103d Congress } SENATE { Rept. 103-40
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DEVELOPMENTS IN AGING: 1992
VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 71, SEC. 19(b), FEBRUARY 25, 1992

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

April 20 (legislative day, April 19), 1993.—Ordered to be printed

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103D CONGRESS
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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, March 8, 1993.

Hon. ALBERT A. GORE, Jr.,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 71, Section 19(b), agreed to February 25, 1992, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1992, volume 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, and securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions taken during 1992 by the Congress, the administration, and the U.S. Senate Special Committee on Aging, which are significant to our Nation's older citizens. It also summarizes and analyzes the Federal policies and programs that are of the most continuing importance for older persons and their families.

On behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

DAVID PRYOR, *Chairman.*

SENATE RESOLUTION 71, SECTION 19(b), 102D CONGRESS, 2ND SESSION [1]

SEC. 19. (a) In carrying out the duties and functions imposed by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4, 1977, and in exercising the authority conferred on it by such section, the Special Committee on Aging is authorized from March 1, 1992 through February 28, 1993, in its discretion (1) to make expenditures from the contingent fund of the Senate, (2) to employ personnel, and (3) with the prior consent of the Government department or agency concerned and the Committee on Rules and Administration, to use on a reimbursable basis the services of personnel of any such department or agency.

(b) The expenses of the committee under this section shall not exceed $1,184,439, of which amount (1) not to exceed $33,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $800 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such Act).

[1] Agreed to February 29, 1991.

PREFACE

The second session of the 102nd Congress found the country's attention riveted on the 1992 Presidential Campaign. As is always the case during an election season, there was considerable attention given to the broad canvas of domestic policy issues, with the Congress attempting to anticipate what legislative changes would result from the outcome of the election.

Arguably, the most prominent theme of the Presidential Campaign was the importance of overhauling the Nation's health care system. Congressional debate on this issue was heightened during 1992, as both the House of Representatives and the Senate prepared to tackle the health reform issue in the 103rd Congress.

The Special Committee on Aging continued to serve as the advocate for older Americans within the Senate, highlighting an array of subjects that have received little attention from other Congressional panels.

As the 102nd Congress came to a close, the reauthorization of the Older Americans Act (OAA) was finally accomplished. The reauthorization package included a host of legislative recommendations developed by the Aging Committee, including provisions regarding transportation and nutrition services.

In 1992, the Aging Committee convened five hearings based in Washington, DC, six other field hearings across the country, and an eclectic mix of other forums. The Committee's Washington-based hearings focused on consumer fraud operations that target elderly victims, the growing phenomenon of grandparents raising their grandchildren, the benefits of art and dance therapy on the aging process, and the effects of fuel assistance cuts on low-income seniors. The field hearings the Aging panel held in 1992 addressed a range of issues including, long-term care concerns, and the continuing increase of prescription drug prices.

The Special Committee on Aging developed a host of legislative initiatives in response to the issues raised in our hearings, including proposals designed to address concerns surrounding billing practices by physicians, reforms in the durable medical equipment industry, frauds perpetrated against the elderly, and a number of other issues that impact the elderly. Several of these initiatives were incorporated into the omnibus tax package that was ultimately vetoed. The Committee plans to reintroduce each of these proposals in the 103rd Congress.

The Special Committee on Aging's experimentation with nonhearing formats has involved into an effective, well-developed method of presenting information through workshops and interactive seminars. During the second session of the 102nd Congress, the Aging Committee used this nontraditional format to highlight guardianship issues and intergenerational mentoring programs.

The Aging Committee also continued its tradition of publishing comprehensive staff reports and consumer information prints. The Committee was inundated with requests for one particular information pamphlet entitled, "Programs to Help Older Americans Obtain Their Medications". This consumer flyer outlined programs sponsored by individual drug companies offering free prescriptions to persons meeting a specific set of eligibility criteria. The Committee received over 60,000 requests for this information, and the inquiries have continued.

We are proud of these collective achievements, and are pleased to present the following report which outlines policy developments of interest and importance to older Americans during the second session of the 102nd Congress. The authors of this report, the excellent staff of the Special Committee on Aging, are deserving of high praise for their continued efforts to make this information available year after year.

Policymakers will be faced with a set of unique challenges as we look to the 103rd Congress, with a new President, and a reinvigorated House and Senate. It promises to be an exciting time. We look forward to watching it unfold, and contributing to the successes this Congress will surely claim.

DAVID PRYOR,
Chairman.
WILLIAM S. COHEN,
Ranking Member.

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DEVELOPMENTS IN AGING: 1992—VOLUME 1

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Mr. PRYOR, from the Special Committee on Aging, submitted the following

REPORT

Chapter 1

SOCIAL SECURITY—OLD AGE, SURVIVORS AND DISABILITY

OVERVIEW

A major political event in 1992 affecting the future of the Social Security Administration (SSA) was the election of Arkansas Governor Bill Clinton as President. Among the issues raised during the 1992 campaign were the growing administrative problems in the disability programs run by SSA. Those programs, including the Social Security Disability Insurance (SSDI) program, were becoming overwhelmed with growing workloads, backlogs, and delays. The election of Bill Clinton raised hope that sufficient attention could be focused on SSA to enable it to process its workload once again.

On the legislative front, the main issues remained the Social Security "notch" issue, and the earnings test. Despite heightened legislative activity, however, no changes were enacted on these issues in 1992.

In 1992, Social Security continued to build large reserves in its trust funds as the program benefit structure remained untouched. Under the budget agreement arrived at in 1990, Social Security was not intended to be subject to changes. On January 1, 1993, Social Security beneficiaries received a full 3-percent increase to offset inflation. While there was no reduction in this amount, many seniors complained that it was insufficient to maintain their

standard of living, particularly because pharmaceutical and medical inflation far outpaced the general inflation rate.

In 1992, as SSA lacked the resources to carry out its administrative responsibilities, many questioned why, after Congress removed Social Security from the Federal budget in 1990, SSA's administrative expenses continued to be considered part of the Federal budget. The Bush Administration assumed that administrative expenses, even though they are financed out of the trust funds, remain on budget. A number of leaders in Congress, including the Chairmen of the Senate Aging and Budget Committees, argued that all trust fund expenditures were taken off budget, as the law stated. Legislation was introduced but not enacted in 1992 to take the administrative funds off-budget. The goal of such legislation is to remove pressure to cut SSA's administrative expenses so that the trust funds can subsidize other Federal expenditures. This issue is likely to be revisited under the new Administration by the Office of Management and Budget (OMB). If OMB does not change course, Congress can be expected to reconsider legislative remedies.

Another source of debate in recent years has emerged because the Social Security tax rate is higher than needed to meet today's benefit costs. Various proposals offered by Senator Moynihan and others during the past 2 years to bring the rate more in line with actual costs have focused attention on whether Social Security taxes should be cut. Senator Moynihan's proposal raised public awareness that Social Security reserves were being used to pay for general government operations. Although the Senate leadership twice permitted Senator Moynihan to take his measure to the Senate floor for a vote in 1990 and 1991, both times it was set aside over procedural objections. Later, however, as the recession lingered, new calls were made for tax cuts to stimulate the economy. Early in 1992, the House passed a version of a proposal by House Ways and Means Committee Chairman Rostenkowski that provided income tax credits based on the level of one's Social Security taxes. Although the Senate bill contained no similar provision, a scaled down version was included in the final package that passed Congress. The proposal died when President Bush vetoed the final package. The Clinton administration is unlikely to support changes in the Social Security tax rate due to concerns over the Federal deficit, so the Moynihan proposal appears likely to take a back seat to deficit reduction in 1993, although it may re-emerge later.

Indeed, in 1993 Social Security is likely to be considered as part of a deficit reduction package. In the early days of the Clinton Administration, certain advisors floated the idea of cutting Social Security cost-of-living adjustments or raising the retirement age. In the final analysis, however, President Clinton decided only to raise taxes on benefits received by certain beneficiaries. The Administration proposal would increase the percentage of Social Security benefits included in taxable income from 50 to 85 percent for beneficiaries with income and benefits exceeding $25,000 for individuals and $32,000 for couples. This plan promises to be the most hotly debated proposal in 1993.

In 1992, Congress continued to oversee how SSA implemented the large number of legislative changes that were enacted by Congress in 1990. Of particular concern was SSA's failure to properly

reopen telephone access to local Social Security offices. New legislation forcing full compliance was approved by Congress as part of the 1992 tax bill that was later vetoed by President Bush.

In 1992, debate over Social Security was connected to concerns over the Nation's massive budget deficit. Although Social Security is a self-financing program that has not contributed to the deficit, it nevertheless plays an enormous role in determining how the Federal Government finances the deficit. Until 1991, under the Gramm-Rudman-Hollings law, Social Security trust funds were factored into the deficit totals used to determine the deficit reduction targets that the Congress was required to meet to avoid across-the-board cuts in Federal spending. Because of this accounting method, the deficit totals were reduced on paper by the amount of the Social Security reserves. In 1992 alone, the inclusion of Social Security reserves offset an estimated $51 billion in the general revenue deficit.

Although provisions in the Omnibus Budget Reconciliation Act of 1990 assure that Social Security will no longer mask the Federal deficit, large Social Security trust fund surpluses continue to allow the Federal Government to borrow less from the public. This factor, it could be argued in turn, helps keep interest rates lower. Current law requires Social Security reserves to be invested in interest-paying Treasury securities. These assets are then used to finance other Federal programs. By borrowing from itself, the Government does not crowd out those in the private sector seeking financing.

Another factor that complicated matters for proposals such as Senator Moynihan's, or those designed to address the "notch" question, were the rules Congress enacted in 1990, known as "fire wall" procedures, designed to make it difficult to diminish Social Security reserves. The Senate provision prohibits the consideration of a budget resolution calling for a reduction in Social Security surpluses and bars consideration of legislation causing the aggregate level of Social Security spending to be exceeded. The House provision creates a point of order to prohibit the consideration of legislation that would change the actuarial balance of the Social Security trust funds over a 5-year or 75-year period. These fire wall provisions were employed by opponents of notch legislation in 1992, who invoked the rule to defeat a proposal by Senator Sanford to increase benefits to notch babies.

A host of problems in the administration of the Social Security programs continued to plague SSA in 1992. The staff at the SSA has been cut by 21 percent, or 17,000 people, over the last 7 years, even though the number of beneficiaries has been increasing. In 1992, SSA found itself falling behind in its workload. In its budget request for fiscal year 1993, SSA proposed funding levels it admitted were inadequate to reverse the trend, so the problems encountered in 1992 appear likely to continue.

In 1992, concerns over the Social Security Disability Insurance (SSDI) centered on the financial status of the disability trust funds and a breakdown in the administration of the program. That year, the annual report of the Social Security trustees warned that the SSDI trust fund could be depleted in 5 years or sooner. Their forecast reflected rapid enrollment increases over the past few years

and tax revenues constrained by a stagnant economy. The financing issue promises to be a focus of Congressional attention in 1993.

At the same time that the increase in enrollment upset the trust fund balances, increasing applications created a backlog of claims that is expected to reach 1.2 million in 1993. SSA has properly made these claims a "priority" workload, but it has done so in part by curtailing reexaminations of existing beneficiaries, loosening evidentiary requirements, and easing up on its reviews of eligibility decisions. This problem presents one of the greatest challenges to the Clinton Administration when it takes office in 1993.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. BACKGROUND

Title II of the Social Security Act, the Old Age and Survivors Insurance (OASI) and Disability Insurance (DI) program—together named the OASDI program—is designed to replace a portion of the income an individual or a family loses when a worker in covered employment retires, dies, or becomes disabled. Known more generally as Social Security, monthly benefits are based on a worker's earnings. In August 1992, $23 billion in monthly benefits were paid to Social Security beneficiaries, with payments to retired workers averaging $630 and those to disabled workers averaging $608. Administrative expenses were $2.6 billion, or around 1 percent of the total benefits paid during that period.

The Social Security program touches the lives of nearly every American. In 1992, there were over 41 million Social Security beneficiaries. Retired workers numbered 26 million, accounting for 62 percent of all beneficiaries. Disabled workers and dependent family members numbered almost 5 million, comprising about 12 percent of the total, while surviving family members of deceased workers totalled over 7 million or 17 percent of all beneficiaries. During the same period, about 135 million workers were in Social Security-covered employment, representing approximately 95 percent of the total American work force.

In 1992, Social Security contributions were paid on up to $55,500 of earnings, a wage cap that is annually indexed to keep pace with inflation. Workers and employees alike paid 7.65 percent of earnings in Social Security taxes (of which 1.45 percent represents contributions to the Hospital Insurance portion of Medicare). For the self-employed, the payroll tax is doubled, or 15.30 percent of earnings. In 1993, the tax rates will remain the same, although the wage cap will rise to $57,600.

Social Security is accumulating large reserves in its trust funds. As a result of increases in Social Security payroll taxes mandated by the Social Security Act Amendments of 1983, the influx of funds into Social Security is increasingly exceeding the outflow of benefit payments. In 1992, the Social Security reserves totalled an estimated $330 billion, compared with $281 billion in 1991.

(A) HISTORY AND PURPOSE

Social Security emerged from the Great Depression as one of the most solid achievements of the New Deal. Created by the Social Security Act of 1935, the program continues to grow and become even more central to larger numbers of Americans. The sudden economic devastation of the 1930's awakened Americans to their vulnerability to sudden and uncontrollable economic forces with the power to generate massive unemployment, hunger, and widespread poverty. Quickly, the Roosevelt Administration developed and implemented strategies to protect the citizenry from hardship, with a deep concern for future Americans. Social Security succeeded and endured because of this effort.

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

While Social Security is generally regarded as a program to benefit the elderly, the program was designed within a larger generational context. According to the program's founders, by meeting the financial concerns of the elderly, some of the needs of young and middle-aged would simultaneously be alleviated. Not only would younger persons be relieved of the financial burden of supporting their parents, but they also would gain a new measure of income security for themselves and their families in the event of their retirement or death.

In the more than half a century since the program's establishment, Social Security has been expanded and changed substantially. Disability insurance was pioneered in the 1950's. Nevertheless, the underlying principle of the program—a mutually beneficial compact between younger and older generations—remains unaltered and accounts for the program's lasting popularity.

Social Security benefits, like those provided separately by employers, are related to each worker's own average career earnings. Workers with higher career earnings receive greater benefits than do workers with low earnings. Each individual's own earnings record is maintained separately for use in computing future benefits. The earmarked payroll taxes paid to finance the system are often termed "contributions" to reflect their role in accumulating credit.

Social Security serves a number of essential social functions. First, Social Security protects workers from unpredictable expenses in support of their aged parents or relatives. By spreading these costs across the working population, they become smaller and more predictable.

Second, Social Security offers income insurance, providing workers and their families with a floor of protection against sudden loss of their earnings due to retirement, disability, or death. By design, Social Security only replaces a portion of the income needed to preserve the beneficiary's previous living standard and is intended to be supplemented through private insurance, pensions, savings, and other arrangements made voluntarily by the worker.

Third, Social Security provides the individual wage earner with a basic cash benefit upon retirement. Significantly, because Social Security is an earned right, based on contributions over the years on the retired or disabled worker's earnings, Social Security ensures a financial foundation while maintaining beneficiaries' self-respect.

Social Security provides a unique set of protections not available elsewhere. Some criticize Social Security for its mix of functions. Some argue that Social Security should be a welfare program, providing basic benefits to the poor and allowing middle and upper income workers to invest their earnings in private vehicles, such as IRAs. Such an approach would undermine the widespread political support that has developed for the broad-based functions of the program.

The Social Security program came of age in the 1980's. In this decade, the first generation of lifelong contributors retired and drew benefits. Also during this decade, payroll tax rates and the relative value of monthly benefits finally stabilized at the levels planned for the system. Large reserves accumulating in the trust funds leave Social Security on a solid footing as it continues through the 1990's.

2. Financing and Social Security's Relation to the Budget

(A) Financing in the 1970's and Early 1980's

As recently as 1970, OASDI trust funds maintained reserves equal to a full year of benefit payments, an amount considered adequate to weather any fluctuations in the economy affecting the trust funds. When Congress passed the 1972 amendments to the Social Security Act, it was assumed that the economy would continue to follow the pattern prevalent in the 1960's: relatively high rates of growth and low levels of inflation. Under these conditions, Social Security revenues would have adequately financed benefit expenditures, and trust fund reserves would have remained sufficient to weather economic downturns.

The experience of the 1970's was considerably less favorable than forecast. The energy crisis, high levels of inflation and slow wage growth increased expenditures in relation to income. The Social Security Amendments of 1972 had not only increased benefits by 20 percent across-the-board, but also indexed automatic benefit increases to the CPI. Inflation fueled large benefit increases, with no corresponding increase in payroll tax revenues due to comparatively lower real wage growth. Further, the recession of 1974–75 raised unemployment rates dramatically, lowering payroll tax income. Finally, a technical error in the initial benefit formula created by the 1972 legislation led to "over-indexing" benefits for certain new re-

tirees, and thereby created an additional drain on trust fund reserves.

In 1977, recognizing the rapidly deteriorating financial status of the Social Security trust funds, Congress responded with new amendments to the Social Security Act. The Social Security Act of 1977 increased payroll taxes beginning in 1979, reallocated a portion of the Medicare (HI) payroll tax rate to OASI and DI, and resolved the technical problems in the method of computing the initial benefit amount. These changes were predicted to produce surpluses in the OASDI Program beginning in 1980, with reserves accumulating to 7 months of benefit payments by 1987.

Again, however, the economy did not perform as well as predicted. The long-term deficit, which had not been fully reduced, remained. The stagflation occurring after 1979 resulted in annual CPI increases exceeding 10 percent, a rate sufficient to double payouts from the program in just 7 years. Real wage changes had been negative or near zero since 1977, and in 1980, unemployment rates exceeded 7 percent. As a result, annual income to the OASDI program continued to be insufficient to cover expenditures. Trust fund balances declined from $36 billion in 1977, to $26 billion in 1980. Lower trust fund balances, combined with rapidly increasing expenditures, brought reserves down to less than 3 months' benefit payments by 1980.

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

Meanwhile, the condition of the Social Security trust funds worsened. By the end of 1981, OASDI reserves had declined to $24.5 billion, an amount sufficient to pay benefits for only 1½ months. By November 1982, the OASI trust fund had exhausted its cashable reserves and in November and December was forced to borrow $17.5 billion from DI and HI trust fund reserves to finance benefit payments through July 1983.

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

(B) THE SOCIAL SECURITY AMENDMENTS OF 1983

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

The underlying principle of the Commission's bipartisan agreement and the 1983 amendments was to share the burden restoring solvency to Social Security equitably between workers, Social Security beneficiaries, and transfers from other Federal budget accounts. The Commission's recommendations split the near-term costs roughly into thirds: 32 percent of the cost was to come from workers and employers, 38 percent was to come from beneficiaries, and 30 percent was to come from other budget accounts—including contributions from new Federal employees. The long-term proposals, however, shifted almost 80 percent of the costs to future beneficiaries.

The major changes in the OASDI Program resulting from the 1983 Social Security Amendments were in the areas of coverage, the tax treatment and annual adjustment of benefits, and payroll tax rates. Key provisions included:

Coverage.—All Federal employees hired after January 1, 1984, were covered under Social Security, as were all current and future employees of private, nonprofit, tax-exempt organizations. State and local governments were prohibited from terminating coverage under Social Security.

Benefits.—COLA increases were shifted to a calendar year basis, with the July 1983 COLA delayed to January 1984. A COLA failsafe was set up so that whenever trust fund reserves do not equal a certain fraction of outgo for the upcoming year—15 percent until December 1988; 20 percent thereafter—the COLA will be calculated on the lesser of wage or price index increases.

Taxation.—One-half of Social Security benefits received by taxpayers whose income exceeds certain limits—$25,000 for an individual and $32,000 for a couple—were made subject to income taxation, with the additional tax revenue being funneled back into the retirement trust fund.

Payroll Taxes.—The previous schedule of payroll tax increases was accelerated, and self-employment tax rates were increased.

Retirement Age Increase.—An increase in the retirement age from 65 to 67 was scheduled to be gradually phased in between the year 2000 to 2022.

(C) TRUST FUND PROJECTIONS

In future years, the Social Security trust fund income and outgo are tied to a variety of economic and demographic factors, including economic growth, inflation, unemployment, fertility, and mortality. To predict the future state of the OASI and DI trust funds, estimates are prepared using three different sets of assumptions. Alternative I is designated as the most optimistic, followed by intermediate assumptions II and finally the more pessimistic alternative III. The intermediate II assumption is the most commonly used

scenario. Actual experience, however, could fall outside the bounds of any of these assumptions.

One indicator of the health of the Social Security trust funds is the contingency fund ratio, a number which represents the ability of the trust funds to pay benefits in the near future. The ratio is determined from the percentage of 1 year's payments which can be paid with the reserves available at the beginning of the year. Therefore, a contingency ratio of 50 percent represents 6 months of outgo.

Trust fund reserve ratios hit a low of 11 percent at the beginning of 1983, but increased to approximately 96 percent by 1992. Based on intermediate assumptions, the contingency fund ratio is projected to increase to 107 percent by the beginning of 1993. Even under pessimistic assumptions, assets are projected to reach 112 percent by the beginning of 1994.

(D) OASDI NEAR-TERM FINANCING

Combined Social Security trust fund assets are expected to increase over the next 5 years. Indeed, according to the 1992 Trustees Report, OASI assets will be sufficient to meet the required benefit payments throughout and far beyond the upcoming 5-year period. However, as discussed earlier, SSDI trust fund assets could decline to dangerously low levels.

The projected expansion in the OASDI reserves is partly a result of recent payroll tax increases—from 7.51 percent (with an upper limit of $48,000) in 1989 to 7.65 percent in 1990. The OASDI reserves are expected to steadily build for the next 20 to 25 years as a result both of the 1990 tax increase and an anticipated leveling off in the growth rate of new retirees.

(E) OASDI LONG-TERM FINANCING

In the long run, the Social Security trust funds will experience 3 decades of rapid growth, followed by continuing annual deficits thereafter. Under the intermediate assumptions, over the next 75 years as a whole, the cost of the program is expected to exceed its income by 10 percent. However, the expected surplus revenue of the system over the next 20 or 30 years provides ample time to monitor the program and take actions to ensure its solvency.

It should be emphasized that the OASDI trust fund experience in each of the three 25-year periods between 1992 and 2066 varies considerably. In the first 25-year period—1992 to 2016—reserves are expected to exceed costs by 1.09 percent of taxable payroll. As a result of these surpluses, contingency fund ratios are expected to build to approximately 334 percent by the year 2015.

In the second 25-year period—2017 to 2041—the financial condition of OASDI is expected to begin to deteriorate and be insolvent by the end of the period. Trust fund reserves are expected to decline to 34 percent of outgo by 2035. Positive actuarial balances are expected through the year 2015, with negative balances occurring thereafter. Negative deficits are projected to peak around the year 2035, at 3.77 percent of taxable payroll. This combination of surpluses and deficits will result in an average deficit of 2.78 percent of taxable payroll over this 25-year period.

The third 25-year period—2042 to 2066—is expected to be one of continuous deficits. Program costs will continue to grow and remain above annual revenues. By the end of this period, continuing deficits are expected to have depleted the trust funds. Under intermediate assumptions, exhaustion of reserves is projected to occur by 2036. If considered separately, depletion of DI reserves is expected by 1997, while OASI Trust Fund exhaustion is projected for the year 2042. Annual OASDI deficits over the 25-year period are expected to average 4.22 percent of taxable payroll.

(1) Midterm Reserves

In the years between 1992 and 2017, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these reserves will be invested in interest-bearing Federal securities, and will be redeemable by Social Security in the years in which benefit expenditures exceed payroll tax revenues—2015 through 2064. During the years in which the assets are accumulating, these reserves will far exceed the amount needed to buffer the OASDI funds from unfavorable economic conditions. As a matter of policy, there is considerable controversy over the purpose and extent of these reserve funds, and the political and economic implications they entail.

During the period in which Social Security trust fund reserves are accumulating, the surplus funds can be used to finance other Government expenditures. During the period of OASDI shortfalls, the Federal securities previously invested will be redeemed, causing income taxes to buttress Social Security. In essence, the assets Social Security accrues represent internally held Federal debt, which is equivalent to an exchange of tax revenues over time.

Though the net effect on revenues of this exchange is the same as if Social Security taxes were lowered and income taxes raised in the 1990's and Social Security taxes raised and income taxes lowered in 2020, the two tax methods have vastly different distributional consequences. The significance lies with the fact that there is incentive to spend reserve revenues in the 1990's and cut back on underfunded benefits after 2020. The growing trust funds reserve enable the Congress to spend more money elsewhere without raising taxes or borrowing from private markets. At some point, however, either general revenues will have to be increased or spending will have to be drastically cut when the debt to Social Security has to be repaid.

(2) Long-Term Deficits

The long-run financial strain on Social Security is expected to result from the problems of financing the needs of an expanding older population on an eroding tax base. The expanding population of older persons is due to longer age spans, earlier retirements, and the unusually high birth rates after World War II, producing the so-called baby-boom generation who will retire beginning in 20 years. The eroding tax base in future years is forecast as a result of falling fertility rates.

This relative increase in the number of beneficiaries will pose a problem if the Social Security tax base is allowed to erode. If cur-

rent trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-third of payroll from Social Security taxes. This would be a substantial erosion of the Social Security tax base and might undermine the long-term solvency of the system.

While the absolute cost of funding Social Security is expected to increase substantially over the next 75 years, the cost of the system relative to the economy as a whole will not necessarily rise greatly over 1970's levels. Currently, Social Security benefits cost approximately 4.93 percent of the GDP. Under intermediate assumptions—with 1.1 percent real wage growth—Social Security is expected to rise to 6.82 percent of the GDP by 2070.

Although there is no question that reserves in the Social Security trust funds will build up well beyond the turn of the century, it nevertheless must be remembered that Social Security remains vulnerable to general economic conditions and should those conditions deteriorate, the Congress may need to revisit the financing of the system. Furthermore, Social Security is not immune from political pressures to change its structure, notwithstanding its financial condition. Indeed, political and economic pressures in coming years to use the trust funds to reduce the Federal budget deficit may overshadow the attention paid to maintaining Social Security's solvency.

