WHCoA Policy Committee, a 25-member body appointed by the President and the Congress, set the dates and place at its first meeting on July 27, 1994. Senator David Pryor (D-AR) chairs the Policy Committee.

On January 25, 1995, the Policy Committee approved a theme and final Conference agenda. The theme is "America Now and Into the 21st Century: Generations Aging Together with Independence, Opportunity and Dignity." Four broad issues comprise the agenda: (1) Assuring Comprehensive Health Care Including Long Term Care, (2) Promoting Economic Security, (3) Maximizing Housing and Support Service Options, and (4) Maximizing Options for a Quality Life. In deciding on the theme and final agenda, the Policy Committee considered public comments on theme possibilities and a draft agenda published in the Federal Register October 12, 1994. In addition, reports and recommendations from hundreds of officially recognized WHCoA events throughout the country were considered in developing the final agenda, which was published in the Federal Register February 2, 1995.

Two cross-cutting concerns pervade the agenda and will influence discussions at the Conference. These are: (1) interdependence among generations and among members of extended families, and the responsibility of individuals to plan for changes that will occur throughout their lifespan; and (2) unique contributions and needs of special populations, especially veterans, caregivers (including grandparents), rural elderly, women, minorities and individuals with disabilities.

Purposes of the WHCoA are to shape resolutions that will influence national aging policy over the next decade and design a strategy for putting policy into action -- for implementing the resolutions the Conference produces.

-over-

The 1995 Conference, authorized by the 1992 Amendments to the Older Americans Act, will have 2,258 delegates. In addition, it will have up to 250 observers, individuals who may attend the Conference but not vote. Delegates are selected by governors, members of Congress, constituent organizations (including national aging organizations and veterans groups), the White House, the HHS Secretary and the WHCoA.

Since President Clinton officially called it on February 17, 1994, the WHCoA has developed a full national program of pre-Conference events and activities. More than 700 events have been held or scheduled, including local, state, regional and mini-conferences. In addition, the WHCoA, in partnership with other organizations, has conducted more than 15 focus groups in a variety of cities throughout the country to gain direct input from individuals, primarily seniors, on their attitudes about aging and their views on what the WHCoA should focus on and strive to accomplish.

President Clinton appointed Robert B. Blancato as executive director of the 1995 WHCoA. Members of the WHCoA Policy Committee are:

David Pryor, U.S. Senate (D-AR), Chair
William S. Cohen, U.S. Senate (R-ME)
Daniel P. Moynihan, U.S. Senate (D-NY)
Barbara A. Mikulski, U.S. Senate (D-MD)
Constance A. Morella, U.S. House of Representatives (R-MD)
Andrew Jacobs, Jr., U.S. House of Representatives (D-IN)
William J. Hughes, U.S. House of Representatives (D-NJ) (retired)
Matthew G. Martinez, U.S. House of Representatives (D-CA)
Donna E. Shalala, Secretary of Health and Human Services
Henry G. Cisneros, Secretary of Housing and Urban Development
Jesse Brown, Secretary of Veterans Affairs
Norman Abramowitz, Mayor of Tamarac, FL
Bea G. Bacon, Central States Coalition on Aging, Olathe, KS
Horace B. Deets, Executive Director, American Association of Retired Persons
James T. DeLaCruz, Coordinator, Quinault Senior Citizens Program, Tahola, WA
Rose Dobrof, Executive Director, Brookdale Center on Aging of Hunter College, New York, NY
Madeleine R. Freeman, Orono, ME
Maralee Lindley, Director, Illinois Department on Aging, Springfield, IL
Thomas H.D. Mahoney, Cambridge, MA
Mary Rose Oakar, President, Healthright, Inc., Cleveland, OH
Herb A. Sanderson, Director, Division of Aging and Adult Services, Arkansas Department of Human Services, Little Rock, AR
Samuel J. Simmons, President and Chief Executive Officer, National Caucus and Center on Black Aged, Inc.
Lawrence T. Smedley, Executive Director, National Council of Senior Citizens
Marta Sotomayor, President, National Hispanic Council on the Aging
Daniel Thursz, President, National Council on the Aging

FEBRUARY 1995