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Before the

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and
The Senate Subcommittee on Retirement Security and Aging

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The National Caucus and Center on Black Aged, Inc. (NCBA)

Recommendations for the 2005 Reauthorization of the Older Americans Act (OAA).

My name is Karyne Jones and I am President and CEO of the National Caucus and Center on Black Aged, Inc.

From its inception The National Caucus and Center on Black Aged, Inc. supported the spirit and objectives of the Older Americans Act (OAA) and continues its long-standing support. As the Congress considers the reauthorization of the OAA, NCBA wants to state its support of the reauthorization as follows:

NCBA strongly opposes any across-the-board cuts to discretionary spending programs. Such cuts are likely to have a disproportionate impact on OAA programs. We do not support eliminating specific references to minorities. It remains a sad reality that minorities are still disproportionately at the lower end of the economic spectrum. Removal of targeting language will undermine efforts to direct services to the neediest older Americans and roll back the progress that has been achieved in minority and low-income participation in the OAA.

NCBA opposes merging disability and aging services. Although many needs of the two groups do converge, the merging of these services will obscure the often distinct priorities. The ability of service agencies and organizations to respond to the needs of the elderly will suffer from the additional bureaucracy. Reluctantly the example of the Office of Homeland Security provides an almost worst-case scenario for this type of administrative umbrella.

NCBA opposes these changes to the Senior Community Service Employment Program (SCSEP) 1. Eliminating national sponsors, 2. Eliminating service to participants under age 65, and 3. Eliminating fringe benefits for participants.

NCBA supports preparation for the demands resulting from the aging of the baby boomer generation. This is overdue in fact. The boomers have already begun to reach 55 and will reach 60 before our systems have been ramped up to meet their needs. The impacts on all services including those authorized by the OAA (including the Senior Community Service Employment Program (SCSEP), National Family Caregiver Support Program (NFCSP), nutrition programs as well as Health Promotion and Disease Prevention activities) will reach unprecedented levels. Service providers at all levels will have to be proactive to meet the needs of the increased number of older Americans potentially utilizing services. Particular attention must be paid to prepare for those who will be near or below the poverty line.

NCBA supports a 25% increase in OAA authorization levels. This increase will offset the impact of inflation and compensate for the flat funding levels of the past several

years. The failure to increase the authorization levels has amounted to cutting spending levels as a result of inflation.

NCBA supports establishment of Aging and Disability Resource Centers. The centers will provide a one stop sources for assisting senior and disabled citizens' with their long term care and service support needs. The ability of well-trained representatives to access and inform clients will reduce the burden of information gathering and the application process involved.

NCBA supports the retaining the current operational structure of the Senior Community Service Employment program (SCSEP) utilizing National sponsors and state aging units. The system has served the goals of the legislation and the clients very effectively. **We support** reinforcing income security for low-income SCSEP participants by providing exemptions for SCSEP wages when determining eligibility for federal benefits programs (e.g. Medicaid). The combination of near poverty line status and fixed incomes demands this relief in order for many elderly to maintain a reasonable quality of life. **NCBA supports** establishing practical assessment standards and performance expectations particularly for unsubsidized placements. The benefits of workers moving to private sector or direct government employment are many, the most important being making room for new participants as more baby boomers become eligible.

NCBA supports affordable housing for seniors, particularly low income seniors. This is an increasingly important necessity for older Americans that the legislation does not address. This is a vital area to be considered during this reauthorization phase. The current lack of affordable senior housing, coupled with the loss of low income housing nationally presents a two-edged sword due to the fact that many seniors reside or resided in public housing. Beyond health care, this will be the most vital area to be addressed as the baby boomers mature. The scope of the OAA should be expanded to authorize AoA to program for this burgeoning necessity.

NCBA supports strengthening the Health Promotion and Disease Prevention capacity of the OAA and its service providers by establishment of evidence-based programs that will be implemented at the local, state and national levels. **NCBA supports** allocating funds for outreach and enrollment assistance for the Medicare prescription drug program. N**CBA supports** directing services to those older individuals with the greatest economic and/or social need with particular attention to low-income minority individuals and demographically dense communities.