(F) SOCIAL SECURITY'S RELATION TO THE BUDGET

Over the last decade, Social Security has repeatedly been entangled in debates over the Federal budget. While the inclusion of Social Security trust fund shortages in the late 1970's initially had the effect of inflating the apparent size of the deficit in general revenues, the reserve that has accumulated in recent years has served to mask its true magnitude. In fact, many Members of Congress contend that the inclusion of the surpluses has disguised the enormity of the Nation's fiscal problems and delayed true deficit reduction. For these same reasons, there has been increasing concern over the temptation to cut Social Security benefits to further reduce the apparent size of the budget deficit.

On October 18, 1990, Senators Heinz, Hollings, and Moynihan successfully offered and passed an amendment to the 1990 Omnibus Budget Reconciliation Act (P.L. 101-508), to remove the Social Security Trust Funds from the GRH deficit reduction calculations by a vote of 98-2.

Many noted economists advocated the removal of the trust funds from deficit calculations. They argued that the current use of the trust funds contributes to the country's growing debt, and that the Nation is missing tremendous opportunities for economic growth. A January 1989 General Accounting Office report states that if the Federal deficit was reduced to zero, and the reserves were no longer used to offset the deficit, there would be an increase in na-

tional savings, and improved productivity and international competitiveness. The National Economic Commission, which released its report in March 1989, disagreed among its members over how to tame the budget deficit. Yet, the one and only recommendation upon which they unanimously agreed is that the Social Security Trust Funds should be removed from the Gramm-Rudman-Hollings deficit reduction process.

Taking Social Security off-budget was partially accomplished by the 1983 Social Security Amendments and, later, by the 1985 Gramm-Rudman-Hollings Act. The 1983 Amendments required that Social Security be removed from the unified Federal budget by fiscal year 1993, and the subsequent Gramm-Rudman-Hollings law accelerated this removal to fiscal year 1986. To further protect the Social Security trust funds, Social Security was barred from any Gramm-Rudman-Hollings across-the-board cut or sequester.

In 1990, as part of the OBRA 1990, Social Security was finally removed from the budget process itself. It was excluded from being counted with the rest of the Federal budget in budget documents, budget resolutions, or reconciliation bills. Inclusion of Social Security changes as part of a budget resolution or reconciliation bill was made subject to a point of order which may be waived by either body.

However, administrative funds for SSA were not placed outside of the budget process by the 1990 legislation, according to the Administration's interpretation of the new law. This interpretation is at odds with the intentions of many Members of Congress who were involved with enacting the legislation. It leaves SSA's administrative budget, which like other Social Security expenditures is financed from the trust funds, subject to pressures to offset spending in other areas of the Federal budget. In the 102nd Congress, Senator Sasser, the Chairman of the Budget Committee, joined with Senator Pryor and others to introduce a bill to take the administrative expenses off-budget. Although the bill was not adopted in 1992, the new Office of Management and Budget under the Clinton Administration will review how administrative funds are treated.

(G) NEW RULES GOVERNING SOCIAL SECURITY AND THE BUDGET

Congress created new rules in 1990, as part of OBRA 1990 (P.L. 101-508), known as "fire wall" procedures designed to make it difficult to diminish Social Security reserves. The Senate provision prohibits the consideration of a budget resolution calling for a reduction in Social Security surpluses and bars consideration of legislation causing the aggregate level of Social Security spending to be exceeded. The House provision creates a point of order to prohibit the consideration of legislation that would change the actuarial balance of the Social Security trust funds over a 5-year or 75-year period. These fire wall provisions will make it more difficult to enact changes in the payroll tax rates or in other aspects of the Social Security programs such as benefit changes.

3. Administrative Issues

In recent years, Congress has monitored closely the performance of the SSA in carrying out its most basic mission—high-quality

service to the public. In the 1950's and 1960's, SSA was viewed as a flagship agency, marked by high employee morale and excellence in management and services. In the past 15 years, however, many have contended that the agency has lost its edge, and the quality of service has declined. Factors cited as causing this decline include new agency responsibilities, including the creation of SSI in 1972, staff reductions in the 1980's, inadequate administrative budgets, and multiple reorganization efforts. Many claim that the agency has sacrificed the quality of service to the public in an effort to cut costs through technology, and that public confidence in the agency consequently has declined. Despite major investments by Congress, SSA remains troubled by computer, telephone, and other technological problems.

These criticisms have led Congress to intensify oversight of SSA, including numerous congressional hearings and requests for General Accounting Office (GAO) investigations of SSA problems. One outcome has been an ongoing review of the agency by the GAO. During the past several years, GAO has released a series of reports on SSA staff reductions and their effect on the quality of service provided to the public, payment accuracy to beneficiaries, problems with the agency's creation of a national 800-number system, and fragmented leadership. In 1993, these concerns will be used to support arguments to remove SSA's administrative expenses from the Federal budget in order to ensure that adequate resources are available to improve public service.

(A) STAFF REDUCTIONS

Efforts to reduce the size of SSA's staff over recent years have continued to raise concerns about a deterioration in the agency's quality of public service. In 1993, SSA personnel totalled 64,000, down 17,000 from the staffing level of 1985. In view of continued congressional attention on the damaging consequences of cutbacks in staff, further proposals regarding staffing levels will be met with concern in the White House and on Capitol Hill. While additional large cuts may not be made, the damage from previous staff cuts continues to hurt public service.

The philosophy guiding the SSA cuts was embodied in the 1983 Grace Commission Report, which recommended that SSA eliminate 17,000 staff positions and close over 800 field offices, based upon the rationale that operating a single large office in a city of 500,000 to 1 million would be cheaper than operating several small offices. Critics pointed out however, that the Grace Commission's rationale rested entirely on cost factors, and failed to assess the effect of closings on the quality of public service.

While most critics recognized that SSA needed to monitor its operating costs closely and that some staff reductions and office closings may have been necessary, they nonetheless believe that SSA has been pursuing cost cuts without regard to the quality of service being provided. Congressional testimony and GAO reports continued to reveal in 1991 that severe stress from increasing workloads is contributing to a deterioration of overall staff effectiveness. Critics cited the consequential loss of confidence in the system among younger workers, a declining number of whom plan to make a

career of Social Security. Moreover, many older workers state that their only reason for remaining with the agency is to keep their Civil Service retirement benefits. The combination of many employees fast approaching retirement age, along with the SSA's increasing difficulty in retaining a pool of younger, lower level employees, threatens the future effectiveness of the agency.

Dr. Arthur Flemming, former Secretary of the Department of Health, Education, and Welfare, has expressed concern that this problem could have severe repercussions, especially given the rapid aging of the American work force. According to Dr. Flemming, morale problems within SSA are so severe that we stand to witness a deterioration in the caliber of SSA personnel at just the time when the burdens become heavier. A panel he chaired recommended in 1992 that 6,000 new staff be added at SSA. The incoming administration will have to take into account the damaging legacy of previous staff cuts in analyzing the future direction SSA should take in staffing levels.

(B) NATIONWIDE TOLL-FREE NUMBER

In 1992, controversy continued to surround SSA's effort to operate a nationwide 800 number. On October 1, 1988, SSA launched a toll-free telephone system throughout 60 percent of the Nation that bypassed the agency's network of local Social Security field offices. From that point, in the entire system, all calls to local Social Security offices were re-routed to a small number of teleservice centers. Despite a number of serious problems with the system and persistent congressional criticism, a year later the toll-free line went into effect throughout the entire country.

During 1990, the first year of nationwide operation, callers to SSA's toll-free line frequently were unable to get through or to obtain accurate information when they did. A hearing of the Special Aging Committee in May 1990 explored evidence that longstanding problems had grown worse. A GAO study commissioned by the Committee found that 43 percent of callers who were evaluated got wrong answers. One in five got wrong answers that could affect their benefit amounts. In addition, it was revealed that busy signal rates above 50 percent were commonplace. A hearing of the Senate Special Committee on Aging in April 1989 had revealed survey results showing that nearly one in four callers was given the wrong answer to questions about Supplemental Security Income (SSI).

With respect to the high busy signal rate, a GAO study conducted before the implementation of the toll-free system at the request of Senator David Pryor outlined a number of special steps SSA claimed that it was going to take to avoid this problem. Among them, the agency stated that it would carefully limit the promotion of the new toll-free line and work closely with aging advocacy groups to ensure that they did not over-sell the number. Many of these steps were not taken.

Amid growing congressional criticism of the toll-free system, SSA began detailing staff out of Social Security field offices and into the teleservice centers to help answer calls. According to GAO, some of these staff were unqualified to do so, while the accompanying drain

on field staff jeopardized the ability of those offices to serve the public. GAO also concluded that studies SSA presented at the Aging Committee hearing showing very low error rates were not methodologically sound and were, therefore, inconclusive.

From the start, SSA aggressively promoted the new service throughout the Nation as giving "the public one more option—for many, the most convenient option—of doing business with SSA". Critics of the new system, however, contended that this was misleading because under the new system the public lost the ability to contact their local Social Security field office.

In theory, many calls to the 800-number which require action by a field office were referred to the field office staff for a follow-up call. In practice, a GAO study for Congressman Andrew Jacobs, Jr., that was released in July 1990 found that about one in four callers surveyed never received a follow-up contact from a field office. This study drew sharp criticism of SSA by a number of Members of Congress and revealed the failure of the system to function as promised.

When callers of the toll-free line realized that they could no longer speak with staff in their local SSA office, many became upset and reluctant to discuss their financial affairs with a stranger. Moreover, callers cannot reach the same person twice over the toll-free line when a problem arises that requires more than one call to settle.

There is also a concern that callers may be given wrong information as a result of their call being handled out of State. For example, individuals with questions about their State's SSI supplementation rate may be given the rate for the State in which their call is taken rather than made.

Given the overwhelming evidence of the 800-number system's problems and widespread public dissatisfaction which was communicated to Members of Congress, a bill by Senator Pryor and Congressman Sander Levin to require SSA to restore access to local offices was enacted in 1990. The bill was strongly opposed by the Bush Administration and SSA. Despite these objections, Congress had become frustrated with the system's repeated failures, SSA's unwillingness to reform and decentralize the system administratively, and the continued drain the system created on other agency resources, including staff. After numerous hearings, GAO reports and Committee investigations, Congress took the extraordinary step of enacting legislation governing SSA's telephone system, because of the perception on Capitol Hill of SSA's unwillingness to address concerns that had been repeatedly expressed.

Congress also enacted as part of OBRA 1990 (P.L. 101–508) a provision to improve the 800-number system by requiring SSA to conduct demonstration projects in no fewer than three teleservice centers. As part of the project, individuals who call SSA will be provided with a written receipt which includes the date of the communication, a description of the nature of the communication, and any action SSA will take or any advice provided. The objective of the projects is to make SSA accountable for information and advice offered over the 800-number, and to provide callers with a receipt of contact to clarify for them what can be expected as a result of the call.

In defense of the new toll-free line, SSA contended that the overwhelming number of calls was evidence of its popularity and the public's implicit approval of the teleservice system. In response, critics pointed to the agency's aggressive promotion of the service and the fact that those in need of assistance from SSA have no choice but to call the toll-free line.

The most controversial problem with SSA's implementation of the legislation arose in 1992 because of SSA's unwillingness to restore telephone lines that were removed when the 800-number was established. Despite calls from Capitol Hill, including concern expressed by Chairman Pryor, SSA insisted that merely publishing local numbers in telephone books was sufficient to meet the requirement to reestablish public access. Hill critics pointed out that the number is of little use if there are not adequate phone lines available on which to contact SSA staff.

As a result, Congress approved legislation in 1992 promoted by Congressman Jacobs and Chairman Pryor to require SSA to restore every phone line that was in place before the 800 number was put into effect. The legislation, however, was included on a 1992 tax bill that was vetoed by the President. While this legislation should have been unnecessary, since it merely restated more explicitly a requirement that had already been approved as part of OBRA 1990, it was prompted by concern on Capitol Hill about SSA's commitment to carrying out the new law. Under a new administration, it is possible that the legislation will be rendered unnecessary by a rededication to locally based service delivery. New administration officials will learn quickly of the concern by key Members of Congress so that telephone lines can be restored on an administrative basis rather than through legislation.

(C) SSA AS AN INDEPENDENT AGENCY

In 1992, the concept of making SSA an independent agency made small progress after having last been given serious consideration in 1989. In 1989, differing proposals to accomplish the same end were approved by the House and the Senate Finance Committee and headed toward enactment. As with many other proposals, it was not included in the final version of the reconciliation bill. Despite this consideration, large differences remained between the House and Senate versions, and the Administration remained intensely opposed to the idea, with top officials threatening to recommend that the President veto any proposal to make SSA independent.

In 1992, the Senate Finance Committee approved a Moynihan bill, S. 33, to make SSA independent along the same lines proposed by the Senate in 1989. However, partly as a result of this lack of consensus, the proposal was not taken up on the Senate floor and the bill died at the end of the 102nd Congress.

During the past two decades, many have argued that SSA's administrative performance would be improved if it were established as a separate agency, independent of the Department of Health and Human Services (HHS). In its March 1981 recommendations, the National Commission on Social Security endorsed the establishment of an independent agency, as did a majority of the members of the 1983 National Commission on Social Security Reform. Many

have recommended that a bipartisan board manage and oversee Social Security, as was the case in the first decade of the program—1935-46. Advocates of an independent agency often cite the need for continuous, consistent leadership in Social Security, which is needed to improve long-term management and effectiveness of the agency, and believe that independence is a means toward that end. They argue that Social Security, as an entitlement program, should be shielded from short-term partisan politics and bureaucratic infighting, and that administrative independence would enhance public confidence in the program. Critics maintain that administrative independence does little by itself to ensure continuity of leadership or to insulate the agency from politics.

The 1983 Social Security Amendments, in keeping with the National Commission's recommendation on agency independence, authorized the establishment of the Congressional Panel on Social Security Organization. The panel was instructed to identify an appropriate method for removing the SSA from HHS and establishing SSA as an independent agency, with its own administrative structure and responsibilities.

The panel recommended to Congress that an independent SSA should be headed by a single administrator, appointed to a statutory 4-year term by the President with the advice and consent of the Senate. It suggested that SSA be responsible for the OASDI and SSI programs only, exclusive of Medicare or Medicaid. To lead the agency, it proposed establishing a permanent, bipartisan advisory board of nine members—five appointed by the President, two by the Senate, and two by the House—to oversee the program and make policy recommendations to the administrator, the President, and Congress.

Sponsors of independent agency proposals often point out that since 1971, SSA has had many different Commissioners and HHS has had numerous Secretaries. SSA has been administratively reorganized a number of times in the past decade, resulting in little continuity or long-term coherence in leadership and policy. Ironically, they propose as a cure a proposal to reorganize SSA. Further, advocates point to major policy debacles that have plagued Social Security in the past decade, including the crisis in the SSDI program created by the overzealous implementation of continuing disability reviews, and the retroactive elimination, and subsequent restoration of the minimum benefit. It is contended that with an independent agency, high level leadership would be more sensitive to the integrity of Social Security and more effective in promoting sound policy and administration.

Both the House and Senate Finance Committee proposals for an independent agency which were approved in 1989 required SSA to handle only the Social Security and disability programs, leaving Medicare and Medicaid to be handled by HHS. They differed in that the House proposal has a three-member bipartisan board in charge of SSA, while the Senate Finance proposal recommended a single administrator. The same was true of the 1992 Senate bill.

Many opponents of an independent SSA argue that conflicts could arise between board members that could impair the agency's efficiency. They add that most agency problems do not result from SSA's location within HHS, but rather result from poor planning

and policymaking. Organizational structure may be less to blame than bad leadership, overwork, and low morale. Some claim that changing the administrative structure will not by itself eliminate policy problems. Improvements can only be accomplished by appointing intelligent and competent officials. Opponents believe that while the creation of an independent SSA might alleviate certain management problems, it could just as easily create others. They maintain that SSA's current administrative problems have not resulted from bureaucratic obstacles imposed by HHS, the Office of Personnel Management, and the General Services Administration, but rather that those agencies provide valuable oversight contributions. Some argue that independence would strengthen the hand of the Office of Management and Budget in dominating the agency. Arguments are also made that independence would not necessarily insulate SSA from politics nor insure elimination of the troublesome, frequent turnover of SSA Commissioners. Indeed, Senator Moynihan proposed in 1989 that SSA should be made a Cabinet level agency, despite arguments that such a move could politicize the agency.

Many believe that Social Security's impact on the Federal fiscal policymaking agenda is too important to allow the program to escape difficult fiscal choices. They argue that an independent agency would not, and should not, put Social Security above politics and that an independent Social Security Administration would not exist in a political and philosophical void. A board appointed by the President and confirmed by the Senate would not necessarily be politically neutral, nor would a single administrator. It is precisely this type of political influence that advocates of an independent agency seek to avoid. They argue that independence would insulate Social Security programs from short-term fiscal policy decisions that could prove detrimental to the program's long-term efficiency. Others, however, assert that by establishing an independent tribunal with diminished accountability to the President, Social Security would be less accountable to the views of the public, and less subject to reform or revision should that become desirable in the future.

In 1989, the Chairman of the Aging Committee requested a study by the GAO and another by the National Academy of Public Administration (NAPA) to examine how to structure the leadership of an independent SSA. Both GAO and Harold Seidman, who authored the NAPA study, strongly recommended that a single administrator be appointed rather than a board.

According to GAO, the idea of an independent SSA presents both advantages and disadvantages. GAO believes that independence could enhance the stature of the Commissioner, thereby attracting highly qualified individuals to the job. Such conditions could indeed enhance policymaking and leadership continuity. However, GAO is troubled by the potentially detrimental effects of establishing a governing board. In supporting this position, the agency cites frequent criticisms of the effectiveness of similar boards, including: (1) untimely decisions; (2) interference by board members in the daily operations of the agency; and (3) diffused accountability. GAO believes that confusion could develop regarding whether the President, the Commissioner, or the board would be accountable to Con-

gress and the public. GAO argued that, "in practice, the board form of organization has not proven effective in providing stable leadership, in insulating decisions from political pressures, and in assuring that diverse viewpoints are considered the decisionmaking process." Although GAO declines to take a position on whether an independent agency is advisable, they do state that "on balance we do not believe that independence of SSA is essential to solving the serious management problems [at SSA]. Independence is not the panacea."

The NAPA concluded, like GAO, that a single administrator is a superior form of organization to a board for a large executive agency like SSA. Seidman, writing for NAPA, observed, "given the difficulty of maintaining a clear dividing line between policy and administration, few boards are willing to delegate responsibility for day-to-day management and operations to a chief executive officer or to refrain from micromanaging." Decrying organizational responses to management and policy problems, Seidman wrote, "In the final analysis, public confidence in a government agency is determined by what it does, not by how it is organized." Former Commissioner Robert M. Ball in a separate statement issued under the same study by NAPA argued for a board form of organization. While conceding that "if all that were at issue was the efficiency of day-to-day operations, it is probably true that a single head would be a slightly better form of organization," Ball argued that the board was needed to give SSA the appearance of being above politics, "to underline the long-range character and trustee nature of the government's responsibility." He also argued that a board would help prevent abrupt shifts in policy that might lead to undermining confidence in the program.

The election of Bill Clinton as President complicates the future plan to create an independent SSA. If his Administration opposes the plan, as is likely to be the case, he may hold even more sway over a Democratically controlled Congress than his predecessor.

(D) COMPUTER MODERNIZATION

Although SSA was once a leader in using automation to improve its operations, the last 10 to 15 years have seen its computer systems deteriorate to the brink of disaster. In the early 1980's, this deterioration affected virtually every aspect of SSA's operations, including its organization, management, personnel, and ability to serve the public. In the past decade SSA has made three attempts to upgrade its computer operations, none of which have been completely successful. The current effort, known as the Systems Modernization Plan (SMP), began in 1982. The SMP was intended to improve four major advanced data processing areas at the agency: (1) software and software engineering; (2) hardware, and therefore SSA's capacity; (3) data communications utility; and (4) database integration. The main thrust of this modernization effort was software improvement.

While the SMP was originally designed as a 5-year modernization effort (1982–87), the project remains to be finalized. The design, testing, and implementation of the computer system will not be completed until some time in the 1990's. According to GAO,

this will result in delaying many needed improvements in SSA's existing post-entitlement system.

It is important to note that SSA has made significant progress in certain areas of its modernization plan, including considerable hardware improvements and some software improvements. However, the agency has been criticized for hastily purchasing new hardware before its future needs were fully understood. In addition, crucial software modernization has been sluggish.

SSA's problems have consistently involved inefficient management and organization, as well as a lack of planning for the future. Efforts to improve these inadequacies will take time, especially when considering the continuing threat of administrative budget cuts. However, faced with continued congressional scrutiny, SSA will likely continue improving its modernization effort.

4. Benefit and Tax Issues and Legislative Responses

Social Security has a complex system of determining benefit levels for the millions of Americans who currently receive them, and for all who will receive them in the future. Over time, this benefit structure has evolved, with Congress mandating changes when it believed they were necessary. Two specific benefit issues drew the attention of Congress in 1992, including the Social Security earnings test, and the "notch."

(A) SOCIAL SECURITY EARNINGS TEST

One of the most controversial issues in the Social Security program is the earnings test, which is a provision in the law that reduces OASDI benefits of beneficiaries who earn income from work above a certain sum. While no changes in the earnings test were approved in the final version of any bills, debate and legislative maneuvering over the earnings test raged in 1992. Proposals earlier had emerged from the Senate Finance and Ways and Means Committee in their respective budget reconciliation bills in 1989. Because these proposals have gained such momentum, the earnings test will remain an urgent issue in 1993.

Under the law in 1992, the earnings test reduces benefits for Social Security beneficiaries under age 65 by $1 for every $2 earned above $7,440, rising to $7,680 in 1993. In 1992, beneficiaries aged 65 to 69 had benefits reduced $1 for each $3 earned above $10,200, rising to $10,560 in 1993. The exempt amounts are adjusted each year to rise in proportion to average wages in the economy. The test does not apply to beneficiaries who have reached age 70.

In late 1991, Senator McCain of Arizona offered a floor amendment to repeal the earnings test that was adopted by voice vote. His amendment was to the Older Americans Act Reauthorization bill, S. 243, which was generally unrelated to the Social Security Act. As a result of controversy over this amendment, the Older Americans Act reauthorization process dragged on through 1992, and was not completed until the last days of the 102nd Congress. House leaders sought to avoid going to conference because they feared a motion would be made on the House floor to instruct conferees to accept McCain's repeal amendment. Instead, the House Education and Labor Committee and the Ways and Means Commit-

tee reached an agreement on modification of the earnings test provision and added other Social Security provisions to the Older Americans Act reauthorization. The bill, H.R. 2967, was then taken up again and passed by the House.

Under budget rules, expansions in entitlement programs must be "paid for" by either reducing benefits or raising revenue (or both). Attempts by Chairman Rostenkowski to pay for the Social Security amendments by increasing the maximum taxable earnings base proved unsuccessful. House leaders then decided to proceed with the bill without the necessary financing. To do so, House leaders avoided having a point of order raised against the bill by adopting a resolution which suspended the rules to allow for consideration of the bill, thus avoiding the fire wall provision. The House earnings test provision would have increased the limit from the current $10,200 to $20,000 in 1997, at a cost of $3.8 billion over 5 years, far less than the $28 billion price tag of Senator McCain's proposal.

The Senate Finance Committee approved a bill in June 1992, that contained earnings test provisions similar to those approved by the House. This bill, unlike the House bill, financed its costs by increasing payroll taxes on higher-income workers. The Finance Committee bill, which was purportedly intended to deal with the issue raised by Senator McCain's amendment, was not given further consideration by the full Senate. Senator McCain also indicated it would not deter him from continuing to advocate for changes in the earnings test to be included on the Older Americans Act bill. As a result, negotiations over that bill dragged on for most of 1992.

Senator McCain's efforts finally came to a head in September 1992, during Senate consideration of the Treasury/Postal Service Appropriations bill, H.R. 5488, when the Senate refused to waive the Budget Act to consider earnings test legislation. This amendment would have increased the earnings test to $50,000 over 5 years. Chairman Bentsen led the opposition to this amendment citing its $13.6 billion cost over 5 years and the fact that it did not contain measures to "pay for" its costs. The Senate failed to waive the Budget Act by a vote of 51–49, when 60 votes would have been required. This vote essentially ended congressional consideration of the earnings test in 1992, leaving the arguments to be played out again in 1993.

The earnings test is among the least popular features of Social Security. This benefit reduction is widely viewed as a disincentive to continued work efforts by older workers. Indeed, many believe that the earnings test penalizes those age 62 to 69 who wish to remain in the work force. Once workers reach age 70, they are not subject to the test. Opponents of the earnings test consider it an oppressive tax that can add 50 percent to the effective tax rate workers pay on earnings above the exempt amounts. Opponents also maintain that it discriminates against the skilled, and therefore more highly paid, worker and that it can hurt elderly individuals who need to work to supplement meager Social Security benefits. They argue that although the test reduces Federal budget outlays, it also denies to the Nation valuable potential contributions of older, more experienced workers. Some point out that no such limit exists when the additional income is from pensions, interest, dividends, or capital gains, and that it is unfair to single out those who

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wish to continue working. Finally, some object because it is very complex and costly to administer.

Defenders of the earnings test say it reasonably executes the purpose of the Social Security program. Because the system is a form of social insurance that protects workers from loss of income due to the retirement, death, or disability of the worker, they consider it appropriate to withhold benefits from workers who show by their substantial earnings that they have not in fact "retired." They also argue that eliminating or liberalizing the test would primarily help relatively better-off individuals who need the help least. Furthermore, they point out that eliminating the earnings test would be extremely expensive. They find it difficult to justify draining the Federal budget by an additional $28 billion over 5 years in order to finance the test's immediate removal. Proponents of elimination counter that older Americans who remain in the work force persist in making contributions to the national economy and continue paying Social Security taxes.

The issue will again be on Congress' agenda in 1993. Among the problems Senator McCain encountered in 1992 was that his amendment was to the Older Americans Act reauthorization bill, which is not normally considered an appropriate vehicle for Social Security legislation. Yet because both Houses of Congress approved some form of a change in the 102nd Congress, the issue remains ripe for resolution. In general, few Members of Congress wish to be seen as opposing the popular provision, even if they personally consider it to be irresponsible. Yet given the high cost of entirely eliminating the earnings test, the final compromise is likely to take shape along the lines charted by Chairmen Rostenkowski and Bentsen.