Following this brief statement are some facts and statistics that illustrate the increasing importance of the services provided for by the OAA. These facts highlight the necessity of carefully addressing the authorization levels, organizational structure of service delivery systems and scope of the Act. There are many areas where racial, ethnic or socioeconomic disparities continue to have an impact in our society and the health and wellbeing of minority seniors.

As we whole-heartedly support the Older Americans Act reauthorization we must be committed to enacting appropriations that effectively empower the agencies to carry out their mission and service provision for our elders. The Congress and Administrative branch can be proud of the Older Americans Act, its goals and achievements. Let's not run the risk of prematurely rolling back its authority or diluting its ability to meet its designed objectives. Thank you for giving me the opportunity to share NCBA's enduring appreciation for the Act and the efforts of the many agencies and organizations that implement the resultant programs.

POPULATION DEMOGRAPHICS

"From 1950 to 2004 the total resident population of the United States increased from 150 million to 294 million, representing an average annual growth rate of 1 percent (figure 1). **During the same period, the population 65 years of age and over grew twice as rapidly** and increased from 12 to 36 million persons. The population 75 years of age and over grew 2.9 times as quickly as the total population, increasing from 4 to 18 million persons. Projections indicate that the rate of population growth from now to 2050 will be slower for all age groups, and **older age groups will continue to grow more than twice as rapidly as the total population**." This ''preretirement age'' population, defined as all adults 55–64 years of age, is projected to be the fastest growing segment of the adult population during the next 10 year period.[1]

HEALTH STATUS OF OLDER AMERICANS

"While many Americans age 55–64 are in good health and relatively well off financially, minorities, primarily African Americans, American Indians, and persons of Hispanic origin, are more likely than non-Hispanic white Americans to have chronic health problems, live in poverty, lack insurance coverage, and be unable to work because of a disability."

The percent of the population that is black or Hispanic is increasing. If current racial and ethnic disparities do not narrow, this trend could indicate even higher prevalence of obesity, diabetes, hypertension, and other diseases more common in minorities and a corresponding higher burden on the health care system.

"Changes in the racial and ethnic composition of the population have important consequences for the Nation's health because many measures of disease and disability differ significantly by race and ethnicity. One of the overarching goals of U.S. public health policy is elimination of racial and ethnic disparities in health."[2]

Adults age 55–64 have more frequent and more severe health problems than younger people. The prevalence of diabetes, hypertension, heart disease, and other chronic diseases increase with age. In addition, hypertension and obesity have been increasing over time for this age group.

Cardiovascular Risk Factors

Hypertension, obesity, and high cholesterol are all independent risk factors for the leading causes of death in the United States—heart disease and stroke. Hypertension is also a major risk factor for congestive heart failure and kidney failure. Being obese is associated with increased risk of morbidity and mortality. High cholesterol increases the likelihood of developing heart disease and raises the risk of heart attacks among those with heart disease.

Between 1988–94 and 1999–2002 the percent of adults 55–64 years of age with one or more of the three cardiovascular risk factors examined remained level at about 70 percent.

Almost one-half of non-Hispanic black adults had two or three of the risk factors, compared with just under one-third of non-Hispanic white and Mexican adults.

Mammography

Breast cancer is the most common type of newly diagnosed cancer among women and the second leading cause of cancer deaths for women. In 2002 approximately 204,000 women in the United States were diagnosed with breast cancer and nearly 42,000 women died from the disease. Rates of newly diagnosed breast cancer, breast cancer survival rates, and death rates vary among race and ethnic groups.

Disparities in mammography screening among underserved women with low income or less education also continue to exist. In 2003 poor women remained less likely than women with higher incomes to have a recent mammogram 55 percent compared with 74 percent.

Pap Smear

A Pap smear is a microscopic examination of cells scraped from the cervix that is used to detect cancerous or precancerous conditions of the cervix and other medical conditions. If detected, precancerous conditions can be treated before they become malignant.