(B) THE SOCIAL SECURITY "NOTCH"

The Social Security "notch" refers to the difference in monthly Social Security benefits between some of those born before 1916 and those born in the 5- to 10-year period thereafter. The difference results from changes in the benefit formula contained in legislation enacted in 1972 and 1977. Differences are substantial primarily for those in the highest benefit levels who defer retirement until age 65.

The Social Security "notch" stems from a series of legislative changes made in the Social Security benefit formula, beginning in 1972. That year, Congress first mandated automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement, known as COLA's or cost-of-living adjustments. The intent was to eliminate the need for ad hoc benefit increases and to adjust benefit levels in relation to changes in the cost of living. However, the method of indexing the formula was flawed in that initial benefit levels were being indexed twice—for increases in both prices and wages. Consequently, initial benefit levels were rising rapidly in relation to the pre-retirement income of beneficiaries. Prior to the effective date of the 1972 amendments, Social Security replaced 38 percent of pre-retirement income for an average worker retiring at age 65. The error in the 1972 amendments, however, caused an escalation of the replacement rate to 55 percent for that same worker.

Without a change in the law, by the turn of the century, benefits would have exceeded a recipient's pre-retirement income. Financing this increase rather than correcting the overindexing of benefits would have entailed doubling the Social Security tax rate. Concern over the program's solvency provided a major impetus for the 1977 Social Security amendments, which substantially changed the benefit computation for those born after 1916. To remedy the problem, Congress chose to partially scale back the increase in relative benefits for those born from 1917 to 1921 and to finance the remaining benefit increase with a series of scheduled tax increases. Future benefits for the average worker under the new formula were set at 42 percent of pre-retirement income.

The intent of the 1977 legislation was to create a relatively smooth transition between those retiring under the old method and those retiring under the new method. Unfortunately, high inflation in the late seventies and early eighties caused an exaggerated difference between the benefit levels of many of those born prior to 1917 and those born later.

Although the notch is actually the result of an over-indexing of benefits for those retiring under the old formula, and does not reflect any reduction in real benefits to those retiring under transition rules, it has been perceived as a benefit reduction by those affected. Those born from 1917 to 1921—the so-called notch babies—have been the most vocal supporters of a "correction," yet these beneficiaries fare as well as those born later. Individual Members of Congress have responded to the notch-babies' complaints by introducing a series of proposals for relief, most of which would give benefit increases to those born after 1916.

At a January 1989 hearing of the Senate Finance Subcommittee on Social Security, studies were examined that dealt a severe blow to arguments of unfairness leveled by the notch movement. The GAO testified on a March 1988 GAO report entitled "Social Security: The Notch Issue." The report traces the origin to the overindexing of the benefits for those born in the period preceding the notch years. Although no position is taken with respect to legislation to compensate notch beneficiaries, the report characterizes these proposals as costly—ranging from $20 billion to $300 billion—and possibly difficult to administer. Assuming the financing of the additional benefits would come from the Social Security trust funds, the ability of Social Security to withstand any economic downturns and to provide benefits from future retirees would be jeopardized.

Also testifying on a recent study with similar findings was the National Academy of Social Insurance (NASI), a nonprofit nonpartisan organization focusing on Social Security and related issues. Robert Meyers, former chief actuary of the SSA and current chair of the NASI study panel, summarized the study's conclusion: "the real problem with regard to this matter is that those persons born before 1917 who worked beyond age 62 after 1978 receive undue windfalls. Those born after 1916 are equitably treated, consistent with the intent of Congress, and receive proper benefit amounts. . . . There is no reason why younger workers should, over the years, pay more taxes to provide windfall benefits to this group. . . . The panel therefore recommends that no legislative action be taken on the notch benefit issue."

Drawing on these reports, the Chairmen of the House and the Senate Social Security Subcommittees, Representative Jacobs and Senator Moynihan, respectively, have gone on record as opposing notch legislation. On September 18, 1992, the Leadership Council of Aging Organizations sent a letter to Capitol Hill reaffirming their "longstanding" opposition to the measures. Among the 19 leading aging organizations who endorsed the letter were the American Association of Retired Persons, Families USA, the Gray Panthers, the National Council of Senior Citizens, and the Older Women's League.

Nevertheless, the notch babies have thus far not been dissuaded from their campaign to receive compensation for what they passionately contend is unfair treatment. As a result, controversy continued and numerous bills were being pushed in 1992. A bill introduced in the House by Congressman Roybal gathered over a majority of the House as cosponsors.

Nevertheless, no action has ever been taken on legislation on the House. Various attempts were made in the past two Congresses to gain support for discharge petitions to force the Ways and Means Committee to report out a bill, but sponsors of the petitions were not able to get enough signatures. In the summer of 1992 a group of Members, led by Representatives Frank and DeFazio, tried unsuccessfully to attach a notch measure to the urban aid tax bill, H.R. 11.

Notch measures have been brought up on the Senate floor a number of times, but none was successful in winning passage. The only time either body of Congress agreed to any notch legislation was when Senator Harry Reid offered an amendment in 1991 to the budget resolution for FY 1992 which made room for $4.5 billion in new benefits for notch babies. The Reid amendment was agreed to in the Senate by voice vote, but was later dropped in conference committee with the House.

The latest attempt to bring up the legislation was made by Senator Sanford when he offered an amendment to attach his notch bill, S. 567, to the Treasury/Postal Service Appropriations Act for FY 1993 on September 10, 1992. The Sanford bill, which had gained 45 cosponsors, would have liberalized the transition rules of the 1977 amendments for people born from 1917–26, generally increasing their benefit amounts. Actuarial projections show that S. 567 could cost $300 billion over the 1992–2020 period. The Sanford measure failed on a 49 to 49 vote to set aside an objection raised by Senator Bentsen that the measure violated the so-called fire wall rules contained in the Budget Enforcement Act. Under those rules, any measure that would increase Social Security spending must be accompanied by offsetting spending cuts or tax increases; 60 votes would have been required to set the objection aside.

Later in the debate over the appropriations bill, the Senate adopted an amendment to set up a Notch Study Commission. In subsequent conference with the House, an agreement was reached to establish a 12-member bipartisan commission with the President, the leadership of the Senate and the House each appointing 4 members. The measure was signed into law when the President signed H.R. 5488 (P.L. 102–393). The commission is required to report to Congress by December 31, 1993. While some notch correc-

tion advocates want to push legislation in 1993, it is widely expected that action will be postponed until the commission can issue its report.

(C) PAYROLL TAX RATES AND THE MOYNIHAN PROPOSAL

Senator Daniel Patrick Moynihan's proposal to reduce Social Security payroll tax rates raised the most fundamental issues about the future of Social Security financing, sparking the most heated debate about Social Security since the 1983 amendments. On April 24, 1991, the proposal was put to rest, for the time being, when the Senate defeated an amendment by Senator Moynihan to the Budget Resolution that would have paved the way for consideration of his bill (S. 11) to cut the payroll tax. In 1992, the issue continued to be raised in the context of proposals for middle-class tax cuts, but no votes were taken on cutting Social Security taxes directly.

Moynihan had called for an end to the practice of using trust fund reserves to finance the budget deficit. The Bush Administration strongly opposed the tax cut plan, proposing instead to retain Social Security revenues and outlays in the Gramm-Rudman-Hollings deficit calculations, while using Social Security surpluses amassed after 1993 to retire publicly held national debt. The specifics of the Administration's plan, prepared under OMB Director Darman's direction, were never seriously considered.

The underlying rationale for the tax cut proposals is that Social Security tax rates are higher than needed to meet today's Social Security costs, which are consuming only about 85 percent of the combined employer and employee contributions. Senator Moynihan is proposing to bring the rate more in line with actual costs, returning the system to a "pay-as-you-go" basis. Under the current financing system, as enacted in the 1983 amendments, large reserves will develop until around 2015, when the retirement of "baby boomers" will require expenditures to outrun receipts. The Moynihan proposal envisions financing the baby boomers' retirement needs by having tax rate increases scheduled in the law for the next century.

Support for tax cut proposals arises from the belief that surplus taxes are not truly being saved for the future. Although under the 1990 budget agreement Social Security is taken off-budget and therefore does not "hide" deficit numbers, in fact the actual reserves are used in the same fashion to finance current Federal outlays. Supporters argue that Social Security taxes are a regressive and dishonest method of financing deficit spending, and some see the tax cut as a means of forcing Congress and the Administration to consider an alternative tax structure, such as raising income taxes. Some argue that politicians cannot be expected not to spend surpluses if they are allowed to continue, and the only way to enforce fiscal discipline is to remove surpluses. They argue that by eliminating the surpluses, the public gains a clearer perception of the system's long-run costs. Some proponents see the proposal as an opportunity to score political points with a working class constituency, contrasting it with the Administration's push for a capital gains tax reduction. Fundamentally, many believe that it is

wrong to finance general government expenditures with taxes raised for Social Security purposes, and that this robs the widespread support for the Social Security system to pay for irresponsible deficit spending.

Critics of tax cut proposals point out that without making up for the revenue loss, an immediate tax reduction would increase the Government's borrowing from the public, thereby reducing the amount of resources available for private investment. It would impair the Nation's savings rate, rather than bolster it to prepare for the demands of the next century. They contend that the surplus receipts allow the Government to borrow less, and insist that any tax cut be accompanied by offsetting revenue increases. Many are concerned that if a tax schedule was enacted to achieve a pay-as-you-go system but proved inadequate because of faulty assumptions, the system's financial solvency could be threatened, eroding public confidence and undermining the benefit structure. Some advocates contend that no tax cut should be made until larger reserves are built up in the trust funds.

One of Senator Moynihan's bills to cut Social Security taxes, S. 3167, was debated in the Senate in 1990. Senator Ted Stevens (R–AK) raised a point of order against the bill because it violated the budget resolution which had recently been approved by Congress. Senator Moynihan moved to waive the point of order, which required 60 votes to waive—54 Senators voted to waive the point of order. Although this was a majority of the Senate, it was insufficient to waive the point of order, effectively ending consideration of the bill.

In 1991, attention again focused on Senator Moynihan's proposal, which he reintroduced as a bill in the first day of the 102nd Congress (S. 11). The proposal received a boost when Majority Leader Mitchell endorsed it and promised to allow it to come to a vote on the Senator floor. The opportunity arose on April 24, 1991, in consideration of the FY 1992 Budget Resolution (S. Con. Res. 29). An exception to the so-called Social Security "fire wall" requirements in the new budget law permits the Senate, during floor debate on the budget resolution, to consider and potentially approve by a simple majority an amendment that would modify the annual surpluses in the Social Security trust funds. Once the budget resolution was passed, a proposal to reduce the payroll tax rate also would have required only a simple majority vote.

In January 1992 when Congress reconvened, the President announced an economic recovery plan which included numerous provisions, but none affecting Social Security. However, Chairman Rostenkowski's proposal to provide a credit based on one's Social Security taxes was still being actively considered as part of alternative economic stimulus packages. In February 1992, the House passed a modified version of Chairman Rostenkowski's tax package, H.R. 4210, including the tax credit idea. An alternative tax bill passed by the Senate did not include the measure, but a scaled-down version of the proposal was included in a compromise tax package agreed to by House and Senate conferees. The proposal died, however, when the President vetoed the entire tax bill on March 20, 1992.

Social Security tax cut opponents predicted that having lost every direct vote would prevent further consideration of Senator Moynihan's proposal for some time. Since that time, Senator Moynihan has been elevated to Chairman of the Finance Committee after former Chairman Bentsen's appointment as Secretary of the Treasury. Senator Moynihan continues to argue that if tax cuts are made to stimulate the economy out of a recession in 1993, as has been suggested, a Social Security tax cut would be the most appropriate method. The debate promises to continue in 1993.

B. SOCIAL SECURITY DISABILITY INSURANCE

1. BACKGROUND

In 1992, Congress continued to raise concern over SSA's administration of the largest national disability program, Social Security Disability Insurance (SSDI). Concern about abuses by SSA in the early 1980's led to reforms that were enacted by the Social Security Disability Reform Act of 1984 (P.L. 98-460). Congress continues to oversee SSA's implementation of that legislation. In 1992, Congress carefully monitored the program to ensure that new patterns of disregard for beneficiaries could be identified and quickly remedied.

In particular, the Senate Aging Committee and other Members of Congress continued to scrutinize the standards and the process SSA used to review the eligibility status of SSDI beneficiaries. Evidence that was compiled by the Aging Committee pointed out disturbing trends. Budget shortfalls forced the agencies responsible for disability determinations to take shortcuts, delay responses, and go without needed medical evidence which might have assisted them to make fairer decisions. The Senate investigation also identified increases in delays and mistakes which resulted in serious cases of deprivation and human suffering. At the same time on the legislative front, no bills affecting the program were enacted in 1992.

Chairman Pryor in 1992 sought to ensure that citizens seeking disability insurance had access to fair evaluations of their conditions, and, if necessary, impartial hearings with administrative due process. In addition to working to improve the disability determination process, he expressed concern about the means by which heart treadmill tests were used to evaluate disabilities. Senator Pryor also investigated problems SSA encountered in implementing legislation he introduced that had been enacted to reform the attorney fee process.

RECENT HISTORY

Since the inception of SSDI, SSA has determined the eligibility of beneficiaries. In response to the concern that SSA was not adequately monitoring continued eligibility, Congress included a requirement in the 1980 Social Security amendments that SSA review the eligibility of nonpermanently disabled beneficiaries at least once every 3 years. The purpose of the continuing disability reviews (CDRs) was to terminate benefits to recipients who were no longer disabled.

The new law was to go into effect in 1982. However, on its own initiative in early 1981, SSA accelerated the implementation of the reviews, increasing its monthly review workload by an additional 30,000 cases. As a result, between March 1981 and April 1984, 1.2 million case reviews were completed and close to 500,000 beneficiaries were determined to be no longer eligible for DI benefits.

Not long after the CDRs were implemented, widespread concern arose about the quality, accuracy, and fairness of the reviews. Many States, on their own initiative or by court order, declared moratoria on the reviews, or began administering the CDRs under guidelines that differed from SSA's official policy. By 1984, more than half the States were either not processing CDRs, or were doing so under modified standards.

In that same year, after extensive hearings and debate over numerous competing proposals, Congress enacted the 1984 Social Security Disability Benefits Reform Act to restore order, fairness, and national uniformity to the SSDI program. The main reform required SSA to prove that a beneficiary's medical condition had improved from the time of the initial disability determination. Under that mandate, SSA created new standards for evaluating disabilities caused by mental impairments, created guidelines for the determination of medical improvement as a prerequisite to the termination of benefits, and revised the medical criteria applicable to the determination of a physical disability.

Although this subsided the controversy, Congress continues to closely monitor the program. More recently, SSA has drastically cut back on CDR's partly due to budget shortfalls that have left it unable to meet the mandated requirements for the number of CDR's it must perform. In addition, in 1992, Congress continued to encounter evidence of a deterioration in the quality of disability determinations being conducted by SSA.

2. Issues and Legislative Response

(A) Financial Status of Disability Insurance Trust Fund

The Social Security trustees warned in April 1992 that the SSDI program is in financial trouble and that its trust fund may be depleted in 1997 or sooner. The trustees 1993 report is likely to project depletion by 1995. Their forecast reflects rapid enrollment increases over the past few years and tax revenues constrained by a stagnant economy.

The SSDI trust fund's looming insolvency has prompted proposals to reallocate taxes to it from Social Security's retirement program. Because the trustees projected that the Old Age and Survivors trust fund would be solvent until 2042, many have proposed to allocate a greater portion to SSDI. Projections show that the two programs could still be kept solvent until 2036, although this estimate may be revised downward by the 1993 trustees report. Such a reallocation would eventually shift about 3 percent of the retirement programs' taxes to SSDI.

Some advocates of reallocation favor quick action to allay fears that the program is in danger and to provide time to assess whether an improving economy will alter the outlook. Others favor only a temporary reallocation to force a careful assessment of the fac-

tors driving up enrollment and whether there are feasible ways to constrain it.

Regardless of whether a reallocation is made permanent or temporary, it is becoming increasingly clear that it will need to be done in the near future. Hearings in the Senate and the House are expected in 1993, and the trustees are likely to propose in their 1993 report that the taxes be reallocated as soon as possible. After debating the causes of the growing insolvency of SSDI, Congress can be expected to close ranks and agree to a reallocation of taxes to SSDI with little disagreement.

(B) DISABILITY DETERMINATION PROCESS

In 1992, Congress focused attention on problems in the administration of SSA's disability determination system. These problems were first identified in 1990 in hearings held in both Senate and House Aging Committees, and the Senate Aging Committee conducted a bipartisan investigation which culminated in a report to the Committee. The issues raised in those investigations continued to fester in 1992, largely because SSA lacked adequate resources to resolve its problems.

Congress has long been interested in these issues because determining if a citizen is disabled for purposes of the SSDI programs is among the most difficult and sensitive tasks of the Federal Government. Congressional offices quickly hear of problems in the disability system because requests for assistance mount when delays occur. Mistakes can have tragic consequences, exposing people who have worked their whole lives until becoming disabled to dire circumstances. While the system must respond to the needs of individuals with disabilities, it cannot afford to casually award benefits without careful scrutiny.

A severe budget crisis continued to hamper the effectiveness of the Disability Determination Services (DDSs), which are administered by the States for SSA. The majority of State DDS directors believed in 1992 that they had inadequate funds to perform their duties properly. Budget shortfalls forced the DDSs to take shortcuts, delay responses, and go without needed medical evidence which might help them make fairer decisions. Many disability examiners are now forced to cut corners, eliminating all consultative examinations and discontinuing any reviews of pending Continuing Disability Reviews (CDR) cases.

In part as a result of the unemployment and problems in the economy, applications for benefits were up to 25 percent higher in 1992 than the average in the 1980's. SSA was unprepared to deal with this increasing workload, having suffered staff cutbacks in the 1980's. SSA admitted that under its budget request for FY 1993, the backlog of individuals waiting for a decision on their claims will increase from 700,000 to 1.2 million by the end of the year. The time individuals will be forced to wait will increase from 3 months to as much as 7 months. In order to accommodate this workload, SSA has all but abandoned processing Continuing Disability Reviews which are designed to remove from the rolls those individuals whose medical condition has improved.

As these figures illustrate, the impact of staff reductions implemented during the 1980's, inadequate budgetary resources, and the sheer administrative complexity of the disability determination process have left the system unable to properly fulfill its mission. When these factors are considered, and combined with the impact of a recent Supreme Court decision requiring SSA to re-evaluate 300,000 children's disability claims—which the Court ruled SSA had unjustly denied in the first place—the threat looms of the entire disability determination process becoming overwhelmed. These factors are resulting in increased delays and errors for individuals of all ages who apply for benefits. According to SSA's own studies, while the number of people who received benefits in error has not changed appreciably, the number of people who were denied in error has increased by over one-third in the last 5 years.

SSA in 1992 requested permission from the Office of Management and Budget (OMB) to draw upon its entire $198 million contingency fund to meet the pending crisis, but OMB approved only $100 million. These funds were requested largely to deal with the disability backlog. Soon after the new administration takes office, it will be faced with the need to release the remaining $98 million in contingency funds.

In considering long-term reform of the system, the Senate Aging Committee report's primary recommendation is that SSA establish a system for interviewing applicants on a face-to-face basis to solicit information and improve the accuracy of decisions. This should be accompanied by an elimination of the reconsideration stage of the appeals process, which many experts have argued is extraneous and only serves to lengthen the process unnecessarily. Given the current budget problems, however, SSA is in no position to implement new responsibilities. While eliminating a step in the bureaucracy might go part of the way toward making funds available for face-to-face interviews, new resources will be required to restore the fairness that Congress originally intended when enacting the disability programs.

The concerns that were raised and documented in Congress in 1992 are likely to continue unabated into 1993. Additional resources will be needed if those concerns will be resolved. Given the tight budget constraints currently faced by Congress, those resources will be difficult to commit to SSA unless the administrative expenses are removed from the budget.

(C) HEART DISEASE AND SSA'S USE OF TREADMILL TESTS

Despite receiving major criticism from Congress and the courts, SSA published a regulation in 1991 that would require thousands of persons to take treadmill stress tests in order to qualify for SSDI benefits. After a major outcry by the Senate Aging Committee, a series of meetings were held to resolve concerns. SSA staff agreed informally to change a number of provisions in a draft regulation before it became final in order to reach agreement with leading experts in the field and in Congress on the issue. The final regulation was not yet issued in 1992, as SSA decided following the election not to issue controversial regulations until the new Administration

has an opportunity to review them. The cardiovascular regulation will be one of the first that will be reviewed by HHS in 1993.

In a major court decision in June 1990, the Second Circuit Court ruled that SSA was violating the Social Security Act by its heavy reliance on the results of treadmill exercise tests in determining whether a person's heart disease is disabling. Meanwhile, SSA has been moving in exactly the opposite direction. In February 1990, SSA sent a draft notice of proposed rulemaking to HHS Secretary Louis Sullivan for approval which would significantly expand its reliance on treadmill test results for cases in which the applicant or beneficiary has ischemic heart disease. Even after an Aging Committee investigation has uncovered the draft notice, SSA officials insisted that they intended to promote that policy, and it was published as a draft rule in 1991. This led to negotiations with the Aging Committee that led to changes in the draft regulation.

SSA uses the treadmill test in two ways. First, in determining whether the person has a listed impairment, if the person has had a treadmill test, SSA will rely on its results even if other tests have also been performed and those tests indicate that the person has ischemic heart disease. Second, if the person is determined not to have a listed impairment, SSA uses the treadmill test results to determine the person's residual functional capacity. It was SSA's exclusive reliance on the treadmill test that the Court determined violates the Social Security Act.

The Court concluded, based on expert testimony, that the treadmill test was unreliable, and that overreliance on the test interfered with proper diagnosis of the illness. In particular, an American College of Cardiology study concluded that misdiagnosis of ischemic heart disease occurred in more than one-third of cases. Further, other tests which are available are considered more reliable.

Under the draft regulation, SSA proposes to purchase treadmill tests for all individuals with ischemic heart disease who have not taken the test in the past 12 months. According to the memo, while SSA would spend $1.4 million per year to purchase the tests, it expects to save $335 million in 1995 alone in benefits which would have otherwise been paid to individuals who would have been determined to be disabled.

The large sums of benefits involved suggest the magnitude of the issue raised by SSA's proposed rule. SSA is likely to reconsider the rule before it is promulgated in final form in order to avoid raising the ire of key Members of Congress. While SSA officials have stated their willingness to alter the rule, Congress will carefully monitor their final product.

(D) ATTORNEY FEES

The issue of Social Security attorney fees has been engulfed in controversy in recent years. In 1990, the issue was thought to be settled by the enactment of legislation deregulating the attorney fee process. The provision was enacted as part of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508). It was based on a bill introduced in 1989 by Chairman Pryor, S. 1570, that was designed to take a consensus approach to streamline the process for awarding fees to attorneys in Social Security cases. Unfortunately,

in 1992 controversy continued because SSA failed to properly implement the new law, resulting in long delays for attorneys awaiting payment for fees that were awarded.

After a somewhat heated dispute between attorneys and SSA in 1987, S. 1570 found a common ground with important improvements for all parties involved. Most importantly, the bill contained provisions to ensure that Social Security claimants will be able to secure representation by attorneys in hearings before SSA, which is fundamental to a full and fair hearing. It was first approved in 1989 by the Senate Finance Committee in its markup of the budget reconciliation bill, but was not included in the final package. In 1990, it was approved by both Houses and signed into law.

From the standpoint of a disabled worker, severe mental or physical conditions can make a complex adjudicative process especially intimidating and confusing. Not surprisingly, disability claimants are increasingly turning to attorneys for assistance. Currently, about two-thirds of claimants appealing decisions to an ALJ are represented by attorneys.

Underlying the issue of attorney fees is the challenge of ensuring adequate safeguards against overcharges while providing fair compensation for services performed on behalf of the claimant. Disability attorneys and SSA agree that the current payment system is cumbersome, drawn out, and in need of reform. The new attorney fee legislation is designed to balance safeguards against the need for fair compensation, while streamlining the process for awarding fees.

Under the previous law, when Social Security beneficiaries were represented by an attorney in pursuing an appeal of an unfavorable decision before the agency, the attorney was required to have his fee approved by SSA. If the fee was approved, SSA directly made payments to the attorney out of any past due benefits, but not more than 25 percent of past due benefits.

In cases where the beneficiary's back award was subject to offset for repayment of SSI benefits or State assistance, SSA's policy was to apply the offset before paying the attorney fee. In practice, this resulted in many cases where there were no funds left to pay the attorney. Similarly, in cases where no back benefits accrued because interim benefits were paid, or where no benefits accrued per se, such as representative payee disputes, Medicare eligibility, or disputes about overpayments, funds were often unavailable for appropriate fees.

Under the new law, in most cases, the current fee petition process will be replaced by a streamlined procedure. Fee agreements under which the attorney will be paid up to a limit of 25 percent (not to exceed $4,000) of the back award will be honored, unless the claimant or the ALJ objects. SSA is given the authority to increase the fee maximum to keep pace with inflation. The current fee petition process remains in place for cases where the fee sought exceeds the limits. An ALJ or other adjudicator may object to the fee agreement "only on the basis of evidence of the failure of the person representing the claimant to represent adequately the claimant's interest or on the basis of evidence that the fee is clearly excessive for services rendered." If a claimant is found to be entitled to both Social Security and SSI, such that a State would be

reimbursed for interim assistance provided to the claimant, SSA must first determine and set aside the amount of the fee owed to the attorney before reimbursing the State from the back award.

The new law was received enthusiastically by many attorneys. Unfortunately, SSA's implementation of the law in 1991 and 1992 was so minimal that none of the benefits of the streamlined process were realized. After intervention by Senator Pryor, the process improved rapidly and by the end of 1992, it was working efficiently in many cases. The procedures may be revisited by the new administration to ensure they are being carried out effectively in 1993.

(E) AN INDEPENDENT APPEALS PROCESS

Chairman David Pryor introduced a bill in the 101st Congress, S. 1571, to ensure the independence of the administrative appeals process within SSA. The bill was designed to ensure the independence of Administrative Law Judges (ALJs) at SSA so that they remain free to make decisions on Social Security cases without political interference. The bill was intended to structurally prevent the problems of the early 1980's, on which the Aging Committee has built a significant record attesting to an assault on thousands of truly disabled Americans who could not argue their case, and a threat by SSA on the independence of ALJs who sought to correct such abuses.

The independence of the appeals process is integral to the Social Security program. SSA is required to conduct hearings to consider appeals of SSA decisions by claimants for benefits. Hearings are conducted by ALJs, who are located organizationally within the Office of Hearings and Appeals, headed by an associate commissioner who reports to the Commissioner of SSA. S. 1571 is designed to prevent ALJs from being subjected to political pressure to save program dollars at the expense of eligible beneficiaries.

ALJs hear and decide cases arising within the jurisdiction of the Department of Health and Human Services, including Medicare and Social Security. The judges are theoretically organized under a Chief ALJ. The position is not a creation of either statute or regulation, making it an ineffective office.

A series of congressional hearings in 1975, 1979, 1981, 1982, 1983, and 1988 on the appeals process at Social Security have documented that bureaucratic interference has sometimes threatened the due process rights of claimants. In 1982, the Aging Committee joined with the Government Affairs Committee to hold a field hearing in Ft. Smith, Arkansas which provided evidence that such abuses had been occurring. A problem with the current structure is that responsibility for the entire hearing process is placed upon individual ALJs, but the managerial authority for the program is in the hands of nonlegally trained bureaucrats who have sometimes been insensitive to the rights of claimants. In the 1984 case of *Association of Administrative Law Judges* v. *Heckler,* a Federal District Court held that the SSA had an ulterior motive in the continuing disability review program to reduce the payment of claims by ALJs and that judges could have reasonably felt pressured to issue fewer allowance decisions.

Although S. 1571 was not enacted in 1992, it was adopted by the Senate Finance Committee as part of S. 33, a bill it approved to make SSA independent of HHS. S. 33 was not taken up by the Senate in 1992, although Majority Leader Mitchell had placed it on a list of priority legislation.

The ALJ provisions of S. 33 would replace the current arrangement of the OHA with the appointment under a special nonpartisan process of a Chief ALJ to administer hearings and appeals. A Chief ALJ would be appointed to administer the hearings and appeals process, reporting directly to the Commissioner of Social Security. The Chief ALJ would be appointed by the Secretary pursuant to recommendations made by a special nominations commission established for that purpose. The Secretary would invite the participation of the President of the American Bar Association, the Federal Bar Association, and the Chairman of the Administrative Conference of the United States, or their respective designees, and other such representatives as the Secretary considered appropriate. The nominations commission would recommend three choices. Then the Commissioner of Social Security would either make a selection, request a new list, or be required to explain to Congress the reasons for not doing so. The nominee must have been an ALJ for at least 3 years preceding his appointment. The Chief ALJ would serve for a fixed term of 5 years and may be removed only pursuant to a finding by the Commissioner of neglect of duty or malfeasance in office.

The approach taken in S. 1571 is now considered a vital component of any proposal to make SSA an independent agency. Even if independent agency legislation is not approved by Congress, a proposal like S. 1571 may be promoted outside the context of the independent agency debate. It could be enacted within the current structure of SSA. Confidence in the appeals system would be increased by placing the process under the operational control of a Chief ALJ.

C. PROGNOSIS

The 1983 changes in Social Security financing are widely recognized as ensuring the solvency of the system well into the next century. That same law which restored fiscal health to Social Security also set into motion rapidly building reserves totaling $330 billion in 1992. These reserves are designed to grow by hundreds of billions of dollars, totaling more than $5 trillion by 2020. This buildup remains controversial because the reserves are used to underwrite the Federal budget deficit.

Despite this large buildup, Social Security in 1993 will once again be considered in the context of proposals to reduce the Federal deficit. President Clinton proposed increasing the taxation of benefits for individuals with relatively higher incomes as part of his large deficit reduction package. Congress is likely to go along with the President's proposal as part of a philosophy of "shared sacrifice." The President had decided, however, to avoid cutting COLAs or raising the retirement age in order to protect lower income individuals. Although partisan bickering over the tax proposal is likely, it

is likely to be enacted so long as the rest of the President's proposal gains support.

In 1993, Senator Moynihan's longstanding effort to reduce Social Security tax rates is likely to take a backseat to deficit reduction. The degree to which he could push the issue was reduced by the posture taken by the Clinton Administration in deciding against proposing a middle-class tax cut. In addition, the 1990 removal of Social Security trust funds from the budget appeared to have settled some of the concern about Social Security financing.

The 1990 budget agreement, designed to cover 5 years, obviated the need for discussion of cutting Social Security benefits in 1992. It was only in the context of another large effort to bring down the budget deficit undertaken by the Clinton Administration that Social Security was included in the mix.

Among the major benefit issues that will be on the agenda for 1993 are the earnings test and the notch. Given the major legislative activity in both the House and the Senate on the earnings test, some liberalization can be expected in 1993. On the notch, considering it was voted down in 1992 and that a Notch Commission was created that will not report until the end of 1993, proposals for change can be expected to be forestalled.

Much of the focus of improving Social Security in 1993 will remain with the new administration to correct the way the program is administered. To make progress on some of the most important problems facing them, SSA will require additional resources. As part of its economic stimulus package, the administration earmarked $1 billion over 5 years to support technological and infrastructure improvements at SSA, as well as a FY 1993 supplemental appropriation of $300 million, signalling a new level of commitment to improving public service. Another question to be addressed is whether to remove SSA's administrative expenses from the budget. If this is done, it will make it far easier to commit the level of resources that will be needed for SSA to carry out its mission. If OMB does not act on its own to take these expenses off-budget, Members of Congress can be expected to step in to enact legislation to do so. Their success will depend in large measure on the posture of the Clinton Administration toward such a proposal.

Among the issues that will take a backseat in 1993 is the proposal to reorganize SSA as an independent agency. If the Clinton Administration opposes such efforts, as can be expected, it will be unlikely for Congress to move legislation.

SSA will remain busy in 1993 implementing the legislative achievements of 1990. Careful scrutiny will be given as to how SSA implements the law requiring SSA to provide the public telephone access to their local Social Security office. In addition, Congress will oversee how SSA implements the complicated and far-reaching legislation reforming the representative payee system and the attorney fee process. A number of improvements in SSA's public service were enacted which require congressional oversight. These and other legislative initiatives will require resources that SSA is in a poor position to provide. Congress will be obligated, therefore, to evaluate SSA's budgetary need on the context of the demands placed on it in 1993 and beyond. The appropriations process in 1992 left SSA facing what may be an inadequate budget for its adminis-

trative needs in 1993, which required the Administration to request supplemental funds in order to avert a serious breakdown in the program's services.

Regarding the SSDI program, the major challenge facing the new Administration in 1993 will be dealing with the large workloads that are creating long delays and backlogs. Supplemental appropriations may be needed simply to prevent a further deterioration of services. In addition, Congress will need to address the shortfall in the SSDI trust funds in the near future with a reallocation from the OASI revenue stream.

In general, it appears clear that the 1984 SSDI reforms have largely succeeded in halting the abusive administrative practices in the continuing disability review process that occurred in the early eighties. Congressional committees will carefully follow the progress of the Disability Determination Services in light of the service delays and mistakes that were caused by budget problems in 1992.

As the stability of the program in 1992 attests, the Social Security system retains the overwhelming support of the general public, the elderly and many in the Congress. Given this support and adequate current financing, Social Security can be expected to continue on a stable path in the coming years.

Chapter 2

EMPLOYEE PENSIONS

OVERVIEW

Many employees receive retirement income from sources other than Social Security. Numerous pension plans are available to employees from a variety of employers, including companies, unions, Federal, State, and local governments, the U.S. military, National Guard, and Reserve forces. The importance of the income these plans provide to retirees accounts for the notable level of recent congressional interest, which culminated in massive pension reforms in 1986.

Congress has not made any major revisions to the pension laws since 1986. Indeed, most of the major retirement income policy issues that have been debated in recent years were either fully or partially resolved by the 1986 legislation. However, there were some exceptions.

In 1987, Congress strengthened the requirements governing employer contributions to defined benefit plans in order to assure adequate levels of assets for employee pension benefits. In 1990, Congress made a number of substantial changes to the rules governing asset reversions from over-funded pension plans and increased Pension Benefit Guaranty Corporation (PBGC) premiums for employers.

A. PRIVATE PENSIONS

1. Background

Employer-sponsored pension plans provide many retirees with a needed supplement to their Social Security income. Most of these plans are sponsored by a single employer and provide employees credit only for service performed for the sponsoring employer. Other private plan participants are covered by multiemployer plans which provide members of a union with continued benefit accrual while working for any number of employers within the same industry and/or region. As of 1990, 50 million workers and retirees were covered by an employer-sponsored pension plan. Employees of larger firms are far more likely to be covered by an employer-sponsored pension plan than are employees of small firms.

Most private plan participants are covered under a defined-benefit pension plan. Defined-benefit plans generally base the benefit paid in retirement either on the employee's length of service or on a combination of his or her pay and length of service. Large private defined-benefit plans are typically funded entirely by the employer.

Defined-contribution plans, on the other hand, specify a rate at which annual or periodic contributions are made to an account. Benefits are not specified but are a function of the account balance, including interest, at the time of retirement.

Some large employers supplement their defined-benefit plan with one or more defined-contribution plans. When supplemental plans are offered, the defined-benefit plan is usually funded entirely by the employer, and the supplemental defined-contribution plans are jointly funded by employer and employee contributions. Defined-benefit plans occasionally accept voluntary employee contributions or require employee contributions. However, fewer than 3 percent of defined-benefit plans require contributions from employees.

Private pensions are provided voluntarily by employers. Nonetheless, the Congress has always required that pension trusts receiving favorable tax treatment benefit all participants without discriminating in favor of the highly paid. Pension trusts receive favorable tax treatment in three ways: (1) Employers can deduct their current contributions even though they do not provide immediate compensation for employees; (2) income earned by the trust fund is tax-exempt; and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax advantages, however, are the tax-free accumulation of trust interest (inside build-up) and the fact that benefits are often taxed at a lower rate in retirement.

In the last decade, the Congress has increasingly used special tax treatment to encourage private pension coverage. In the Employee Retirement Income Security Act (ERISA) of 1974, Congress first established minimum standards for pension plans to ensure a broad distribution of benefits and to limit pension benefits for the highly paid. ERISA also established standards for funding and administering pension trusts and added an employer-financed program of Federal guarantees for pension benefits promised by private employers.

In 1982, Congress sought in the Tax Equity and Fiscal Responsibility Act (TEFRA) to prevent discrimination in small corporations by requiring so-called "top heavy" plans (plans in which more than 60 percent of plan assets benefit key employees) to accelerate vesting and to provide a minimum benefit for short-service workers. Most of the general safeguards provided in TEFRA were expanded in the Tax Reform Act of 1986.

In 1984, Congress enacted the Retirement Equity Act (REA) to improve the delivery of pension benefits to workers and their spouses. REA lowered minimum ages for participation to 21, provided survivor benefits to spouses of vested workers, and clarified the division of benefits in a divorce.

Title XI of the Tax Reform Act of 1986 made major changes in pension and deferred compensation plans in four general areas. The Act:

(1) limited an employer's ability to "integrate" or reduce pension benefits to account for Social Security contributions;

(2) reformed coverage, vesting, and non-discrimination rules;

(3) changed the rules governing distribution of benefits; and

(4) modified limits on the maximum amount of benefits and contributions in tax-favored plans.

2. Issues and Legislative Responses

(A) Benefit Adequacy

The objective of retirement plans is to replace workers' pre-retirement earnings with benefits, together with Social Security, sufficient to maintain their standard of living during retirement. In 1981, the President's Commission on Pension Policy recommended that, to achieve this goal, the average wage earner would need income from pensions, Social Security, and other sources equal to approximately 75 percent of pre-retirement earnings. The Commission also recommended that "replacement ratios" for low-wage earners should be higher than for high-wage earners.

According to the U.S. Bureau of the Census, of all retirees receiving pension benefits in 1987, 68 percent were men. While the mean monthly pension income of male retirees was approximately $744, pension income for women averaged $417 per month. The Census Bureau found that retirees under age 65 received higher pension income than those above age 65. Older retirees, however, were far more likely to receive Social Security benefits concurrently with their pension.

Career patterns have the greatest effect on the amount of benefits paid by pension plans. Workers who enter plans late in life or work for short periods under a plan earn substantially lower benefits than those who enter early and work a full career. The U.S. Department of Labor has found that the median benefit for workers with 10 years of service under their last pension plan replaced only 6 percent of their pre-retirement income, while the median benefit of those with 35 years of service replaced 37 percent of pre-retirement income. Similarly, workers who entered the plan at a young age accumulate larger pensions than those who entered the plan late in life.

(1) Coverage

In 1990, 50 million workers were covered by an employer-sponsored pension plan. Employers who offer pension plans do not have to cover every employee. The law governing pensions—ERISA—permits employers to exclude part-time, newly hired, and very young workers from the pension plan.

In 1986, the Tax Reform Act increased the proportion of an employer's work force that must be covered under a company pension plan. Under prior law, a plan (or several comparable plans provided by the same employer) had to meet either a "percentage test" or a "classification test" to be qualified for deferral of Federal income taxes. Employers who were unwilling to meet the straightforward percentage test found substantial latitude under the classification test to exclude a large percentage of lower paid workers from participating in the pension plan. Under the percentage test, the plan(s) had to benefit 70 percent of the workers meeting minimum age and service requirements (56 percent of the workers if the plan made participation contingent upon employee contributions). A plan could avoid this test if it could show that it benefited a classification of employees that did not discriminate in favor of highly compensated employees. The classifications actually approved by

the Internal Revenue Service, however, permitted employers to structure plans benefiting almost exclusively highly compensated employees.

Pension coverage was expanded in the Tax Reform Act by raising the percentage of employees that must be covered under the percentage test, and by eliminating the classification test and replacing it with much tougher and more specific alternative tests: The "ratio test" and the "average benefit test." Under the new percentage test, 70 percent of non-highly-compensated workers must benefit (as opposed to 70 percent of all workers). Alternatively, an employer can benefit a smaller percentage of the company's work force if the number of non-highly-compensated workers benefiting is at least 70 percent of the number of highly compensated workers. The average benefit test permits employers to adjust the coverage requirements to take into account the level of benefits in the plan. Employers can meet this test by providing non-highly-compensated employees, on average, with at least 70 percent of the average benefit of highly compensated employees (counting non-covered employees as having zero benefits). Plans were required to meet these new coverage requirements by January 1, 1989.

Most noncovered workers work for employers who do not sponsor a pension plan. Nearly three-quarters of the noncovered employees work for small employers. Small firms often do not provide pensions because pension plans can be administratively complex and costly. Often these firms have low profit margins and uncertain futures, and the tax benefits of a pension plan for the company are not as great for small firms.

Projected trends in future pension coverage have been hotly debated. The expansion of pension coverage has slowed over the last decade. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. It is unlikely that pension coverage will grow significantly without some added incentive for small business to add pension plans and for employers to include currently excluded workers in their plans.

(2) Vesting

Simply because a worker may be covered by a pension plan does not insure that he or she will receive retirement benefits. To receive retirement benefits, a worker must vest under the company plan. Vesting entails remaining with a firm for a requisite number of years and thereby earning the right to receive a pension.

Vesting provisions are a simple way to insure that benefits do not go to short-term workers, as well as to induce certain workers to remain on the job. Indeed, those employees who are only a few years short of vesting tend to remain on the job until they are assured of receiving a retirement benefit.

To enable more employees to vest either partially or fully in a pension plan, the 1986 Tax Reform Act required more rapid vesting. The new provisions, which applied to all employees working as of January 1, 1989, require that, if no part of the benefit is vested prior to 5 years of service, then benefits fully vest at the end of 5 years. If a plan provides for partial vesting before 5 years of service, then full vesting is required at the end of 7 years of service.

(3) Benefit Distribution and Deferrals

Vested workers who leave an employer before retirement age generally have the right to receive vested deferred benefits from the plan when they reach retirement age. Benefits that can only be paid this way are not "portable" because the departing worker may not transfer the benefits to his or her next plan or to a savings account.

Many pension plans, however, allow a departing worker to take a lump-sum cash distribution of his or her accrued benefits. Federal policy regarding lump-sum distributions has been inconsistent. On the one hand, Congress formerly encouraged the consumption of lump-sum distributions by permitting employers to make distributions without the consent of the employee on amounts of $3,500 or less, and by providing favorable tax treatment through the use of the unique "10-year forward averaging" rule. On the other hand, Congress has tried to encourage departing workers to save their distributions by deferring taxes if the amount is rolled into an individual retirement account (IRA) within 60 days. IRA rollovers, however, have attracted only a minority of lump-sum distributions.

Workers that receive lump-sum distributions tend to spend them rather than save them. Thus, distributions appear to reduce retirement income rather than increase it. Recent data indicate that only 5 percent of lump-sum distributions are saved in a retirement account and only 32 percent are retained in any form. Even among older and better educated workers, fewer than half roll their preretirement distributions into a retirement savings account.

Traditionally, different types of plans have distributed their benefits in different forms. Defined-benefit pension plans have generally provided distributions only in the form of an annuity at retirement, while defined-contribution pension, profit-sharing, or thrift plans have generally provided distributions as a lump-sum payment whenever an employee leaves the company.

The extension of emergency unemployment benefits signed into law on July 3, 1992, includes several provisions designed to raise revenue to offset the cost of these extra benefits. One provision mandates 20-percent income tax withholding on all lump-sum distributions after December 31, 1992, except those transferred directly from one plan to another without passing through a participant's hands. All pension plans will be required to offer direct transfers that bypass the participant and, hence, are not subject to withholding. Participants will be permitted to roll over any portion of their pension assets when received as a lump sum. Prior law permitted rollovers only when a distribution amounted to at least half of a participant's assets in the plan. The major goal of these changes is to encourage plan participants to preserve retirement savings for later use and to discourage the immediate consumption of savings. Critics argue that the changes burden plan sponsors, may trap unwary participants, and fail to address the major reasons why workers often lose much of the value of future pension benefits when changing jobs.

(4) Pension Integration

Current rules permitting employers to compute pension benefits by taking into account Social Security benefits can result in lower paid workers receiving less generous pension benefits. Under the Social Security program, employees generally pay a uniform tax rate but receive Social Security benefits that are proportionately higher at lower levels of income. Employers who want to blend their pension benefits with Social Security benefits to achieve a more uniform rate of income replacement for their retirees use integration to accomplish this goal. The integration rules define the amount of the difference in benefits between high and lower paid workers before the plan is considered discriminatory.

In general, two types of integration methods exist—excess and offset. In excess integration, plans pay a higher contribution or benefit on earnings above a particular level (the "integration level") than they pay on earnings below that level. In offset integration, plans reduce the pension benefit by a percentage of the Social Security benefit.

The 1986 Tax Reform Act modified the amount of integration permissible under the revenue rulings to prevent the elimination of pension benefits in the case of certain low-paid or short-service workers. Under the new integration rules, defined-benefit plan participants receive a minimum of 50 percent of the pension benefit they would receive without integration. Defined-contribution plans cannot contribute above the wage base ($55,500 in 1992) at a rate more than twice the rate they contribute below the wage base, and in no case can they have a differential greater than that under prior law (5.7 percent). Excess plans cannot pay benefits on final pay above the wage base at a rate exceeding twice the rate they pay below the wage base, nor can they have a differential in the rate exceeding three-fourths of a percent multiplied by years of service. Offset plans cannot pay less than 50 percent of the pension benefit that would have been paid without integration, and in no case can they reduce the pension by more than three-fourths of a percent of the participant's final average pay multiplied by years of service.

(B) TAX EQUITY

Private pensions are encouraged through tax benefits, estimated by the Treasury to be $56.5 billion in FY 1993. In return, Congress regulates private plans to prevent over-accumulation of benefits by the highly paid. Congressional efforts to prevent the discriminatory provision of benefits have focused on voluntary savings plans and on the effectiveness of current coverage and discrimination rules.

(1) Limitations on Tax-Favored Voluntary Savings

The Tax Reform Act of 1986 tightened the limits on voluntary tax-favored savings plans. The Act repealed the deductibility of contributions to an IRA for participants in pension plans with adjusted gross incomes (AGIs) in excess of $35,000 (individual) or $50,000 (joint)—with a phased-out reduction in the amount deductible for those with AGIs above $25,000 or $40,000, respectively. It

also reduced the dollar limit on the amount employees can elect to contribute through salary reduction to an employer plan from $30,000 to $7,000 per year for private sector 401(k) plans and to $9,500 per year for public sector and nonprofit 403(b) plans. The dollar limits are subject to annual inflation adjustments. Additionally, the Act tightened the nondiscrimination test, which further limits the elective contributions of highly compensated employees in relation to the actual contributions of lower paid employees. Finally, the Act encourages small-employer adoption of pension plans by permitting employers with fewer than 25 employees to adopt simplified employer pensions (SEPs) with elective employee deferrals.

(2) Limitations on Benefits and Contributions

The Internal Revenue Code limits the amount of additional accumulation an individual can have each year in a tax-favored plan. In recent years, the Congress has reduced and frozen the Section 415 limits largely to raise revenue for Federal deficit reduction. The Tax Reform Act restored the indexing of the Section 415 limits, modified the relationship between the benefit and contribution amounts to establish parity, and changed the adjustment in the defined-benefit dollar limit for early retirement.

To reduce the potential for an individual to overaccumulate by using several plans, the Tax Reform Act both retained the current law combined limit and added a 15 percent excise tax to recapture the tax benefits of annual benefits (including IRA withdrawals) in excess of 125 percent of the defined-benefit limit (but not less than $150,000).

One of the major purposes of the retirement provisions of the Tax Reform Act of 1986 was to expand the proportion of the population receiving pension benefits and raise average benefits from employer-sponsored plans. Data prepared by ICF, Inc. for the American Association of Retired Persons (AARP) indicates that the combination of expanded coverage, 5-year vesting, limits on pension integration, and tighter distribution rules is expected to increase substantially future benefits paid to today's younger workers. The study simulated the pension income received by the families of workers who will reach age 67 in the years 2011–2020. The benefit improvements in the Tax Reform Act will raise average annual family pension income from $8,400 (under prior law) to $10,200 (1986 dollars) and will increase the percentage of families receiving pension income from 68 percent (under prior law) to 77 percent. Women, in particular, are expected to benefit from the pension reforms. ICF estimated that the Tax Reform Act changes will increase the number of women with pension benefits during the 2011–2020 period by 23 percent.

(C) PENSION FUNDING

The contributions that plan sponsors set aside in pension trusts are invested to build sufficient assets to pay benefits to workers throughout their retirement. The Federal Government, through the Employee Retirement Income Security Act of 1974 (ERISA), regulates the level of funding and the management and investment

of pension trusts. Under ERISA, plans that promise a specified level of benefits (defined-benefit plans) must either have assets adequate to meet benefit obligations earned to date under the plan or must make additional annual contributions to reach full funding in the future. Plans pre-dating ERISA are allowed 40 years to reach full funding. Under ERISA, all pension plans are required to diversify their assets, are prohibited from buying, selling, exchanging, or leasing property with a "party-in-interest," and are prohibited from using the assets or income of the trust for any purpose other than the payment of benefits or reasonable administrative costs.

Prior to ERISA, participants in underfunded pension plans lost some or all of their benefits when employers went out of business. To correct this problem, ERISA established a program of termination insurance to guarantee the vested benefits of participants in single-employer defined-benefit plans. This program guaranteed benefits up to $28,277 a year in 1992 (adjusted annually). The single-employer program is funded through annual premiums paid by employers to the Pension Benefit Guaranty Corporation (PBGC)—a Federal Government agency established in 1974 by title IV of ERISA to protect the retirement income of participants and beneficiaries covered by private sector, defined-benefit pension plans. When an employer terminates an underfunded plan, the employer is liable to the PBGC for up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multi-employer defined-benefit plans, using a lower annual premium, but guaranteeing only a portion of the participant's benefits.

The past years have brought increasing concern that the single-employer termination insurance program is inadequately funded. A major cause of the PBGC's problem has been the ease with which economically viable companies could terminate underfunded plans and dump their pension liabilities on the termination insurance program. Employers unable to make required contributions to the pension plan requested funding waivers from the IRS, permitting them to withhold their contributions, and thus increase their unfunded liabilities. As the underfunding grew, the company terminated the plan and transferred the liability to the PBGC. The PBGC was helpless to prevent the termination and was also limited in the amount of assets that it could collect from the company to help pay for underfunding to 30 percent of the company's net worth. PBGC was unable to collect much from the financially troubled companies because they were likely to have little or no net worth.

During the past few years, the PBGC has assumed responsibility for several large claims. The largest was that of the LTV Corporation, which filed for Chapter 11 bankruptcy in 1986. LTV's three terminated steel pension plans doubled PBGC's deficit from $2 billion to $4 billion and illustrated a fundamental weakness of the termination insurance program. Under the law, companies such as LTV could eventually become profitable, in part because they had succeeded in dumping pension liabilities on the PBGC. The result was that participants in the pension plans of such companies (through some loss in benefits) and the companies' competitors (through higher premiums to the PBGC) were subsidizing the

firm's future profitability. In 1990, the Supreme Court decided that the PBGC did have the authority to revert LTV's pension obligations back to the corporation.

During 1986, several important changes were enacted to improve PBGC's financial position. First, the premium paid to the PBGC by employers was increased per participant. In addition, the circumstances under which employers could terminate underfunded pension plans and dump them on the PBGC were tightened considerably. A distinction is now made between "standard" and "distress" terminations. In a standard termination, the employer has adequate assets to meet plan obligations and must pay all benefit commitments under the plan, including benefits in excess of the amounts guaranteed by the PBGC that were vested prior to termination of the plan. A "distress" termination allows a sponsor that is in serious financial trouble to terminate a plan that may be less than fully funded.

While significant accomplishments were made in 1986, these changes did not solve the PBGC's financing problems. As a remedy, a provision in OBRA 1987 (P.L. 100-203) called for a PBGC premium increase in 1989 and an additional "variable-rate premium" based on the amount that the plan is underfunded.

In OBRA 1990, Congress increased the flat premium rate to $19 a participant. Additionally, it increased the variable rate to $9 per $1,000 of unfunded vested benefits. Also, the Act increased the per participant cap on the additional premium to $53.