Pap smear screening rates remained lower for Asian and Hispanic women than for non-Hispanic black and non-Hispanic white women.

Health and Healthcare Disparities

African Americans are 10 times more likely than whites to be diagnosed with AIDS.
African Americans are 10% more likely than whites to have poor access to healthcare and 9% more likely to receive poorer quality care.

Hispanics are 3.7 times more likely than whites to be diagnosed with AIDS.
Hispanics are 87% more likely than whites to have poor access to healthcare and 16% more likely to receive poorer quality care.

EMPLOYMENT STATUS

Employment, or past employment, is a determinant of access to health care both in terms of supplying income to pay for care and also because employer-sponsored health

insurance is frequently offered to employees. In 2002–03 employment status differed by race and ethnicity. Non-Hispanic white men and Hispanic men were more likely to be working (about 65 percent) than non-Hispanic black men (57 percent). Among women, a little over one-half of non-Hispanic white women were working compared with 46 percent of non-Hispanic black women and 41 percent of Hispanic women. Hispanic women in this age group were more likely to be taking care of home or family than non-Hispanic women. Hispanic men and women were less likely to be retired than non-Hispanic adults 55–64 years.

Unemployment due to disability was higher for non-Hispanic black men and women age 55–64 years than for other racial and ethnic groups. In 2002–03, about one-fifth of non-Hispanic black men and one-quarter of non-Hispanic black women were unemployed due to a disability compared with 15 percent of Hispanic adults and 10 percent of non-Hispanic white adults.

LOW INCOME

People with low income are more likely to be in poor health and have a higher prevalence of many serious chronic diseases than those with higher incomes. Their worse health is a result of many factors including a higher prevalence of health risk factors, poor nutrition and housing, occupational and environmental hazards, and other social ills (1). Poor health may also contribute to poverty by reducing the ability to earn income. People living below or near the poverty level are also more likely to lack health insurance, which, combined with their low incomes reduces their access to health care.

In general the preretirement age population 55–64 years has higher incomes than older persons age 65 and over. In 2003 more than one-fifth of the population age 55–64 had incomes below 200 percent of poverty, compared with almost two-fifths of older persons age 65 years and over. More older adults than preretirement age adults had incomes in the 100–199 percent of poverty range. The percent living below 100 percent of poverty, however, was similar for the two groups (about 10 percent). There is large variation in the poverty distribution by gender and race and Hispanic origin for the preretirement age population. In 2003 women 55–64 years of age were more likely than men to be living in poverty (10 percent compared with 8 percent). Both non-Hispanic black and Hispanic men and women were about twice as likely to be living in or near poverty as non-Hispanic white adults. In addition, non-Hispanic black and Hispanic women were more likely to be poor than their male counterparts.

Income for persons age 55–64 is not likely to increase and will probably decrease upon retirement. Persons 55–64 currently living in poverty most often cannot expect future increases in their employment-based incomes. Employment prospects at this age for poor and near poor persons diminish and are most often limited to low income jobs with few fringe benefits.

HEALTH INSURANCE COVERAGE

Health insurance coverage is an important determinant of access to health services and is of particular importance for people with chronic conditions that require ongoing care. Whereas Americans age 55–64 years are more likely to be insured than other working-age adults under age 65, preretirement age adults do not have the guarantee of health insurance coverage that Medicare offers to almost all older adults age 65 and over.

Adults 55–64 years of age are reaching a time of life when health problems are likely to become more frequent and more serious. Consequently, persons of this age group are likely to have greater health care needs, on average, than younger persons. Because being married is associated with higher rates of health insurance, minority women, in particular, are more at risk for being uninsured than other groups, as well as more likely to live in poverty.

SOURCES

1. National Center for Health Statistics, Health, United States, 2005, With Chartbook on Trends in the Health of Americans, Hyattsville, Maryland: 2005
2. 2005 National Healthcare Disparities Report., Agency for Healthcare Research and Quality