The financial viability of the PBGC continued to be an issue in 1991. This concern was demonstrated in the Senate's refusal to pass the Pension Restoration Act of 1991, a bill that would have extended PBGC's pension guarantee protections to individuals who had lost their pension benefits before the enactment of ERISA in 1974. (For further discussion of the Pension Restoration Act, see Chapter 12.)

(D) PENSION ACCRUAL

A provision in OBRA 1986 required that the IRS, the Equal Employment Opportunity Commission (EEOC), and the Department of Labor issue regulations requiring employers to continue accruing pension benefits for employees working beyond normal retirement age by early 1988. In April 1988, the IRS proposed a rule providing that all years of service be taken into account in determining retirement benefits in defined benefit plans. In contrast, with respect to defined-contribution plans, the law would not be applied retroactively under the IRS ruling. Under the rule, a worker with a defined-benefit plan and who turns age 65 prior to 1988 would accrue pension credits for years of service prior to the law's 1988 effective date. However, if the same worker were covered by a defined-contribution plan, only employment after January 1988 would be credited.

3. Prognosis

The financial picture of the Pension Benefit Guaranty Corporation continues to be of concern. American workers and retirees have come to expect that their pensions will be protected. However,

PBGC's dire financial straits and future conditions in certain sectors of the economy may put this guaranty to a test. Coming on the heels of the savings and loan collapse and the massive taxpayer bailout, the situation causes alarm. Unless significant changes are made in the way pension insurance is priced and benefits are funded, it may be necessary to curtail the portion of the pension promise that Government can guarantee.

The issue of pension portability also promises to receive some attention. Pension benefit portability involves the ability to preserve the value of an employee's benefits upon a change in employment. Proponents argue that the mobility of today's work force demands benefit portability. Alternatives to expand pension portability that may receive attention during 1993 include proposals to establish a Federal portability agency or a central clearinghouse, which would maintain accounts on behalf of workers, and proposals to expand the current retirement arrangements to require or facilitate rollovers of pre-retirement distributions to an employer plan or an IRA.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. BACKGROUND

Pension funds covering 15.7 million State and local government workers and retirees currently hold assets worth about $878 billion; those assets may reach $1 trillion by 1993. Although some public plans are not adequately funded, most State plans and large municipal plans have substantial assets to back up their benefit obligations. At the same time, State and local governments are facing crushing fiscal problems, and some are seeking relief by reducing or deferring contributions into their pension plans to free up cash for other purposes. Those who are concerned that these actions may jeopardize future pension benefits suggest that the Federal Government should regulate State and local government pension fund operations to ensure adequate funding.

State and local pension plans intentionally were left outside the scope of Federal regulation under ERISA in 1974, even though there was concern at the time about large unfunded liabilities and the need for greater protection for participants. Although unions representing State and municipal employees from the beginning have supported the application of ERISA-like standards to these plans, opposition from local officials and interest groups thus far have successfully counteracted these efforts, arguing that the extension of such standards would be unwarranted and unconstitutional interference with the right of State and local governments to set the terms and conditions of employment for their workers.

(A) TAX REFORM ACT OF 1986

Public employee retirement plans were affected directly by several provisions of the Tax Reform Act of 1986. The Act made two changes that apply specifically to public plans: (1) The maximum employee elective contributions to voluntary savings plans (401(k), 403(b), and 457 plans) were substantially reduced, and (2) the once-

favorable tax treatment of distributions from contributory pension plans was eliminated.

(B) ELECTIVE DEFERRALS

The Tax Reform Act set lower limits for employee elective deferrals to savings vehicles, coordinated the limits for contributions to multiple plans, and prevented State and local governments from establishing new 401(k) plans. The maximum contribution permitted to an existing 401(k) plan was reduced from $30,000 to $7,000 a year and the nondiscrimination rule that limits the average contribution of highly compensated employees to a ratio of the average contribution of employees who do not earn as much was tightened. The maximum contribution to a 403(b) plan (tax-sheltered annuity for public school employees) was reduced to $9,500 a year and employer contributions for the first time were made subject to nondiscrimination rules. In addition, pre-retirement withdrawals were restricted unless due to hardship. The maximum contribution to a 457 plan (unfunded deferred compensation plan for a State or local government) remained at $7,500, but is coordinated with contributions to a 401(k) or 403(b) plan. In addition, 457 plans are required to commence distributions under uniform rules that apply to all pension plans. The lower limits were effective for deferrals made on or after January 1, 1987, while the other changes generally were effective January 1, 1989.

(C) TAXATION OF DISTRIBUTIONS

The tax treatment of distributions from public employee pension plans also was modified by the Tax Reform Act of 1986 to develop consistent treatment for employees in contributory and noncontributory pension plans. Before 1986, public employees who had made after-tax contributions to their pension plans could receive their own contributions first (tax-free) after the annuity starting date if the entire contribution could be recovered within 3 years, and then pay taxes on the full amount of the annuity. Alternately, employees could receive annuities in which the portions of noticeable contributions and taxable pensions were fixed over time. The Tax Reform Act repealed the 3-year basis recovery rule that permitted tax-free portions of the retirement annuity to be paid first. Under the new law, retirees from public plans must receive annuities that are a combination of taxable and nontaxable amounts.

The tax treatment of pre-retirement distributions was changed for all retirement plans in an effort to discourage the use of retirement money for purposes other than retirement. A 10-percent penalty tax applies to any distribution before age 59½ other than distributions in the form of a life annuity at early retirement at or after age 55, in the event of the death of the employee, or in the event of medical hardship. In addition, refunds of after-tax employee contributions and payments from 457 plans are not subject to the 10-percent penalty tax. The Tax Reform Act of 1986 also repealed the use of the advantageous 10-year forward-averaging tax treatment for lump-sum distributions received prior to age 59½, and provides for a one-time use of 5-year forward-averaging after age 59½.

2. Issues and Legislative Responses

(A) Federal Regulation

Issues surrounding Federal regulation of public pension plans have changed little in the past 10 years. A 1978 report to Congress by the Pension Task Force on Public Employee Retirement Systems concluded that State and local plans often were deficient in funding, disclosure, and benefit adequacy. The Task Force reported many deficiencies that still exist today.

Government retirement plans, particularly smaller plans, frequently were operated without regard to generally accepted financial and accounting procedures applicable to private plans and other financial enterprises. There was a general lack of consistent standards of conduct.

Open opportunities existed for conflict-of-interest transactions, and frequent poor plan investment performance.

Many plans were not funded on the basis of sound actuarial principles and assumptions, resulting in adequate funding that could place future beneficiaries at risk of losing benefits altogether.

There was a lack of standardized and effective disclosure, creating a significant potential for abuse due to the lack of independent and external reviews of plan operations.

Although most plans effectively met ERISA minimum participation and benefit accrual standards, two of every three plans, covering 20 percent of plan participants, did not meet ERISA's minimum vesting standard.

There remains considerable variation and uncertainty in the interpretation and application of provisions pertaining to State and local retirement plans, including the anti-discrimination and tax qualification requirements of the Internal Revenue Code. While most administrators seem to follow the broad outlines of ERISA benefit standards, they are not required to do so. The sheer size of the investment funds suggests that a Federal standard might be prudent.

However, the need for improved standards has not obscured the latent constitutional question posed by Federal regulation. In *National League of Cities* v. *Usery*, the U.S. Supreme Court held that extension of Federal wage and maximum hour standards to State and local employees was an unconstitutional interference with State sovereignty reserved under the 10th Amendment. State and local governments have argued that any extension of ERISA standards would be subject to court challenge on similar grounds. However, the Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority* overruling *National League of Cities* largely has resolved this issue in favor of Federal regulation.

Perhaps in part because of the lingering question of constitutionality, the focus of Congress has been fixed on regulation of public pensions with respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be improved by greater disclosure.

A definitive statement on financial disclosure standards for public plans was issued in 1986 by the Government Accounting

Standards Board (GASB). Statement No. 5 on "Disclosure of Pension Information by Public Employee Retirement Systems and State and Local Governmental Employers" established standards for disclosure of pension information by public employers and public employee retirement systems (PERS) in notes in financial statements and in required supplementary information. The disclosures are intended to provide information needed to assess the funding status of PERS, the progress made in accumulating sufficient assets to pay benefits, and the extent to which the employer is making actuarially determined contributions. In addition, the statement requires the computation and disclosure of a standardized measure of the pension benefit obligation. The statement further suggests that 10-year trends on assets, unfunded obligations, and revenues be presented as supplementary information.

3. PROGNOSIS

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation. There is also concern about cash-strapped government "raiding" pension plan assets and tinkering with the assumptions used in determining plan contributions. Critics of this position generally believe that the diversity of plan design and regulation is necessary to meet divergent priorities of different localities and is the strength, not weakness, of what is collectively referred to as the State and local pension system. While State and local governments consistently oppose Federal action, increased pressures to improve investment performance, coupled with the call for responsible social investment, may lessen some of the opposition of State and local plan administrators to some degree of Federal regulation.

C. FEDERAL CIVILIAN EMPLOYEE RETIREMENT

1. BACKGROUND

From 1920 until January 1, 1987, the Civil Service Retirement System (CSRS) was the retirement plan for all Federal civilian employees. That was changed with the enactment of legislation creating the Federal Employees Retirement System (FERS). CSRS covers all employees hired before January 1, 1984, who did not transfer to FERS by December 31, 1987. CSRS will cease to exist when the last employee or survivor in the system dies. FERS covers all Federal employees hired on or after January 1, 1984.

A key difference in the plans is that the FERS benefit includes Social Security. Enactment of the Social Security Amendments of 1983 implemented a recommendation of the 1981 National Commission on Social Security Reform and mandated Social Security coverage for all Federal employees hired on or after January 1, 1984. Social Security coverage of Federal employees compelled the Congress to review the retirement benefits for such employees and examine various retirement options. The Social Security coverage duplicated some CSRS benefits and would have increased combined employee contributions to more than 13 percent of pay. Therefore, with P.L. 98–168 in 1983, Congress established an interim arrangement, pending the enactment of a permanent new plan. After ex-

tended debate, Congress approved the Federal Employees' Retirement System Act of 1986 (P.L. 99-335).

(A) CIVIL SERVICE RETIREMENT SYSTEM

CSRS is the largest pension plan in the country, a pay-as-you-go system financed roughly one-fifth from employees' payroll taxes, one-fifth from the employing agency, and the balance from Federal general revenues. CSRS participants contribute 7 percent of total basic pay and neither pay Social Security tax nor receive Social Security coverage.

The annual cost of the retirement system increased from $2.5 billion in 1970 to a total of $33.3 billion in fiscal year 1991 ($33.07 billion for CSRS; $249.6 million for FERS). The number of annuitants grew from 962,000 to an estimated 2.2 million during this same period. During the 1969 through 1992 period, CSRS retirement benefits increased 285 percent, military retirement benefits 285 percent, and Social Security benefits 368 percent. The Consumer Price Index increased 364 percent from 1969 through 1991 (data for all of 1992 are not yet available).

The CSRS benefits structure is as follows: After 5 years of service, vested benefits equal a percentage of the highest 3 years of pay. Unreduced benefits are payable at age 55 with at least 30 years of service; age 60 with at least 20 years of service; and age 62 with at least 5 years of service. Employees receive credit for unused sick leave if they continue to work until retirement. Payment of benefits for those who leave Federal service before they are eligible for retirement cannot start before age 62. Employees have the right to withdraw their own contributions without interest and forfeit all CSRS benefits. CSRS also provides disability and survivors benefits.

The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119) protects CSRS cost-of-living adjustments (COLAs) from sequestration under the Gramm-Rudman-Hollings Act. However, Congress could still mandate reductions or cancellations of the COLAs to meet budget deficit reduction targets. On January 1, 1993, a COLA of 3 percent was provided to retirees under CSRS.

Since 1987, a Thrift Savings Plan (TSP) option has been available to CSRS participants which allows an employee to invest up to 5 percent of pay in a tax-deferred plan. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) exempts the TSP from antidiscrimination rules which apply to similar tax-deferred plans in the private sector. Therefore, all CSRS participants may contribute to TSP and will not face possible reduction of the allowable contribution rate, no matter what their income level. The Government makes no matching contribution to the TSP for CSRS employees.

(B) THE FEDERAL EMPLOYEES RETIREMENT SYSTEM (FERS)

(1) Social Security Plus a Basic Defined Benefit Plan

The FERS plan is comprised of three tiers: a defined-benefit plan, Social Security, and a Thrift Savings Plan. The FERS benefit plan is similar to private-sector plans in many respects and allows work-

ers to earn 1 percent of the average of their highest 3 consecutive years of wages for each year of service completed. Workers retiring at age 62 or later with at least 20 years of service will receive an additional 0.1 percent of pay for each year of service. Unlike CSRS, unused sick leave cannot be used for computation of retirement benefits.

In contrast to CSRS, the FERS benefit is reduced if an employee retires before age 62. Unreduced benefits from FERS will be payable at age 62 with 5 years of service, at age 60 with 20 years of service, and at the minimum retirement age (MRA) with 30 years of service. Workers who leave Federal service involuntarily at any age with at least 25 years of service, or after age 50 with at least 20 years of service, will be eligible for unreduced benefits.

The MRA is 55 for workers who reach that age by the year 2002, and increases 2 months per year, reaching age 56 in 2009. Beginning in 2021, the MRA again rises by 2 months per year until the full retirement age (57) is reached in 2027. Reduced benefits are payable to retiring employees over the MRA with 10 years of service. The reduction is 5 percent for each year under age 62.

Retirees with unreduced benefits between the MRA and age 62 will be paid a supplement approximately equal to the amount of the estimated Social Security benefit based on Federal service payable to the retiree at age 62. This supplement also will be paid to involuntarily separated workers from ages 55 to 62. Supplemental payments will be subject to an earnings test similar to that for Social Security beneficiaries.

Deferred benefits will be payable at age 62 to workers who leave Federal service before retirement, provided they have at least 5 years of service and have not withdrawn their contributions. Deferred benefits also are payable without reduction to workers at the MRA with 30 years of service at separation or at age 60 with 20 years of service at separation. Reduced deferred benefits also are available at age 55 with at least 10 years of service. The reduction is 5 percent for each year under 62.

COLAs will be paid annually based on changes in prices as measured by the Consumer Price Index (CPI) for retirees age 62 or over. The COLA will match the CPI increase up to 2 percent. If the CPI increase exceeds 2 percent, the COLA will be the greater of 2 percent or the CPI increase minus 1 percent. On January 1, 1993, a COLA of 2 percent was provided to FERS retirees.

(2) Employee Contributions

Unlike CSRS participants, employees participating in FERS are required to contribute to Social Security. The tax rate for Social Security coverage was 5.7 percent of pay in 1986 and 1987, 6.06 percent in 1988, and 6.2 percent in 1990, 1991, and 1992 up to the taxable wage ceiling ($57,600 in 1993). The wage ceiling is indexed to the annual growth of wages in the national economy. In FERS, employees contribute the difference between 7 percent of basic pay and the Social Security tax rate.

At separation from service, employees have the option of withdrawing their contributions to FERS. This means the employee relinquishes the employer's contribution. An employee separating

after 1 year of service will receive interest on their contributions. An important difference between CSRS and FERS is that FERS employees who withdraw their contributions will not be able to redeposit money in order to recapture credit for that service.

(3) Disability Benefits

After 18 months of creditable service, employees are eligible for disability retirement if they are unable, because of disease or injury, to perform useful and efficient services in their current position or a vacant position at the same grade level in the same agency and commuting area. Employees applying for disability benefits under FERS may also apply for disability benefits under the Social Security system. Benefits will be based on the 3 highest years of pay and be offset, to an extent, by Social Security benefits.

(4) Survivor Benefits

The FERS survivor benefit provides lump-sum payments to surviving spouses of workers who die before retirement, as well as annuities for the survivors in certain areas. Survivors of retired workers are eligible for an annuity if the couple has elected the survivor annuity plan. The survivor annuity plan may be waived only if the spouse provides written, notarized consent.

Children's survivor benefits under FERS are payable to surviving children until age 18, or until 21 if they are full-time students. Disabled children incapable of self-support may continue to receive benefits for life if the disability began prior to age 18. All children's benefits are offset by any Social Security benefits for which they are eligible.

(5) Thrift Savings Plan (TSP)

FERS supplements the defined benefits plan and Social Security with a contribution plan that is similar to the 401(k) plans used by private employers. Employees accumulate assets in the TSP in the form of a savings account that either can be withdrawn in a lump sum or converted to an annuity when the employee retires. One percent of pay is automatically contributed to the TSP by the employing agency. Employees can contribute up to 10 percent of their salaries to the TSP. The employing agency will match the first 3 percent of pay contributed on a dollar-for-dollar basis and match the next 2 percent of pay contributed at the rate of 50 cents per dollar. The maximum matching contribution to the TSP by the Federal agency will equal 4 percent of pay plus the 1 percent automatic contribution. Therefore, employees contributing 5 percent or more of pay will receive the maximum employer match. An open season is held every 6 months to permit employees to change levels of contributions and direction of investments. Employees are allowed to borrow from their accumulated TSP for the purchase of a primary residence, educational or medical expenses, or financial hardship.

FERS originally contained restrictions on optional investment opportunities, such as fixed-income securities or a stock index fund, phasing-in the funds over a 10-year period. Public Law 101-335

eliminated the 10-year phase-in period for FERS TSP participants and for the first time allowed CSRS TSP participants to invest in these funds. The legislation also exempted TSP annuities from State and local premium taxes, as was done for the Federal Employees Group Life Insurance Program in 1981.

2. Issues and Legislative Responses

(A) Lump-Sum Withdrawal of Contributions

The law creating FERS contained a provision allowing those retiring under CSRS or FERS to withdraw at the time of their retirement their contributions to the system in exchange for a reduction in their annuity to reflect the withdrawn sum. The pension is then actuarially reduced so that over the retiree's lifetime the amount received as a monthly payment plus the withdrawal would be the same amount that would have been received if the withdrawal had not been made.

The OBRA 1990 (P.L. 101-508) suspended the lump-sum annuity option for 5 years, beginning December 1, 1990. Employees retiring before November 30, 1990, will receive the lump sum in two payments (40 percent and 60 percent). However, the Act did create exceptions which will allow certain individuals to elect the lump-sum annuity option during the 5-year suspension period. The exceptions are as follows:

—Employees who are terminally ill and meet the age and service requirements for voluntary retirement may elect the lump sum in a 100 percent payment;

—Employees who are involuntarily separated for reasons other than misconduct or delinquency and who meet the age and service requirements for voluntary retirement may elect the lump sum in two payments of 50 percent each; this category does not include Members of Congress, Schedule C appointees or non-career members of the Senior Executive Service; and

—Employees who were employed in direct support of Operation Desert Shield and who were eligible for retirement before December 1, 1990, could retire before December 1, 1991 and elect the lump sum in two payments (40 percent and 60 percent).

The legislation also precludes the distribution of the two lump-sum payments in 1 year to avoid harsh tax consequences.

(B) Social Security Public Pension Offset

Social Security benefits payable to spouses of retired, disabled, or deceased workers generally are reduced to take into account any public pension the spouse receives from government work not covered by Social Security. The amount of the reduction equals two-thirds of the government pension. In other words, $2 of the Social Security benefit is reduced for every $3 of pension income received. Workers with at least 5 years of FERS coverage are not subject to the offset.

According to a 1988 General Accounting Office report entitled: "Federal Workforce—Effects of Public Pension Offset on Social Security Benefits of Federal Retirees," 95 percent of Federal retirees

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had their Social Security spousal or survivor benefits totally eliminated by the offset.

(C) SOCIAL SECURITY WINDFALL BENEFIT REDUCTION

Workers who have less than 30 years of Social Security coverage and a pension from non-Social Security covered employment are subject to the windfall penalty formula when their Social Security benefit is computed. The windfall penalty was enacted as part of the Social Security Amendments of 1983 in order to reduce the disproportionately high benefit "windfall" that such workers would otherwise receive from Social Security. Because the Social Security benefits formula is weighted, low-income workers and workers with fewer years of covered service receive a higher rate of return on their contributions than high income workers who are more likely to also have private pension or other retirement income. However, the formula did not distinguish between workers with low-income earnings and workers with fewer years of covered service which resulted in a windfall to the latter group. To eliminate this windfall, Congress adopted the windfall benefit formula and then modified the formula before it was fully phased-in.

Under the regular Social Security benefit formula, the basic benefit is determined by applying three factors (90 percent, 32 percent, and 15 percent) to three different brackets of a person's average indexed monthly earnings (AIME). These dollar amounts increase each year to reflect the increase in wages. The formula for a worker who turns age 62 in 1992 is 90 percent of the first $387 in average monthly earnings, plus 32 percent of the amount between $370 and $2,333, and 15 percent of the amount over $2,333.

Under the original 1983 windfall benefit formula, the first factor in the formula was 40 percent rather than 90 percent with the 32 percent and 15 percent factors remaining the same. With the passage of the Technical Corrections and Miscellaneous Revenue Act of 1988, Congress modified the windfall reduction formula and created the following schedule:

Years of Social Security coverage:	*First factor in formula (percent)*
20 or fewer	40
21	45
22	50
23	55
24	60
25	65
26	70
27	75
28	80
29	85
30 or more	90

Under the windfall benefit provision, the windfall formula will reduce the Social Security benefit by no more than 50 percent of the pension resulting from noncovered service.

(D) TAXATION OF LUMP SUM PAYMENTS AT RETIREMENT

The Tax Reform Act of 1986 treats post-retirement lump sum payments of employee contributions the same as full annuity payments. That is, the value of the lump sum payment and the re-

maining annuity amount are combined and the proportionate shares of the employer's and employee's contributions are assessed. This rate is then applied to both the monthly annuity payments and the total lump sum payment.

The law places a penalty on the withdrawal of an employee's contributions in certain limited circumstances. The 10 percent penalty on early withdrawals from Individual Retirement Accounts (IRAs), except in cases of hardship, is extended to early withdrawals from qualified pension plans. This penalty affects Federal workers under age 55 who retire under early retirement provisions pertaining to job abolishments, reorganizations, reductions-in-force, or job categories that allow retirement at age 50 with 20 years of service.

3. Prognosis

Congress is unlikely to make major changes in either CSRS or FERS in the foreseeable future. Some minor changes may be made in the Thrift Savings Plan to address unforeseen administrative needs of a large investment plan.

D. MILITARY RETIREMENT

1. Background

For more than four decades following the establishment of the military retirement system at the end of World War II, the retirement system for servicemen remained virtually unchanged. However, the enactment of the Military Retirement Reform Act of 1986 (P.L. 99-348) brought major reforms to the system. The Act affected the future benefits of servicemembers first entering the military on or after August 1, 1986. Because a participant only becomes entitled to military retired and retainer pay after 20 years of service, the first nondisability retirees affected by the new law will be those with 20 years of service retiring on August 1, 2006.

In fiscal year 1990, 1.6 million retirees and survivors received military retirement benefits. For fiscal year 1990, total Federal military retirement outlays have been estimated at $21.5 billion. Three types of benefits are provided under the system: Standard retirement benefits, disability retirement benefits, and survivor benefits under the Survivor Benefit Program (SBP). With the exception of the SBP, all benefits are paid by contributions from the employing branch of the armed service, without contributions by the participants.

Servicemembers who retire from active duty receive monthly payments based on a percentage of their retired pay computation base. For persons who entered military service before September 8, 1980, the computation base is the final monthly base pay being received at the time of retirement. For those who entered service on or after September 8, 1980, the retired pay computation base is the average of the highest 3 years of base pay. Base pay comprises approximately 65-70 percent of total pay and allowances.

Retirement benefits are computed using a percentage of the retired pay computation base. The retirement benefit for someone entering military service prior to August 1, 1986, is determined by

multiplying the years of service by a multiple of 2.5. Under this formula, the minimum amount of retired pay to which a retiree is entitled after a minimum of 20 years of service is 50 percent of base pay. A 25-year retiree receives 62.5 percent of base pay, with a 30-year retiree receiving the maximum—75 percent of base pay.

The Military Reform Act of 1986 (P.L. 99-348) changed the computation formula for military personnel who enter military service on or after August 1, 1986. For retirees under age 62, retired pay will be computed at the rate of 2 percent of the retired pay computation base for each year of service through 20, and 3.5 percent for each year of service from 21 through 30. Under the new formula, a 20-year retiree under age 62 will receive 40 percent of his or her basic pay, 57.5 percent after 25 years, and 75 percent after 30 years. Upon reaching 62, however, all retirees have their benefits recomputed using the old formula. The changed formula, therefore, favors the longer serving military careerist to a greater extent than the previous formula, providing an incentive to remain on active duty longer before retiring. Since most military personnel retire after 20 years, the cut from 2.5 percent to 2 percent will cut program costs. These changes in the retired pay computation formula apply only to active duty nondisability retirees. Disability retirees and Reserve retirees are not affected.

Benefits are payable immediately upon retirement from military service, regardless of age, and without taking into account other sources of income, including Social Security. By statute, all benefits are fully indexed for changes in the CPI. In the event of an across-the-board budget cut under Gramm-Rudman-Hollings, military retirement cost-of-living adjustments COLAs are exempt from sequestration. Under the Military Retirement Reform Act of 1986, however, COLAs will be held at 1 percentage point below the CPI for military personnel beginning their service after August 1, 1986.

2. Issues and Legislative Responses

(a) cost

Prior to 1986, the military retirement system was repeatedly criticized for providing generous benefits, costing too much, and being too expensive. The Military Retirement Reform Act of 1986 was enacted in response to these criticisms. The Act's purpose was to contain the costs of the military retirement system and provide incentives for experienced military personnel to remain on active duty.

Approximately 1.6 million retired officers, enlisted personnel, and their survivors received nearly $21.5 billion in annuity payments in fiscal year 1990. At the current rate of growth, this expenditure will reach an estimated $38.4 billion annually by the year 2000. In fiscal year 1990, military retirees received an average of $13,378 in annuities.

Four features of the military retirement system contribute to its cost:

(1) Full benefits begin immediately upon retirement; the average retiring enlisted member begins drawing benefits at 43, the average officer at 46. Benefits continue until the death of the participant.

(2) Military retirement benefits are generally indexed for inflation.

(3) The system is basically noncontributory, although in order to provide survivor protection, the participant must make some contribution.

(4) Military retirement benefits are not integrated with Social Security benefits. (They may, however, be integrated with other benefits earned as a result of military service, i.e., Veterans benefits, or may be subject to reductions under dual compensation laws.)

Supporters of the current military retirement scheme have identified several characteristics unique to military life that justify relatively more liberal benefits to military retirees than other Federal retirees:

(1) All retired personnel are subject to involuntary recall in the event of a national emergency; retirement pay is considered part compensation for this exigency. Several hundred military retirees were recalled to active duty involuntarily for Operations Desert Shield and Desert Storm.

(2) Military service places different demands on military personnel than civilian employment, including higher levels of stress and danger and more frequent separation from family.

(3) The benefit structure has provided a significant incentive for older personnel to leave the service and maintain "youth and vigor" in the armed services. In this respect, it has been largely successful. Almost 90 percent of military retirees are under age 65, 50 percent under the age of 50.

Military personnel do not contribute to their retirement benefits, though they do pay Social Security taxes and offset a certain amount of their pay to participate in the Survivor Benefit Program. Very few of the studies conducted in the past decade have recommended contributions by individuals. As a result, no refunds of contributions are available to those leaving the military before the end of 20 years. The full cost of the program appears as an agency expense in the budget, unlike the civilian retirement system where four-fifths of the retirement plan costs appear in the agency budgets.

Since the beginning of full Social Security coverage for military personnel in 1957, military retirement benefits have been paid without any offset for Social Security. Taking into account the frequency with which military personnel in their mid-forties retire after 20 years of service, it is not unusual to find them retiring from a second career with a pension from their private employment along with their military retirement and a full Social Security benefit. Lack of integration of military retirement and Social Security benefits may add to the perception that military retirement benefits are overly generous.

Military retirement is fully indexed for inflation, as are Social Security and the Civil Service Retirement system, a feature that retirees traditionally have considered central to the adequacy of retirement benefits. In recent years, full indexing of military and other Federal retirement benefits has been the object of the Administration's deficit-reduction measures. As a result of the original provisions of the Gramm-Rudman-Hollings Act, the 1986 mili-

tary retiree COLA was cancelled. Since that time, however, legislation was enacted that excluded the COLA from sequestration.

(B) RETIREMENT ADEQUACY

The pivotal issue in evaluating the military retirement system is the appropriate balance among costs to the Government, benefits to the individual retiree, and the qualitative and quantitative manpower needs of the armed forces. Some have alleged that the major features of the military retirement system that differentiate it from civilian retirement systems—20-year retirement with an immediate annuity—are essential to recruiting and retaining sufficient high-quality career military personnel who can withstand the rigors of wartime service and high-stress peacetime training. Others allege that the system simply costs too much, has lavish benefits, and contributes to inefficient military personnel management because no vesting is available before the 20-year mark.

Commentators periodically have called for shorter vesting schedules, comparable to those required for private plans under ERISA or for the Federal service jobs. Some military manpower experts have argued that such a change would adversely impact the ability to maintain a vigorous and youthful military force. On the other hand, some military manpower analysts argue that the need for youth and vigor is overstated in view of new technologies that put a premium on technical skills rather than physical endurance.

(C) THE MILITARY SURVIVOR BENEFIT PLAN

The Military Survivor Benefit Plan (SBP) was created in 1972 by Public Law 92–425. Under the plan, a military retiree can have a portion of his or her retired pay withheld to provide a survivor benefit to a spouse, spouse and child(ren), child(ren) only, person with an "insurable interest," or a former spouse. Under the SBP, a military retiree can provide a benefit of up to 55 percent of his or her own military retired pay at the time of death to a designated beneficiary. A retiree is automatically enrolled in the SBP at the maximum rate unless he or she (with spousal or former spousal written consent) opts not to participate or to participate at a reduced rate. SBP benefits are protected by inflation under the same formula used to determine cost-of-living adjustments for military retired pay.

The benefit payable to a spouse or former spouse may be modified when a respective survivor reaches age 62 under one of two circumstances.

(1) Survivor Social Security Offset

Coverage of military service under Social Security entitles the surviving spouse of a military retiree to receive Social Security survivor benefits based on contributions made to Social Security during the member's/retiree's military service. For certain surviving spouses, military SBP is integrated with Social Security. For those survivors subject to those provisions, military SBP benefits are offset by the amount of Social Security survivor benefits earned as a result of the retiree's military service. This offset occurs when the survivor reaches age 62 and is limited to 40 percent of the mili-

tary survivor benefit. Taken together, the post-62 SBP benefit and the offsetting Social Security benefit must be no less than 55 percent of base military retired pay. In essence, this offset recognizes the Government's/taxpayer's contributions to both Social Security and the military SBP and thereby prevents duplication of benefits based on the same period of military service.

(2) The Two-Tiered SBP

For retirees who decide to participate in the SBP, the amount of Social Security at the time of death (i.e., the amount available for offset purposes) is unknown. Thus, retirees must decide to provide a benefit at a certain level subject to an unknown offset level. For this reason (and the fact that the offset formula is terribly complicated) Congress modified SBP provisions. Under these modified provisions, known as the "two-tier" SBP, a surviving spouse is eligible to receive 55 percent of base retired pay. When this survivor reaches age 62, the benefit is reduced to 35 percent of base retired pay. This reduction occurs regardless of any benefits received under Social Security and thereby eliminates the integration of Social Security and any subsequent offset. With the elimination of the Social Security offset, a military retiree will know the exact amount of SBP benefits he/she is purchasing at the time of retirement.

Under the rules established by Congress, two selected groups will have their SBP payments calculated under either the pre-two-tier plan (including the Social Security offset) or the two-tier plan, depending upon which is more financially advantageous to the survivor. The first group includes those beneficiaries (widows or widowers) who were receiving SBP benefits on October 1, 1985. The second group includes the spouse or former spouse of military personnel who were qualified for or were already receiving military retired pay on October 1, 1985. The spouses or former spouses of military personnel who were not qualified to receive military retired pay on October 1, 1985 (i.e., those who had not been on active duty with 20 or more years of creditable service) will have their SBP benefits calculated using the two-tier method. Levels of participation in the SBP have increased since the introduction of the two-tier method.

(3) Survivor Benefit Plan High Option

Beneficiary dissatisfaction with both the Social Security offset and the two-tier method has prompted Congress once again to consider modifying the military SBP. As a result of this action, a 1-year open season was created starting on April 1, 1992. Certain retirees and retirement-eligible members of the armed services can opt to increase withholdings from military retired to reduce or eliminate any reduction occurring when the survivor reaches age 62. The costs of these additional benefits are actuarially neutral—participants will pay the full cost of this option. Thus, under the high option, certain personnel and retirees can insure that limited or no reductions to SBP benefits occur when the survivor reaches age 62.

(4) Cost-of-Living Adjustment

Military retirees, along with Social Security and other Federal retirees, received a 3.7 percent COLA effective January 1, 1992.

3. PROGNOSIS

No major legislative reforms are expected in the military retirement system, although minor modifications may be anticipated. A full COLA is anticipated in the President's upcoming fiscal year budget.

E. RAILROAD RETIREMENT SYSTEM

1. BACKGROUND

The Railroad Retirement System is a federally managed retirement system covering employees in the rail industry, with benefits and financing coordinated with Social Security. The system was authorized in 1935, prior to the creation of Social Security, and remains the only federally administered pension program for a private industry. It covers all railroad firms and distributes retirement and disability benefits to employees, their spouses, and survivors. Benefits are financed through a combination of employee and employer payments to a trust fund, with the exception of vested so-called "dual" or "windfall" benefits, which are paid with annually appropriated Federal general revenue funds through a special account.

In fiscal year 1992, $7.7 billion in railroad retirement, disability, and survivor benefits were paid to 854,000 beneficiaries.

2. ISSUES AND LEGISLATIVE RESPONSES

(A) THE STRUCTURE OF THE RAILROAD RETIREMENT SYSTEM

In the final quarter of the 19th century, railroad companies were among the largest commercial enterprises in the Nation and were marked by a high degree of centralization and integration. As first established in 1934, the Railroad Retirement System was designed to provide annuities to retirees based on rail earnings and length of service. However, the present Railroad Retirement System was a result of the Railroad Retirement Act of 1974, which fundamentally reorganized the program. Most significantly, the Act created a two-tier benefit structure in which Tier I was intended to serve as an equivalent to Social Security and Tier II as a private pension.

Tier I benefits of the Railroad Retirement System are computed on credits earned in both rail and nonrail work, while Tier II is based solely on railroad employment. The total benefit continued traditional railroad annuities and eliminated duplicate Social Security coverage for nonrail and rail employment.

The Bush Administration, as the Reagan Administration before it, proposed to dismantle the Railroad Retirement System and replace it with a combination of direct Social Security coverage and a privately administered rail pension. Past Congresses have not taken the proposal under consideration on the grounds that it

could lead to a cut in benefits for present and future retirees and undermine confidence in the system.

(B) FINANCING RAILROAD RETIREMENT, UNEMPLOYMENT, AND SICKNESS BENEFITS

The railroad industry is responsible for the financing of (1) all Tier II benefits, (2) any Tier I benefits paid under different criteria from those of Social Security (unrecompensed benefits), (3) supplemental annuities paid to long-service workers, and (4) benefits payable under the unemployment and sickness program.

The Federal Government finances windfall benefits under an arrangement established by the 1974 Act, the legislation by which the current structure of railroad retirement was created. The principle of Federal financing of the windfall through the attrition of the closed group of eligible persons has been reaffirmed by Congress on several occasions since that date.

With the exception of the dual benefit windfalls, the principle guiding railroad retirement and unemployment benefits financing is that the rail industry is responsible for a level of taxation upon industry payroll sufficient to pay all benefits earned in industry employment. Rail industry management and labor officials participate in shaping legislation that establishes the system's benefits and taxes. In this process, Congress weighs the relative interests of railroads, their current and former employees, and Federal taxpayers. Then it guides, reviews, and to some extent instructs a collective bargaining activity, the results of which are reflected in new law. Thus, railroad retirement benefits are earned in and paid by the railroad industry, established and modified by Congress, and administered by the Federal Government.

(1) Retirement Benefits

Tier I benefits are financed by a combination of payroll taxes and financial payments from the Social Security Trust Funds to pay for Tier I benefits that are based on earnings covered by Social Security. The payroll tax for Tier I is exactly the same as collected for the Old Age, Survivors, and Disability Insurance (OASDI) Social Security program. In 1992, the tax was 6.2 percent of pay for both employers and employees up to a maximum taxable wage of $55,500.

A common cause of confusion about the Federal Government's involvement in the financing of railroad retirement benefits is the system's complex relationship with Social Security. Each year since 1951, the two programs—railroad retirement and Social Security—have determined what taxes and benefits would have been collected and paid by Social Security had railroad employees been covered by Social Security rather than railroad retirement. When the calculations have been performed and verified after the end of a fiscal year, transfers are made between the two accounts, called the "financial interchange." The principle of the financial interchange is that Social Security should be in the same financial position it would have occupied had railroad employment been covered at the beginning of Social Security. The net interchange has been in the direction of railroad retirement in every year since 1957, pri-

marily because of a steady decline in the number of rail industry jobs.

Because a lag between the end of the accounting period and actual payment affected the RRA's capacity to meet benefit demands, the Railroad Retirement Solvency Act of 1983 (the 1983 Act) gradually placed the relationship between the programs on a current or month-to-month basis. The 1983 Act also established the SSEB Account which manages revenues and expenditures for benefits that would be managed by Social Security if railroad retirement did not exist.

Tier II benefits are also financed by a payroll tax. In 1992, the payroll tax was 16.10 percent for employers and 4.90 percent for employees on the first $41,400 of a worker's covered railroad wages. The relative share of employer and employee financing of Tier II benefits is collectively bargained, and reflects compromises not directly related to retirement—compensation tradeoffs inherent in reaching labor-management agreements.

When Congress, with rail labor and management support, eliminated future opportunities to qualify for windfall benefits in 1974, it also agreed to use general revenues to finance the cost of phasing out the dual entitlement values already held by a specific and limited group of workers. The historical record suggests that congressional acceptance of a Federal obligation for the costs of phasing out the windfalls rests on the view that it was imperative that the advantages be eliminated prospectively and that no other alternative to General Fund financing was satisfactory. It was successfully argued that railroad employers should not be required to pay for phasing out dual entitlements, because those benefit rights were earned by employees who had left the rail industry, and that rail employees should not be expected to pick up the costs of a benefit to which they could not become entitled.

Congressional acceptance of the Federal responsibility for the cost of windfall phaseout also caused some people to believe that the Federal Government should assume the retroactive responsibility for windfall costs borne by railroad retirement from 1954 through 1974. This argument has never been widely accepted because it is generally believed that the general taxpayer should not bear the cost of an advantage in social insurance benefits for which only a limited group of employees in one industry is eligible. Indeed, administration analysts have made this point in arguing that the Federal Government should not have agreed to finance the phaseout of windfalls in the 1974 legislation.

The actual procedure by which the RRA was reimbursed for windfall phaseout payments meant that from 1975 to 1981 windfall payments exceeded Treasury reimbursement. The growing deficit between windfall benefit outlays and Federal Treasury reimbursement to the RRA became controversial as the account began to be threatened with insolvency. By 1983, this deficit, plus an imputed lost interest, had reached $1.9 billion. The 1983 Act repaid this outstanding reimbursement in three annual installments, beginning January 1984.

Supplemental annuities are financed on a current-cost basis, by a cents-per-hour tax on employers, adjusted quarterly to reflect payment experience. Some railroad employers (mostly railroads owned

by steel companies) have a negotiated supplemental benefit paid directly from a company pension. In such cases, the company is exempt from the cents-per-hour tax for such amounts as it pays to the private pension, and the retiree's supplemental annuity is reduced for private pension payments paid for by those employer contributions to the private pension fund.

(2) Unemployment and Sickness Benefits

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

During the rapid decline in industry employment in 1981 and 1982, the RUIA experienced substantial borrowing from the pension funds, reaching a peak level of $850 million at the end of 1986. Legislation in 1983, 1986, and 1988 (Public Laws 98-76, 99-272, and 100-647) enacted special taxes to facilitate repayment of the RUIA debt to the retirement funds, and all outstanding loans, including interest, are expected to be repaid by the end of 1994.

(C) TAXATION OF RAILROAD RETIREMENT BENEFITS

Tier I benefits are subject to the same Federal income tax treatment as Social Security. Under those rules, up to one-half of the Tier I benefit is subject to income taxes if the adjusted gross income (AGI) of an individual exceeds $25,000 ($32,000 for a married couple). Proceeds from this tax are transferred from the General Fund to the Social Security Trust Funds to help finance Social Security and railroad retirement Tier I benefits.

Unrecompensed Tier I benefits (Tier I benefits paid in circumstances not paid under Social Security) and Tier II benefits are taxed as ordinary income, on the same basis as all other private pensions. The proceeds from this tax are transferred to the railroad retirement Tier II account to help defray its costs under temporary legislation enacted as part of the 1983 Act. The transfer of taxes on Tier II benefits to the Tier II account has been extended several times, and although Congress passed legislation making the transfer permanent on October 5, 1992 (H.R. 11, the Revenue Act of 1992), President Bush vetoed the bill. Nevertheless, supporters of the provision are optimistic that an extension (probably permanent) will be enacted and applied retroactively.

This transfer is a direct General Fund subsidy to the Tier II account's financial outlook, a unique taxpayer subsidy for a private industry pension. Yet, the importance of the rail industry to the national heritage and economy is widely recognized in Congress, as is the probability that some costs of the rail industry may well have to be "socialized across the rest of the economy" (in the words of former OMB Director David Stockman) if the rail industry is to remain viable in the future.

Furthermore, because the financial outlook for the Tier II account is optimistic for the next decade at least, these transferred taxes on Tier II benefits do not actually result in immediate Federal budget outlays; they remain on the account balances as unspent

budget authority. As such, there will be no impact of this transfer on Federal taxpayers or on the Federal budget deficit. However, positive balance could encourage benefit increases without corresponding increases in the Tier II tax rate, or an otherwise necessary tax rate increase could be delayed because the account balance is perceived to be high enough to forgo it. If the ratio of taxes-to-benefits is insufficient to maintain a growing, or at least level, account balance, the program will begin to add to annual Federal budget deficits.

(D) THE OUTLOOK FOR FINANCING FUTURE BENEFITS

The Omnibus Reconciliation Act of 1987 (P.L. 100-203) created the Commission on Railroad Retirement Reform to examine and review perceived problems in the railroad benefit programs. The Commission reported its findings in September 1990. In addition to several technical recommendations, the Commission concluded that railroad retirement financing is sound for the intermediate term and probably sound for the 75 years of the actuarial valuation.

The combinations of RUIA and retirement taxes projected by the RRB, the Federal agency responsible for administering the railroad retirement and unemployment/sickness insurance programs, exceed the industry's obligations for total payments from these programs over the next decade. If the Board's assumptions are a reasonably dependable yardstick of the future economic position of the rail industry, then it would follow that the current benefit/tax relationship of the two programs considered together is adequate. Of course, as employment in the industry declines, the mechanical relationship between payroll tax income and rail employment levels darkens the outlook for both programs. Benefit increases in either program without corresponding increases in railroad industry taxes to the program would have a similar effect.

Because revenue to support industry benefits is raised through taxes on industry payroll, there is a direct link between railroad retirement financing and the actual number of railroad employees. Thus, when the number of industry employees falls, retirement program revenue drops as well. It should be kept in mind, however, that a decline in employment may result from improvements in efficiency as well as diminished demand for railroad services. Thus, the industry's capacity to generate adequate revenues to the program cannot be determined solely by reference to industry employment levels.

The program, in spite of the direct relationship between benefit payments and money raised through a tax on worker payroll, is not a transfer between generations, at least not in the same sense that current Social Security benefits are financed by taxes on today's workers. Since the burden for generating sufficient revenue to support rail industry benefits is upon the industry as a whole, the payroll tax is primarily a method for distributing through the industry the operating expense of retirement benefits incurred by individual rail carriers. The industry could adopt some other method for distributing the costs among its components and, indeed, from time-to-time alternatives are proposed. Yet, inevitably there exists an ongoing bargaining tension over the amount of in-

dustry revenue to be claimed by competing labor sectors—the active, unemployed, and retired workers—and the amount to be claimed by the railroad companies themselves.

3. Prognosis

The Railroad Retirement and Unemployment Programs will likely remain in the present form for the forseeable future.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

The Federal tax code has historically recognized the special needs of older Americans. Helping to preserve a standard of living threatened by reduced income, the loss of earning power, and increases in nondiscretionary expenditures has been a primary tax policy objective relating to the elderly.

Until 1984, both Social Security and Railroad Retirement benefits, like veterans' pensions, were fully exempt from Federal taxation. That year, to help restore financial stability to Social Security, up to one-half of Social Security and Railroad Retirement Tier I benefits of higher income taxpayers became taxable under a formula contained in the Social Security Act Amendments of 1983 (P.L. 98-21). Those Federal taxes collected on Social Security income are returned to the Social Security trust fund.

The Tax Reform Act of 1986 (P.L. 99-514) resulted in a number of other changes to tax laws affecting older men and women. While the Act repealed some longstanding tax advantages for elderly persons, it increased others. For example, the elderly lost the extra personal exemption for the aged, which was replaced by an extra standard deduction amount available to many.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) also made a number of changes to the tax laws that may affect the tax burden of elderly persons. These include the addition of a third tax rate bracket and increases in a number of excise taxes such as those on gasoline, alcohol, and tobacco.

A. TAXES

1. Background

A number of longstanding provisions in the tax code are of special significance to older men and women. These include the exclusion of Social Security and Railroad Retirement Tier I benefits for low and moderate income beneficiaries, the tax credit for the elderly and permanently and totally disabled, and the one-time exclusion of up to $125,000 in capital gains from the sale of a home for persons at least 55 years of age.

The Tax Reform Act of 1986 altered many provisions of the Internal Revenue Code including a number of tax provisions of importance to older persons. For example, the extra personal exemption for the aged was removed, but replaced by a larger personal exemption amount (adjusted for inflation) and an additional stand-

ard deduction amount for elderly and/or blind taxpayers who do not itemize.

(A) TAXATION OF SOCIAL SECURITY AND RAILROAD RETIREMENT BENEFITS

For more than four decades following the establishment of Social Security, benefits were exempt from Federal income tax. The Congress did not explicitly exclude those benefits from taxation. Rather, their tax-free status arose from a series of rulings in 1938 and 1941 from what was then called the Bureau of Internal Revenue. These rulings were based on the determination that Congress did not intend for Social Security benefits to be taxed, as implied by the lack of an explicit provision to tax them, and that the benefits were intended to be in the form of "gifts" and gratuities, not annuities which replace earnings, and therefore were not to be considered as income for tax purposes.

In 1983, the National Commission on Social Security Reform recommended that the Social Security benefits of higher income recipients be taxed, with the revenue put back into the Social Security trust funds. The proposal was part of a larger set of recommendations entailing financial concessions by employees, employers, and retirees alike to rescue Social Security from insolvency.

The Congress acted on this recommendation with the passage of the Social Security Act Amendments of 1983. As a result, up to one-half of the benefits of Social Security and Railroad Retirement recipients with incomes over $25,000 ($32,000 for joint filers) became subject to taxation. Because taxes already have been paid on the retired worker's share to the Social Security system, only the one-half regarded as the employer's contribution (and on which income taxes have not previously been paid) is taxable. In the case of Railroad Retirement recipients, only the Social Security-equivalent portion (Tier I) is affected.

The limited application of the tax on Social Security benefits reflects the congressional concern that lower and moderate income taxpayers not be subject to this tax. Because the tax thresholds are not indexed, however, with them, beneficiaries of more modest means will also be affected.

The tax treatment of Social Security benefits is noteworthy for another reason. Under the 1983 formula, Social Security income became the only initially tax-exempt income which can be pulled (up to 50 percent) into taxable income status by the total of other taxable income and tax-exempt interest income.

Revenues from the taxation of Social Security benefits have continued to increase. In 1984, approximately $3 billion in taxes were paid into the Social Security trust funds. In 1990, that figure rose to $5 billion. By the year 2000, they will reach an estimated $11 billion.

(B) ELDERLY TAX CREDIT

Officially named the tax credit for the elderly and the permanently and totally disabled, it was formerly known as the retirement income credit and the tax credit for the elderly. Congress established the credit to correct inequities in the taxation of different

types of retirement income. Prior to 1954, retirement income generally was taxable, while Social Security and Railroad Retirement (Tier I) benefits were tax-free. The congressional rationale for this credit is to provide roughly similar treatment for various forms of retirement income.

The credit has changed over the years with the current version enacted as part of the Social Security Amendments of 1983. Individuals who are age 65 or older are provided a tax credit of 15 percent of their taxable income up to the initial amount, described below. Individuals under age 65 are eligible only if they are retired because of a permanent or total disability and have disability income from either a public or private employer based upon that disability. The 15 percent credit for the disabled is limited only to disability income up to the initial amount.

For those persons age 65 and retired, all types of taxable income are eligible for the credit, including not only retirement income but all investment income. The initial amount for computing the credit is $5,000 for a single taxpayer age 65 or over, $5,000 for a married couple filing a joint return where only one spouse is age 65 or over, $7,500 for a married couple filing a joint return where both are age 65 or over, and $3,750 for a married individual age 65 or over filing a separate return. The initial amount must be reduced by tax-exempt retirement income, such as Social Security. The initial amount must also be reduced by $1 for each $2 if the taxpayer's adjusted gross income exceeds the following levels: $7,500 for single taxpayers, $10,000 for married couples filing a joint return, and $5,000 for a married individual filing a separate return.

(C) ONE-TIME EXCLUSION OF CAPITAL GAINS ON THE SALE OF A HOME

A taxpayer may elect to exclude from gross income up to a $125,000 gain from the sale of a residence, provided: (1) the taxpayer was at least 55 years of age before the date of the sale or exchange, and (2) he owned and occupied the property as his principal residence for a period totalling at least 3 years within the 5-year period ending on the date of the sale. Short periods of absence, such as for vacations, even if rented during those periods, are counted toward the 3-year required period. Taxpayers meeting both requirements can elect to exclude from gross income the entire capital gain from the sale or exchange if the capital gain is less than $125,000, or the first $125,000 profit if the gain is greater. If the property is held in joint name and both spouses file a joint return, they qualify for the exclusion even though only one spouse has attained the age of 55, provided he or she also satisfies the holding and use requirements. The election may be made only once in a lifetime. If either spouse has previously made an election (individually, jointly, or from a previous marriage), then neither is eligible to elect the exclusion.

The Revenue Act of 1964 provided the first exclusion from taxation for capital gains on the sale of a primary residence by the elderly. The House Committee on Ways and Means stated in its report that "an individual may desire to purchase a less expensive home or move to an apartment or to a rental property at another location. He may also require some or all of the funds obtained

from the sale of the old residence to meet his and his wife's living expenses. Nevertheless, under present law, such an individual must tie up all of his investment from the old residence in a new residence, if he is to avoid taxation on any of the gain which may be involved. Your committee concluded that this is an undesirable burden on our elderly taxpayers."

The Committee was primarily concerned with the average and smaller home selling for $20,000 or less. Therefore, it limited the application of the provision so that a full exclusion of gain would be attributable only to the first $20,000 of the sales price. Above that level, a ratio was to be used to determine the gain subject to taxation. This ratio was such that the lower the adjusted sales price, the greater the benefits derived from the exclusion. Over the years, Congress raised the maximum excludable gain to $125,000 to reflect increases in inflation and average market prices for housing. It also lowered to 55 the age at which the exclusion can be taken due to decreasing retirement ages.

(D) TAX REFORM ACT OF 1986

The Tax Reform Act of 1986 made such sweeping changes to the Internal Revenue Code that the Congress chose to issue the Code as a completely new edition—something that had not occurred since 1954. As a result of the 1986 Act, the elderly like other taxpayers saw many changes in their taxes. The following is a brief summary of some of the tax changes which had an impact on many aged taxpayers.

(1) Extra Personal Exemption for the Elderly

The extra personal exemption for elderly persons was enacted in 1948. The Senate Finance Committee Report stated the reason for the additional exemption was that "The heavy concentration of small incomes among such persons reflects the fact that, as a group, they are handicapped at least in an economic sense. They have suffered unusually as a result of the rise in cost of living and the changes in the tax system which occurred since the beginning of the war. Unlike younger persons, they have been unable to compensate for these changes by accepting full-time jobs at prevailing high wages. Furthermore, this general extension appears to be a better method of bringing relief than a piecemeal extension of the system of exclusions for the benefit of particular types of income received primarily by aged persons." At that time, this provision removed an estimated 1.4 million elderly taxpayers and others (blind persons also were provided the extra personal exemption) from the tax rolls, and reduced the tax burden for another 3.7 million.

With the passage of the 1986 Act, the extra personal exemption was eliminated due to a dramatic increase in the personal exemption amount, the provision of future inflation adjustments, and the addition of an extra standard deduction amount for those elderly taxpayers that do not itemize.

(2) Deduction of Medical and Dental Expenses

Under prior law, medical and dental expenses, including insurance premiums, co-payments, and other direct out-of-pocket costs, were deductible to the extent that they exceeded 5 percent of a taxpayer's adjusted gross income. The 1986 Act raised the threshold to 7.5 percent.

In the 1989 discussion of health care spending appearing in Health Care Financing Review, the annual average per capita expenditure for the elderly was reported to be $5,360, compared to only $745 for children under age 19, and $1,535 for adults between the ages of 19 and 65. Elderly people use more health care than younger people and also consume some services not generally used by the non-aged. In 1987, people over age 65 accounted for 35 percent of hospital expenditures, almost three times as large as their proportion of the population. The elderly are also disproportionate consumers of nursing home care, accounting for almost 90 percent of nursing home services. Most of that is used by the "old old" (those 85 years old and over).

Health services for the elderly are financed disproportionately by the public sector. Private sources financed 74 percent of health care for people under age 65, but only 37 percent of care for the elderly. Public funds, primarily Medicare, financed 63 percent of health care spending for the elderly, so growth in the elderly population is expected to have a pronounced effect on public sector health spending. The proportion of health care spending accounted for by the elderly is likely to grow because of projected growth in the elderly population.

(3) Private Pensions

Prior to 1986, retirees under the Civil Service Retirement System or any other contributory pension plans generally had the benefit of the so-called 3-year rule. The effect of this rule was to exempt, up to a maximum of 3 years, pension payments from taxation until the amount of previously taxed employee contributions made during the working years was recouped. Once the employee's share was recouped, the entire pension became taxable.

Under the 1986 Act, the employer's contribution and previously untaxed investment earnings of the payment are calculated each month on the basis of the worker's life expectancy, and taxes are paid on the annual total of that portion. Retirees who live beyond their estimated lifetime then must begin paying taxes on the entire annuity. The rationale is that the retiree's contribution has been recouped and the remaining payments represent only the employer's contribution. For those who die before this point is reached, the law allows the last tax return filed on behalf of the deceased to treat the unrecouped portion of the pension as a deduction.

With a higher taxable income, some pensioners may be pushed into a higher tax bracket as a result of the provision. However, any initial tax increases will likely be offset over the long run by the tax break on the retired worker's share of the pension during his or her estimated lifetime.

(4) *Personal Exemptions, Standard Deductions, and Additional Standard Deduction Amounts*

The Treasury Department annually adjusts personal exemptions, standard deductions, and additional standard deduction amounts for inflation. The personal exemption a taxpayer may claim on a return for 1991 is $2,150. The standard deduction is $3,400 for a single person, $5,000 for a head of household, $5,700 for a married couple filing jointly, and $2,850 for a married person filing separately. The additional standard deduction amount for an elderly single taxpayer is $850 while married individuals (whether filing jointly or separately) may each receive an additional standard deduction amount of $650.

(5) *Filing Requirements and Exemptions*

The 1986 Act and indexation of various tax provisions has raised the levels below which persons are exempted from filing Federal income tax forms. Single persons age 65 or older do not have to file a return if their income is below $6,400. For married couples filing jointly, the limit is $10,650 if one spouse is age 65 or older or $11,300 if both spouses are age 65 or older. Persons who are age 65 or older or blind and who are claimed as dependents on another individual's tax return do not have to file a tax return unless their unearned income exceeds $1,400 or their gross income exceeds their maximum allowable standard deduction ($4,250 for single dependents age 65 or older or blind, $5,100 for single dependents who are both age 65 or older and blind).

(6) *The Impact of Tax Reform of 1986*

One study prepared for the American Association of Retired Persons concludes that the 1986 tax reform measure ultimately will remove about 2 percent of the elderly from the tax rolls, and that tax payments for this age group as a whole will decline overall by about 1 percent. The study also concludes that, overall, the benefits of the new code to the elderly are substantially less than those to the nonelderly. Average tax savings are estimated at $18 and $401, respectively, for the two groups.

B. SAVINGS

1. Background

There has been considerable emphasis on increasing the amount of resources available for investment. By definition, increased investment must be accompanied by an increase in saving and foreign inflows. Total national saving comes from three sources: individuals saving their personal income, businesses capital consumption allowances and retained profits, and Government saving when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal saving and capital accumulation have been enacted in recent years.

Retirement income experts have suggested that incentives for personal saving be increased to encourage the accumulation of greater amounts of retirement income. Many retirees are depend-

ent primarily on Social Security for their income. Thus, some analysts favor a better balance between Social Security, pensions, and personal savings as sources of income for retirees. The growing financial crisis that faced Social Security in the early 1980's reinforced the sense that individuals should be encouraged to increase their pre-retirement saving efforts.

The life-cycle theory of saving has helped support the sense that personal saving is primarily saving for retirement. This theory postulates that individuals save little as young adults, increase their saving in middle age, then consume those savings in retirement. Survey data suggests that saving habits are largely dependent on available income versus current consumption needs, an equation that changes over the course of most individuals' lifetimes.

The consequences of the life-cycle saving theory raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those who are already saving at above-average incomes, and subject to relatively high marginal tax rates. Whether this group presently is responding to these incentives by saving at higher rates or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject of disagreement among policy analysts.

For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Raising the saving rate in this group necessitates a trade-off of increased saving for current consumption, a behavior which they are not under most circumstances inclined to pursue. As a result, some observers have concluded that tax incentives will contribute little to the adequacy of retirement income for most individuals, especially for those at the lower end of the income spectrum.

The dual interest of increased capital accumulation and improved retirement income adequacy has sparked an expansion of tax incentives for personal retirement saving over the last decade. However, in recent years, many economists have begun to question the importance and efficiency of expanded tax incentives for personal saving as a means to raise capital for national investment goals, and as a way to create significant new retirement savings. These issues received attention in 1986 as part of the effort to improve the fairness, simplicity, and efficiency of Federal tax incentives.

The role of savings in providing income in retirement has increased gradually over the last decade as new generations of older Americans with greater assets have reached retirement. In 1986, 26 percent of elderly income came from assets, compared with only 16 percent in 1962. Fully, 67 percent of the elderly had some income from assets in 1984, compared with 54 percent in 1962.

The distribution of asset income varies for different elderly subgroups. As 1986 figures indicate, the oldest old are less likely to have asset income than the younger elderly. Only 62 percent of those 80 and older had asset income in 1986, compared with 68 percent of those in the 65–69 age group. In 1986, 71 percent of elderly men had asset income, compared with 66 percent of elderly women. Whites are more than twice as likely to have asset income as other races; 71 percent of elderly whites had asset income, compared to

only 30 percent for blacks and 31 percent of the elderly of Spanish origin.

Finally, the likelihood of asset income receipt is directly proportional to total income. Asset income is much more prevalent among individuals with high levels of retirement income. Only 27 percent of elderly persons with incomes less than $5,000 receive income from assets, while 84 percent of those with incomes between $10,000 and $20,000 and 95 percent of those with income over $20,000 receive some asset income. One-third of the elderly with incomes greater than $20,000 relied on assets to provide more than half of their retirement income, while only 11 percent of those with income less than $5,000 relied on assets for more than half their retirement income.

Historically, income from savings and other assets has furnished a small but growing portion of total retirement income. Assets remain a far more important source of income for the retired population on the whole than pension annuities, largely because less than 1 in 3 retirees receive pension benefits.

The effort to increase national investment springs from a perception that governmental, institutional, and personal saving rates are lower than the level necessary to support a more rapidly growing economy. Except for a period during World War II when personal saving approached 25 percent of income, the personal saving rate in the United States has ranged between 4 percent and 8 percent of disposable income. Many potential causes for these variations have been suggested, including demographic shifts in the age and composition of families and work forces, and efforts to maintain levels of consumption in the face of inflation. Personal saving rates in the United States historically have been substantially lower than in other industrialized countries. In some cases, it is only one-half to one-third of the savings rates in European countries.

For 1991, Commerce Department figures indicate that the personal savings rate was 4.3 percent, compared to 4 percent for 1990. For the second and third quarters of 1992, the rates were 4.7 percent and 4.5 percent, respectively.

Even assuming present tax policy creates new personal saving, critics suggest this may not guarantee an increase in total national savings available for investment. Federal budget surpluses constitute saving as well; the loss of Federal tax revenues resulting from the tax incentives may offset the new personal saving being generated. Under this analysis, net national saving would be increased only when net new personal saving exceeded the Federal tax revenue foregone as a result of tax-favored treatment.

Recent studies of national retirement policy have recommended strengthening individual saving for retirement. Because historical rates of after-tax saving have been low, emphasis has frequently been placed on tax incentives to encourage saving in the form of voluntary tax-deferred capital accumulation mechanisms.

The final report of the President's Commission on Pension Policy issued in 1981 recommended several steps to improve the adequacy of retirement saving, including the creation of a refundable tax credit for employee contributions to pension plans and individual retirement savings. Similarly, the final report of the National Commission on Social Security recommended increased contribution

limits for IRAs. In that same year, the Committee for Economic Development—an independent, nonprofit research and educational organization—issued a report which recommended a strategy to increase personal retirement savings that included tax-favored contributions by employees covered by pension plans to IRAs, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased saving opportunities. In each Congress since the passage of the Employee Retirement Income Security Act (ERISA) in 1974, there have been expansions in tax-preferred saving devices. This continued with the passage of the Economic Tax Recovery Act of 1981 (ERTA). From the perspective of retirement-specific savings, the most important provisions were those expanding the availability of IRAs, simplified employee pensions, Keogh accounts and employee stock ownership plans (ESOP's). ERTA was followed by additional expansion of Keogh accounts in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which sought to equalize the treatment of contributions to Keogh accounts with the treatment of contributions to employer-sponsored defined contribution plans.

The evolution of Congress' attitude toward expanded use of tax incentives to achieve socially desirable goals holds important implications for tax-favored retirement saving. When there is increasing contribution for Federal tax expenditures, the continued existence of tax incentives depends in part on whether they can stand scrutiny on the basis of equity, efficiency in delivering retirement benefits, and their value to the investment market economy.

2. Issues

(A) INDIVIDUAL RETIREMENT ACCOUNTS (IRAS)

(1) Pre-1986 Tax Reform

The extension of IRAs to pension-covered workers in 1981 by ERTA resulted in dramatically increased IRA contributions. In 1982, the first year under ERTA, IRS data showed 12.1 million IRA accounts, nearly four times the 1981 number. In 1983, the number of IRAs rose to 13.6 million, 15.2 million in 1984, and 16.2 million in 1985. In 1986, contributions to IRAs totalled $38.2 billion. The Congress anticipated IRA revenue losses under ERTA of $980 million for 1982 and $1.35 billion in 1983. However, according to Treasury Department estimates, revenue losses from IRA deductions for those years were $4.8 billion and $10 billion, respectively. By 1986, the estimated revenue loss had risen to $16.8 billion. Clearly, the program had become much larger than Congress anticipated.

The rapid growth of IRAs posed a dilemma for employers as well as Federal retirement income policy. The Increasingly important role of IRAs in the retirement planning of employees began to diminish the importance of the pension bond which links the interests of employers and employees. Employers began to face new problems in attempting to provide retirement benefits to their work forces.

A number of questions arose over the efficiency of the IRA tax benefit in stimulating new retirement savings. First, does the tax incentive really attract savings from individuals who would be un-

likely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional saving or does it merely redirect existing savings to a tax-favored account? Third, are IRAs retirement savings or are they tax-favored saving accounts used for other purposes before retirement?

Evidence indicated that those who used the IRA the most might otherwise be expected to save without a tax benefit. Low-wage earners barely used IRAs. The participation rate among those with less than $20,000 income was two-fifths that of middle-income taxpayers ($20,000 to $50,000 annual income) and one-fifth that of high-income taxpayers ($50,000 or more annual income). Also, younger wage earners, as a group, were not spurred by the IRA tax incentive. As the life-cycle savings hypothesis suggests, employees nearing normal retirement age are three times more likely to contribute to an IRA than workers in their twenties. Those without other retirement benefits also appear to be less likely to use an IRA. Employees with job tenures greater than 5 years display a higher propensity toward IRA participation at all income levels. For those not covered by employer pensions, utilization generally increases with age, but is lower across all income groups than for those who are covered by employer pensions. In fact, 46 percent of IRA accounts are held by individuals with vested pension rights.

Though a low proportion of low-income taxpayers utilize IRAs relative to higher income counterparts, those low-income individuals who do contribute to an IRA are more likely than their high-income counterparts to make the contributions from salary rather than pre-existing savings. High-income taxpayers apparently are more often motivated to contribute to IRAs by a desire to reduce their tax liability than to save for retirement.

One of the stated objectives in the creation of IRAs was to provide a tax incentive for increased saving among those in greatest need. This need appears to be most pressing among those with low pension coverage and benefit receipt resulting from employment instability or low average career compensation. However, the likelihood that a taxpayer will establish an IRA increases with job and income stability. Thus, the tax incentive appears to be most attractive to taxpayers with relatively less need of a savings incentive. As a matter of tax policy, IRAs could be an inefficient way of improving the retirement income of low-income taxpayers.

An additional issue was whether all IRA savings are in fact retirement savings or whether IRAs were an opportunity for abuse as a tax shelter. Most IRA savers probably view their account as retirement savings and are inhibited from tapping the money by the early 10 percent penalty on withdrawals before age 59½. However, those who do not intend to use the IRA to save for retirement, can still receive tax benefits from an IRA even with early withdrawals. Most analysts agree that the additional buildup of earnings in the IRA, which occurs because the earnings are not taxed, will surpass the value of the 10-percent penalty after only a few years, depending upon the interest earned. Some advertising for IRA savings emphasized the weakness of the penalty and promoted IRAs as short-term tax shelters. Although the tax advantage of an IRA is greatest for those who can defer their savings until retirement, they are not limited to savings deferred for retirement.

An additional concern is that the IRA was not equally available to all taxpayers who might want to save for retirement. Nonworking spouses of workers saving in an IRA could contribute only an additional $250 a year. Some contended that this created an inequity between two-earner couples who could contribute $4,000 a year and one-earner couples who could contribute only $2,250 in the aggregate. They argued that it arbitrarily reduces the retirement income of spouses, primarily women, who spend part or all of their time out of the paid work force. Those who opposed liberalization of the contribution rules contended that any increase would primarily advantage middle and upper income taxpayers, because the small percentage of low-income taxpayers who utilized IRAs often did not contribute the full $2,000 permitted them each year.

(2) Post-1986 Tax Reform

The IRA provisions of the 1986 Tax Reform Act were among the most significant changes affecting individual savings for retirement. To focus the deduction more effectively on those who need it, the Act repealed the deductibility of IRA contributions for pension plan participants and their spouses, with an adjusted gross income (AGI) in excess of $35,000 (individual) or $50,000 (family). For pension-covered workers and their spouses with AGIs between $25,000 and $35,000 (individual) or $40,000 and $50,000 (family), the maximum deductible IRA contribution is reduced in relation to their incomes. Workers in families without pensions, and pension-covered workers with AGIs below $25,000 (individual) and $40,000 (family) retain the $2,000 per year IRA contribution. Even with the loss of the IRA deduction for some workers, however, all IRA accounts, even those receiving only after-tax contributions, continue to accumulate earnings tax free. Nevertheless, the number of tax returns reporting IRA contributions fell to 7.3 million in 1987.

There are proposals to enhance IRAs and to use them either directly or as models to support other individual saving goals. Some congressional leaders have proposed increased tax benefits for IRA contributions to restore tax benefits taken away by the Tax Reform Act of 1986, to increase the national saving rate, and to facilitate desirable social goals such as homeownership. Opponents argue that these proposals would use Federal revenue to help mainly higher income people and that they would achieve little in the way of increased savings.

Some proposals to modify IRA contribution and withdrawal rules would expand the deductibility of contributions, or tax contributions but allow for tax-free retirement withdrawals. Other proposals would loosen the restrictions on early withdrawals if IRA funds were used for certain purposes, such as the purchase of a first-time residence, educational expenses, or long-term care insurance. Some proposals call for entirely new individual savings accounts to encourage saving for selected purposes. The potential for expanded IRAs to boost the national saving rate has become a central issue in this policy debate.

(C) RESIDENTIAL RETIREMENT ASSETS

Tax incentives, which have long promoted the goal of home ownership, include the income tax deductions for real estate taxes and home mortgage interest. The other major homeowner incentives include the ability to "rollover" the gains (profits) from the sale of a principal residence without paying taxes if a more expensive home is purchased and, for taxpayers who are age 55 or older, a one-time tax-free exclusion on up to $125,000 of capital gains from the sale of one's home. These tax incentives recognize that for many elderly persons, a home may represent their principal or only retirement asset.

Prior to 1986, there was no limit on the amount of mortgage interest that could be deducted. Under current law, the amount of mortgage interest that can be deducted on a principal or second residence (on loans taken out after 1987) is limited to the interest paid on the combined debt on these homes of up to $1.1 million. The $1.1 million limit on debt includes up to $100,000 of home equity loans that can be used for any purpose.

Now that interest on personal loans is no longer deductible, more homeowners are taking out home equity lines of credit and using the proceeds to pay off or take on new debt for autos, vacations, educational and medical expenses, or credit card purchases. In effect, homeowners are converting nondeductible debt into tax deductions.

Aside from the fairness issues (for example, that renters and most homeowners cannot take advantage of this tax provision), there is concern that some homeowners may find it too easy to spend their home equity (retirement savings in many cases) on consumer items or for college expenses and first-home down payments for their children. At the same time, many elderly homeowners are finding home equity conversion programs useful because they make it easier to convert the wealth in a home into much needed supplemental retirement income. Others are using this wealth to pay for property taxes, home repairs, and entrance into retirement communities or nursing homes. Some fear that the inappropriate use of home equity loans in the early or mid-years could mean that for some, substantial mortgage payments might continue well into later life and that there will be less retirement security than originally planned.

C. THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) made a number of substantial changes to the Internal Revenue Code. It replaced the previous two rates with a 3-tiered statutory rate structure: 15 percent, 28 percent, and 31 percent. Starting in 1991, the new 31 percent rate will apply to single individuals with taxable income (not gross income) of $49,300 or more. It will apply to joint filers with taxable income of $82,150 or more, to single heads of households with taxable incomes of $70,450 or more, and to married individuals filing separately with taxable income of $41,075 or more. The Act sets a maximum tax rate of 28 percent on the sale of capital assets.

The Act also repeals the so-called "bubble" from the Tax Reform Act of 1986 whereby middle income taxpayers paid higher marginal tax rates on certain income as personal exemptions and the lower 15 percent rate were phased out. However, in place of the "bubble," OBRA 1990 provides for the phasing out of personal exemptions and limiting itemized deductions for high income taxpayers. The phase out of personal exemptions begins in 1991 at $100,000 for single filers, $150,000 for joint filers, $125,000 for heads of households, and $75,000 for married individuals filing separately. OBRA 1990 provides a new limitation on itemized deductions. Allowable deductions are reduced by 3 percent of the amount by which a taxpayer's adjusted gross income exceeds $100,000. Deductions for medical expenses, casualty and theft losses, and investment interest are not subject to this limitation.

Additionally, the Act raised excise taxes on alcoholic beverages, tobacco products, gasoline, and imposed new excise taxes on luxury items such as expensive airplanes, yachts, cars, furs, and jewelry.

On the positive side, the Act provides a tax credit to help small businesses attempting to comply with the Americans with Disabilities Act. The bill, sponsored by Senators Pryor, Kohl, and Hatch, allows small businesses a nonrefundable 50-percent credit for expenditures of between $250 and $10,250 in a year to make their businesses more accessible to disabled persons. Such expenditures can include amounts spent to remove physical barriers and to provide interpreters, readers, or equipment that make materials more available to the hearing or visually impaired. To be eligible, a business must have grossed less than $1 million in the preceding year or have no more than 30 full-time employees.

According to estimates provided by the Congressional Budget Office, most elderly persons should be fairly untouched by the changes made by the OBRA 1990. However, as might be expected, some high-income elderly will pay higher Federal taxes. Some of the excise taxes will have a negative effect on the elderly, in particular the 5 cents a gallon increase on gasoline. Like all changes of the tax laws, certain individuals will be negatively affected, but as a class, the elderly will pay the same or even less in Federal income taxes since passage of OBRA 1990.

Chapter 4

EMPLOYMENT

OVERVIEW

The time that older Americans spend in retirement has dramatically lengthened in recent years. Not only are people living longer, but many are choosing to retire at a much earlier age. In fact, early retirement is fast becoming a part of the American way of life. However, a growing number of persons desire or need to work in their later years. For them, age discrimination often is an obstacle.

Age, like race, sex, religion, and national origin, is a protected category under Federal law. Eliminating age bias in the workplace is consistent with the American tradition of barring arbitrary policies that discriminate against individuals on the basis of their beliefs or personal characteristics. The nearly unanimous opposition to mandatory retirement by the American public indicates a strong sentiment against age-based employment policies. Nevertheless, statutory protections against age discrimination remain incomplete and somewhat ineffective.

Although the unemployment rate for older persons is approximately half that of younger persons, once an older worker loses a job, his or her duration of unemployment tends to be much longer. In 1990, workers age 55 to 64 years were out of work for an average of 18.5 weeks, while workers age 65 and over were unemployed for an average of 17.6 weeks. The average length of unemployment for all workers age 16 and over was 12.1 weeks.

A. AGE DISCRIMINATION

1. Background

Numerous obstacles to older worker employment persist in the workplace, including negative stereotypes about aging and productivity; job demands and schedule constraints that are incompatible with the skills and needs of older workers; and management policies that make it difficult to remain in the labor force, such as early retirement incentives.

Age discrimination in the workplace plays a pernicious role in blocking employment opportunities for older persons. The development of retirement as a social pattern has helped to legitimize this form of discrimination. Although there is no agreement on the extent of age-based discrimination, nor how to remedy it, few would argue that the problem exists for millions of older Americans. Despite Federal laws banning most forms of age discrimination in the workplace, most Americans view age discrimination as

a serious problem. Two nationwide surveys conducted by Louis Harris & Associates, in 1975 and in 1981, found nearly identical results: 8 out of 10 Americans believe that "most employers discriminate against older people and make it difficult for them to find work."

The public's perception of widespread age discrimination also is shared by a majority of business leaders. According to a 1981 nationwide survey of 552 employers conducted by William M. Mercer, Inc., 61 percent of employers believe older workers are discriminated against on the basis of age; 22 percent claim it is unlikely that without negative legal consequences a company would hire someone over age 50 for a position other than senior management; 20 percent admit that older workers, other than senior executives, have less opportunity for promotions or training; and 12 percent admit that older workers' pay raises are not as large as those of younger workers in the same category.

The forms of age discrimination range from the more obvious, such as age-based hiring or firing, to the more subtle, such as early retirement incentives. Other discriminatory practices involve relocating an older employee to an undesirable area in the hopes that the employee will instead resign, or giving an older employee poor evaluations to justify the employee's later dismissal. The pervasive belief that all abilities decline with age has fostered the myth that older workers are less efficient than younger workers. Part of this problem is that younger workers, rather than older workers, tend to receive the skills and training needed to keep up with technological changes. Too often, employers wrongly assume that it is not financially advantageous to retrain an older worker. They believe that a younger employee will remain on the job longer, simply because of his or her age. In fact, the mobility of today's work force does not support this perception. According to the Bureau of Labor Statistics, the median job tenure for a current employee is as little as 4.2 years.

Age-based discrimination in the workplace poses a serious threat to the welfare of many older persons who depend on their earnings for their support. While the number of older persons receiving maximum Social Security benefits is increasing, most retirees receive less than the maximum. According to the 1990 edition of the U.S. Senate Special Committee on Aging's report entitled "Aging America: Trends and Projections," in 1988, 73 percent of persons age 65 or older had a total annual income of less than $15,000. Other reports reveal that only slightly more than half of the work force is covered by a private pension plan, and most older persons do not have substantial holdings in savings, stocks, insurance policies, or bonds.

According to the Bureau of Labor Statistics (BLS), in 1990, the unemployment rate was 3.3 percent for workers age 55 to 64, 3.2 percent for workers age 65 to 69, and 2.7 percent for workers age 70 and over. Although older workers as a group have the lowest unemployment rate, these numbers do not reflect those older individuals who have withdrawn completely from the labor force due to a belief that they cannot find satisfactory employment.

Duration of unemployment is also significantly longer among older workers. As a result, older workers are more likely to ex-

haust available unemployment insurance benefits and suffer economic hardships. This is especially true because many persons over 45 still have significant financial obligations.

Prolonged unemployment can often have mental and physical consequences. Psychologists report that discouraged workers can suffer from serious psychological stress, including hopelessness, depression, and frustration. In addition, medical evidence suggests that forced retirement can so adversely affect a person's physical, emotional, and psychological health that a lifespan may be shortened.

Despite the continuing belief that older workers are less productive, there is a growing recognition of older workers' skills and value. A 1985 study by Waldman and Avolio revealed little evidence to support the "somewhat widespread belief that job performance declines with age." Their findings showed a strong correlation between improved job performance and increasing age, especially in objective measures of productivity. They concluded that "although chronological age may be a convenient means for estimating performance potential, it falls short in accounting for the wide range of individual differences in job performance for people at various ages."

Many employers also have reported that older workers tend to stay on the job longer than younger workers. Some employers have recognized that older workers can offer experience, reliability, and loyalty. A 1989 AARP survey of 400 businesses reported that older workers generally are regarded very positively and are valued for their experience, knowledge, work habits and attitudes. In the survey, employers gave older workers their highest marks for productivity, attendance, commitment to quality, and work performance.

2. The Equal Employment Opportunity Commission

The Equal Employment Opportunity Commission (EEOC) is responsible for enforcing laws prohibiting discrimination. These include: (1) Title VII of the Civil Rights Act of 1964; (2) The Age Discrimination in Employment Act of 1967; (3) The Equal Pay Act of 1963; (4) Sections 501 and 505 of the Rehabilitation Act of 1973; and (5) the Americans With Disabilities Act of 1990.

When originally enacted, enforcement responsibility for the ADEA was placed with the Department of Labor (DOL) and the Civil Service Commission. In 1979, however, the Congress enacted President Carter's Reorganization Plan No. 1, which called for the transfer of responsibilities for ADEA administration and enforcement to the EEOC, effective July 1, 1979.

The EEOC has alternately been praised and criticized for its performance in enforcing the ADEA. In recent years, concerns have been raised over EEOC's decision to refocus its efforts from broad complaints against large companies and entire industries to more narrow cases involving few individuals. Critics also point to the large gap between the number of age-based complaints filed and the EEOC's modest litigation record. In fiscal year 1989, the EEOC received 14,789 complaints and filed only 133 suits on behalf of complainants.

3. The Age Discrimination in Employment Act

Over two decades ago, the Congress enacted the Age Discrimination in Employment Act of 1967 (ADEA) (P.L. 90-202) "to promote employment of older persons based on their ability rather than age; to prohibit arbitrary age discrimination in employment; and to help employers and workers find ways of meeting problems arising from the impact of age on employment."

In large part, the ADEA arose from a 1964 Executive order issued by President Johnson declaring a public policy against age discrimination in employment. Three years later, the President called for congressional action to eliminate age discrimination. The ADEA was the culmination of extended debate concerning the problems of providing equal opportunity for older workers in employment. At issue was the need to balance the right of older workers to be free from age discrimination in employment with the employers' prerogative to control managerial decisions. The provisions of the ADEA attempt to balance these competing interests by prohibiting arbitrary age-based discrimination in the employment relationship. The law provides that arbitrary age limits may not be conclusive in determinations of nonemployability, and that employment decisions regarding older persons should be based on individual assessments of each older worker's potential or ability.

The ADEA prohibits discrimination against persons age 40 and older in hiring, discharge, promotions, compensation, term, conditions, and privileges of employment. The ADEA applies to private employers with 20 or more workers; labor organizations with 25 or more members or that operate a hiring hall or office which recruits potential employees or obtains job opportunities; Federal, State, and local governments; and employment agencies.

As originally enacted, the ADEA prohibited employment discrimination against persons age 40 to 65. As a result of amendments to the law in 1986, however, there currently is no upper-limit cap on these protections, except in a select few professions. The ADEA now covers virtually all employees 40 years of age or older.

Since it's enactment in 1967, the ADEA has been amended a number of times. The first set of amendments occurred in 1974, when the law was extended to include Federal, State, and local government employers. The number of workers covered also was increased by limiting exemptions for employers with fewer than 20 employees. (Previous law exempted employers with 25 or fewer employees.)

In 1978, the ADEA was amended by extending protections to age 70 for private sector, State, and local government employers, and by removing the upper age limit for employees of the Federal Government.

In 1982, the ADEA was amended by the Tax Equity and Fiscal Responsibility Act (TEFRA) to include the so-called "working aged" clause. As a result, employers are required to retain their over-65 workers on the company health plan rather than automatically shifting them to Medicare. Under previous law, Medicare was the primary payer and private plans were secondary. TEFRA reversed the situation, making Medicare the payer of last resort.

Amendments to the ADEA were also contained in the 1984 reauthorization of the Older Americans Act (P.L. 98-459). Under the 1984 amendments, the ADEA was extended to U.S. citizens who are employed by U.S. employers in a foreign country. Support for this legislation stemmed from the belief that such workers should not be subject to possible age discrimination just because they are assigned abroad. Also, the executive exemption was raised from $27,000 to $44,000, the annual private retirement benefit level used to determine the exemption from the ADEA for persons in executive or high policymaking positions.

The Age Discrimination in Employment Act Amendments of 1986 contained provisions that eliminated mandatory retirement altogether. By removing the upper age limit, Congress sought to protect workers age 40 and above against discrimination in all types of employment actions, including forced retirement, hiring, promotions, and terms and conditions of employment. The 1986 Amendments to the ADEA also extended through the end of 1993 an exemption from the law for institutions of higher education and for State and local public safety officers.

In 1990, Congress amended the ADEA by enacting the Older Workers Benefit Protection Act (P.L. 101-433). This legislation restored and clarified the ADEA's protection of older workers' employee benefits. In addition, it established new protections for workers who are asked to sign waivers of their ADEA rights. These important changes in the ADEA are discussed below.

(A) THE OLDER WORKERS BENEFIT PROTECTION ACT

The Older Workers Benefit Protection Act (P.L. 101-433) was signed into law by President Bush on October 16, 1990. Title I of this legislation was designed to overturn *Public Employees Retirement System of Ohio* v. *Betts,* 109 S.Ct. 2854 (1989), in which the Supreme Court held that the ADEA does not protect older workers from discrimination in the area of employee benefits. Title II placed new protections in the ADEA which should help to prevent abuses by some employers who ask employees to sign waivers of their ADEA rights.

Congressional concern over the *Betts* case resulted in the introduction of S. 1511, the Older Workers Benefit Protection Act, on August 3, 1989, by Senators Pryor, Jeffords, Metzenbaum, Kennedy, DeConcini, and Bumpers. The House companion, H.R. 3200, was introduced on August 4, 1989, by Congressmen Roybal, Hawkins, Clay, Martinez and Bilbray.

H.R. 3200 and the *Betts* decision were the subjects of a joint hearing of the House Select Committee on Aging and the House Education and Labor Subcommittees on Employment Opportunities and Labor-Management Relations on September 21, 1989. The Senate Special Committee on Aging and the Labor and Human Resources Subcommittee on Labor held a joint hearing on S. 1511 on September 27, 1989.

S. 1511 was favorably reported by the Senate Labor and Human Resources Committee on February 28, 1990. The Committee amended S. 1511 by attaching to it a modified version of S. 54, the Age Discrimination in Employment Waiver Protection Act of 1989. The

Senate passed a compromise version of S. 1511 by a 94 to 1 vote on September 24 1990. The compromise was passed in the House by a 406 to 14 vote on October 3, 1990.

(1) Protection of the Employee Benefits of Older Workers

June Betts was a public employee in Ohio. At age 61 she became permanently and seriously disabled and had no choice but to retire. Ohio's Public Employee Retirement System (PERS), as enacted in 1933, provided for basic retirement and disability retirement. Disability retirement, however, is limited to employees under 60.

In 1976, PERS was amended to provide that disability retirement payments could never be less than 30 percent of the retiree's salary. Under basic retirement, Betts would have received $158.50 per month in benefits; under disability retirement, she would have received $355.00 per month. Betts was not allowed to take disability retirement because she was over age 60, and she was forced to settle for basic retirement benefits. She filed suit in Federal court contending that the PERS plan discriminated against older workers in violation of the ADEA.

Until the Supreme Court handed down its decision in June Betts' case, it has been widely accepted for 20 years that the ADEA protected older workers from discrimination in employee benefits.

In 1967, when the Senate was considering the bill that would become the ADEA, then Senator Javits offered an amendment with the goal of insuring that employers would not be discouraged from hiring older workers due to the fact that the cost of some benefits increases with age. This amendment, which would become section 4(f)(2) of the ADEA, created an exception from the proscriptions of the ADEA for a bona fide employee benefit plan "which is not a subterfuge to evade the purposes of [the Act]. . . ." 29 U.S.C. section 623(f)(2).

The DOL issued a three paragraph regulation interpreting section 4(f)(2) in 1969. This regulation stated that "[a] retirement, pension or insurance plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred, in behalf of an older worker is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of pension or retirement benefits, or insurance coverage." 29 C.F.R. section 860.120 (1969). This "equal benefit or equal cost" standard became the test for an employee benefit plans's compliance with the ADEA.

In 1977, the U.S. Supreme court decided *United Airlines, Inc.* v. *McMann*, 434 U.S. 192 (1977), in which a retirement plan was forcing the early retirement of older workers. The court held that the term "subterfuge," as used in section 4(f)(2), has a plain meaning (a scheme, plan, stratagem, or artifice of evasion), and by definition an employee benefit plan adopted prior to the enactment of the ADEA in 1967 could never be a "subterfuge." The court therefore ruled that this retirement plan fell within the section 4(f)(2) exception and did not violate the ADEA.

In 1978, Congress reacted to the *McMann* decision by amending section 4(f)(2) with the phrase "no such . . . employee benefits plan shall require or permit the involuntary retirement of any individ-

ual [protected by this Act] because of the age of such individual[.]" 29 U.S.C. section 623(f)(2). Congress also called on the DOL to further clarify its ADEA regulations.

During the Senate debate over the 1978 amendments to the ADEA, Senator Javits essentially endorsed the DOL's interpretation of section 4(f)(2) by clarifying what he had intended with his 1967 amendment:

> The purpose of section 4(f)(2) is to take account of the increased cost of providing certain benefits to older workers as compared to younger workers.
>
> Welfare benefit levels for older workers may be reduced only to the extent necessary to achieve approximate equivalency in contributions for older and younger workers. Thus a retirement, pension, or insurance plan will be considered in compliance with the statute where the actual amount of payment made, or cost incurred in behalf of an older worker is equal to that made or incurred in behalf of a younger worker, even though the older worker may thereby receive a lesser amount of pension or retirement benefits, or insurance coverage.

In response to the Congressional request, the DOL issued a more comprehensive version of the 1969 regulation. This expanded version was ultimately adopted by the EEOC when it took over enforcement of the ADEA in 1979. In its regulations the EEOC concluded that "[t]he legislative history of this provision indicates that its purpose is to permit age-based reductions in employee benefit plans where such reductions are justified by significant cost considerations." (29 CFR section 1625.10(a)(1).) The EEOC then adopted the same equal benefit or equal cost interpretation contained in the 1969 Department of Labor regulation and used by Senator Javits in the 1978 floor debate.

Believing that the actions of PERS of Ohio violated the ADEA, Mrs. Betts' family filed a lawsuit on her behalf. Using the EEOC's equal benefit or equal cost test, the district court held in favor of Betts, finding that PERS did not qualify for the section 4(f)(2) exception to the ADEA. The U.S. Court of Appeals for the Sixth Circuit affirmed the district court's decision.

To the surprise and dismay of the Betts family and aging advocacy groups, the Supreme Court reversed the decision of the lower court. In the words of Justice Marshall, the *Betts* decision "immunize[d] virtually all employee benefit programs from liability under the Age Discrimination in Employment Act [(ADEA)]. . . ."

In spite of a friend of the court brief submitted by the Administration in support of the EEOC's regulation, the Supreme Court rejected this long-standing interpretation of the section 4(f)(2) exception, and instead adopted a "plain meaning" approach to the term "subterfuge." In doing so, the Court first reaffirmed its 1977 ruling in *McMann* that an employee benefit plan adopted prior to the enactment of the ADEA in 1967 could not be a subterfuge to evade the purposes of the Act. In other words, discriminatory pre-ADEA benefit plans can never be found to be unlawful under the ADEA. However, since PERS was amended in 1976, the Court could not dispose of the case on that basis.

Next, the Court held that a post-ADEA employee benefit plan does not violate the ADEA "so long as the plan is not a method of

discriminating in other, nonfringe-benefit aspects of the employment relationship. . . ." In other words, it is not a violation of the ADEA for an employer to discriminate against an older worker in terms of employee benefits as long as the benefit plan is not a vehicle for discrimination in other prohibited ways, such as salary, hiring, or firing. Further, the Court held that an employee challenging an employee benefit plan under the ADEA has the burden of proving that the plan discriminates in some non-benefit way. Based on these holdings, the Court reversed the lower court decision.

Advocates of elderly workers were very concerned about the large loophole left in the ADEA by the *Betts* decision. In addition, the EEOC was concerned because it had over 30 cases pending which faced dismissal based on the Supreme Court's decision. The business community contended that the equal benefit or equal cost regulation was not widely accepted and that the law in this area was anything but settled prior to the Court's decision. A number of large employers and business associations believed that *Betts* was correctly decided and should be allowed to stand.

Significant concerns over S. 1511 as reported were expressed in four areas: retroactive application of the bill; application of the equal benefit or equal cost rule to early retirement incentive plans; integration of pension and severance benefits; and integration of pension and disability benefits. Each of these concerns were addressed in the final compromise version of the *Betts* provisions, and guidance on some of these issues was provided in the Statement of Managers, included in the Congressional Record at the time of passage. See 136 C.R. S13596 (101st Cong., Sept. 24, 1990).

Title I of the Older Workers Benefit Protection Act amended section 4(f)(2) by deleting the term "subterfuge" and codifying the EEOC's long-accepted equal benefit or equal cost test for all employee benefits, with one notable exception. Early retirement incentive plans instead are required to be voluntary and consistent with the relevant purpose or purposes of the ADEA.

In addition, safe harbor exceptions from ADEA coverage are included for two particular types of early retirement incentives, subsidized early retirement benefits and Social Security bridge payments. While the practice of denying severance pay to pension eligible employees continues to be a violation of the ADEA, Title I does allow an employer to offset severance pay against any retiree health benefits or lay-off triggered pension sweetners received by an employee.

Further, Title I allows an employer to offset any pension benefits that an employee has voluntarily elected to receive, or, if the employee has reached normal retirement age, any pension benefits the employee is eligible to receive, against disability benefits to which the employee is entitled. This eliminates any possibility of an employer being forced to make duplicate payments of benefits. Other sections of Title I clarify that pre-1967 employee benefit plans are subject to the provisions of the ADEA, and that the 4(f)(2) exclusion is an affirmative defense under the ADEA which the employer must prove.

The retroactive application of the *Betts* provisions, included in earlier versions of S. 1511, was eliminated in the final compromise

version. The general effective date for this title is 180 days following the date of enactment. Collectively bargained benefit plans have a delayed effective date until the expiration of the collective bargaining agreement or June 1, 1992, whichever occurs first. State and local public employee plans have a delayed effective date until 2 years following the date of enactment.

(2) Waiver of Rights Under the ADEA

Although certain substantive sections of the ADEA were taken from Title VII of the Civil Rights Act, Congress was careful to incorporate into section 7 of the ADEA the higher level of protection afforded by the Fair Labor Standards Act of 1938 (FLSA). The Supreme Court noted the incorporation of FLSA enforcement procedures into the ADEA in its decision in *Lorillard* v. *Pons,* 434 U.S. 575 (1978), stating that "[the] selectively that Congress exhibited in incorporating provisions and in modifying certain FLSA practices strongly suggests that but for those changes Congress expressly made, it intended to incorporate fully the remedies and procedures of the FLSA."

Under the pre-ADEA case law dealing with contractual waivers of private rights under the FLSA, there were two Supreme Court cases which, taken together, may be interpreted to hold that FLSA rights cannot be privately waived. See *Brooklyn Savings Bank* v. *O'Neil,* 324 U.S. 697 (1945), and *Schulte, Inc.* v. *Gangi,* 328 U.S. 108 (1946). It would follow, then, that under the ADEA enforcement scheme nonsupervised private agreements to waive ADEA rights would also be impermissible.

In *Runyan* v. *National Cash Register Corp.,* 787 F.2d 1039 (6th Cir. 1986), however, a private release form purporting to waive all claims against an employer was held by the U.S. Court of Appeals for the Sixth Circuit to be binding under the ADEA. By a vote of 11 to 2, the court rejected the argument that an unsupervised private release of rights under ADEA is void as a matter of law. The court's holding was limited to the circumstances of the case where nothing indicated that the employer had exploited its superior bargaining power by forcing the employee to accept an unfair settlement.

Many who believed that waivers were not permitted under the ADEA were highly critical of the *Runyan* decision's overall applicability to the ADEA. The plaintiff in the case was an experienced labor attorney and, therefore, extremely knowledgeable of the law. This prompted arguments that *Runyan* was more the exception than the rule. Indeed, according to a 1981 Louis Harris survey conducted for the National Council on the Aging, over half the workers age 40 to 70 (those protected by the ADEA as of 1981) were unaware of the protections afforded them under the ADEA. Waiver opponents argued that, given this fact, it would be extremely difficult for most workers to execute knowing and voluntary waivers.

In the past, the EEOC recognized that application of the FLSA enforcement provisions to the ADEA could be interpreted to mean that individuals could not waive their rights or release potential liability, even if the action is voluntary and knowing, except under EEOC supervision. On October 7, 1985, however, EEOC published

in the Federal Register a Notice of Proposed Rulemaking to allow for non-EEOC supervised waivers and releases of private rights under the ADEA. Nearly 2 years later, on July 30, 1987, the EEOC approved a final rule to permit unsupervised waivers.

The exemption allowed employers and employees to issue private agreements which contain waivers and/or releases of private rights under the ADEA without the supervision or approval of the EEOC. The Commission argued that the remedial purposes of the Act would be better served by allowing agreements to resolve claims whenever employees and employers perceive them to serve their mutual interests, provided such waivers of rights are knowing and voluntary. To support this view, the Commission cited the similarities between the ADEA and Title VII of the Civil Rights Act of 1964, and noted that under Title VII, such unsupervised waivers of private rights are permissible.

However, in *Lorillard,* while the Court acknowledged that many of the ADEA's prohibitions were modeled after Title VII, it found significant differences in the remedial and procedural provisions of the two laws. The Court stated that "rather than adopting the procedures of Title VII for ADEA actions, Congress rejected that course in favor of incorporating the FLSA procedures even while adopting Title VII's substantive prohibitions . . . [The] petitioner's reliance on Title VII, therefore, is misplaced."

In justifying its regulation, the EEOC heavily relied upon the *Runyan* case. Opponents of the rule, however, noted the limited scope of the *Runyan* decision and argued that such a narrow decision did not justify the EEOC's decision to grant blanket waivers of individuals' ADEA rights without Government supervision. Waiver opponents also cited the filing of a strong dissent in the case and noted that EEOC's proposed regulation was cited in the final *Runyan* decision. Therefore, they argued, EEOC's heavy reliance on the court's ruling was somewhat misplaced.

In short order, the EEOC rule became the focal point of controversy, with a number of older worker advocacy organizations and Members of Congress strongly opposing the EEOC's action. Although the EEOC claimed that the rule was in the best interest of the older worker, the Congress did not agree and enacted legislation to suspend the effect of the rule in fiscal years 1988, 1989, and 1990.

Following a September 1987 hearing of the Senate Special Committee on Aging, legislation to suspend the rule during the 1988 fiscal year was enacted in the fiscal year 1988 Continuing Resolution (P.L. 100-202). Nevertheless, at a May 24, 1988, hearing of the Senate Labor and Human Resources Subcommittee on Labor, a representative of the EEOC continued to defend the rule.

To provide sufficient time to develop a bipartisan policy in this area, legislation to extend the suspension through fiscal year 1989 was included in the fiscal year 1989 Commerce, Justice, State appropriations bill (P.L. 100-459). Close to the end of the 100th Congress, S. 2856, the proposed "Age Discrimination in Employment Waiver Protection Act" was introduced, with the backing of major seniors groups, to resolve the issues surrounding unsupervised waivers. Except in the settlement of a bona fide age discrimination claim, the legislation would have barred unsupervised waivers of

older workers' rights. Congress failed to act on this bill before the end of the 100th Congress.

S. 54, the "Age Discrimination in Employment Waiver Protection Act of 1989," was introduced by Senators Metzenbaum, Heinz, Pryor, and others early in the 101st Congress, and the suspension of the EEOC's waiver rule was extended through fiscal year 1990 by the fiscal year 1990 Commerce, Justice, State appropriations bill (P.L. 101-162).

A modified version of S. 54 was added to S. 1511 during markup in the Senate Labor and Human Resources Committee. Title II of the Older Workers Benefit Protection Act does not contain any requirement of Federal supervision for ADEA waivers. Instead, it contains requirements which will insure that employees who are asked to sign waivers in exchange for enhanced benefits will have sufficient information and time to consider the offer.

The waiver must: (1) Be written in understandable language; (2) inform the employee of his/her rights under the ADEA; (3) not include rights or claims arising after the waiver is executed; and (4) be only in exchange for benefits in addition to those to which the employee is already entitled. In addition, the employee must be advised in writing to consult an attorney, and must be given 21 days in the case of an individual offering and 45 days in the case of a group offering in which to consider signing. Some further information is required in the case of group offerings.

The effective date for Title II was the date of enactment. Also, the EEOC's rule on waivers was invalidated on the date the bill became law.

(B) THE AGE DISCRIMINATION CLAIMS ASSISTANCE AMENDMENTS

The EEOC's continuing failure to process ADEA claims in a timely manner was an important issue during the 101st Congress. Following the discovery that between 1984 and 1988 more than 8,000 ADEA charges may have exceeded the 2-year statute of limitations due to the EEOC's neglect, Congress passed the Age Discrimination Claims Assistance Act of 1988 (ADCAA) (P.L. 100-283). ADCAA extended for 18 months the statute of limitations on those claims that had lapsed prior to the date of enactment through no fault of the claimant.

On February 6, 1990, the Senate Judiciary Committee held a confirmation hearing on the nomination of then EEOC Chairman Clarence Thomas to be a U.S. Circuit Judge. At that hearing it was revealed that the EEOC had allowed an additional 1,500 ADEA charges, most of which had been contracted out to State fair employment practice agencies (FEPAs), to lapse since 1988. An October 5, 1990, GAO report, requested by the House Select Committee on Aging, Committee on Education and Labor, and Subcommittee on Employment Opportunities, concluded that 2,801 charges had lapsed since ADCAA was enacted.

The "Age Discrimination Claims Assistance Amendments of 1990" (ADCAA II) (P.L. 101-504), sponsored by Congressman Roybal and others, extended by 15 months the statute of limitations on ADEA charges that lapsed due to EEOC neglect after the enactment of ADCAA but prior to the date that is 6 months after

the enactment of the Amendments. ADCAA II was signed into law by President Bush on November 3, 1990.

1992 was a year of record high age discrimination claims filed with the EEOC. The number of complaints received by the Special Committee on Aging against the EEOC's investigation procedures and case backlog also rose. In an effort to improve ADEA investigation procedures without legislative interference, the Committee requested an objective study of the EEOC's ADEA investigative practices by the General Accounting Office (GAO). The recommendations of this report will be procedural with the hopes of reducing the case backlog and offering suggestions for streamlining the agency's investigative practices in general.

(C) TENURED FACULTY EXEMPTION

Provisions in the 1986 amendments to the ADEA to temporarily exempt universities from the law reflect the continuing debate over the fairness of the tenure system in institutions of higher education. During consideration of the 1986 amendments, several legislative proposals were made to eliminate mandatory retirement of tenured faculty, but ultimately a compromise allowing for a temporary exemption was enacted into law.

The exemption allows institutions of higher education to set a mandatory retirement age of 70 years for persons serving under tenure at institutions of higher education. This provision is in effect for 7 years, until December 31, 1993. The law also required the EEOC to enter into an agreement with the National Academy of Sciences to conduct a study to analyze the potential consequences of the elimination of mandatory retirement for institutions of higher education. The study findings are to be submitted to the President and to Congress within 5 years of enactment. The law sets forth the composition of the study panel to include administrators and teachers or retired teachers at institutions of higher education.

Most agree that the tenure system is different from many other employment situations. Tenure protects academic freedom by prohibiting dismissals except under specific conditions. Many have argued that without mandatory retirement at age 70, institutions of higher education will not be able to continue to bring in those with fresh ideas. The older faculty, it is claimed, would prohibit the institution from hiring younger teachers who, with their current state of knowledge, are better equipped to serve the needs of the school. The argument also is made that allowing older faculty to teach or research past the age of 70 denies women and minorities access to the limited number of faculty positions.

Opponents of the exemption claim that there is little statistical proof that older faculty keep minorities and women from acquiring faculty positions. Indeed, they cite statistical information gathered at Stanford University and analyzed in a paper by Allen Calvin which suggests that even with mandatory retirement and initiatives to hire more minorities and women, there was only a slight change in the percentage of tenured minority and women.

Proponents of an exemption cite a study by the Labor Department that the salaries of faculty nearing retirement are about

twice those of newly hired faculty. Accordingly, they argue that prohibiting mandatory retirement might also exacerbate the financial problems many colleges and universities are facing.

Those who oppose the exemption believe that there are not sufficient reasons to single out faculty for special, discriminatory treatment. They call it double discrimination—once on the basis of age and again on the basis of occupation—and argue that colleges and universities are using mandatory retirement to rid themselves of both undesirable and unproductive professors, instead of dealing directly with a problem that can afflict faculty members of any age. The use of performance appraisals, they argue, is a more reliable and fair method of ending ineffectual teaching service than are age-based employment policies. Finally, they claim that there is no evidence that many professors would stay past age 70 even if they could, and that predications of dire consequences from uncapping the retirement age may be exaggerated. According to the Teachers Insurance Annuity Association and College Retirement Equities Fund, the average age at which faculty members being collecting their pensions—which usually represents a retirement date—has been declining over the past 10 years.

(D) STATE AND LOCAL PUBLIC SAFETY OFFICERS

The ADEA allows a defense to a charge of age discrimination in the workplace where "age is a bona fide occupational qualification (BFOQ) reasonably necessary to the normal operation of a particular business, or where the differentiation is based on reasonable factors other than age." The BFOQ defense has been most successful in cases that involve the public safety. Some courts have allowed maximum hiring ages and mandatory retirement ages for bus drivers and airline pilots, and, on occasion, police officers and firefighters. The courts, however, have been inconsistent and the lack of clear judicial guidance has prompted calls for reform.

The issue of whether public safety officers should be treated like other employees under the ADEA arose after the Supreme Court, in *EEOC* v. *Wyoming,* 460 U.S. 226 (1983), determined that the State's game wardens were covered by the ADEA. Wyoming's policy of mandatory retirement at age 55 for State game wardens was ruled invalid unless the State could show that age is a BFOQ for game wardens. Wyoming had not attempted to establish a BFOQ in this case, but had instead argued that application of the ADEA to the State was precluded by constraints imposed by the 10th amendment on Congress' commerce powers—an argument not sustained by the Court.

In addition, in June 1985, the Supreme Court rendered two decisions in cases arising under the ADEA which were favorable to employees who had challenged the mandatory retirement policies of their employers. The first case, *Johnson* v. *Mayor and City Council of Baltimore,* 472 U.S. 353 (1985), involved six firefighters who challenged the City of Baltimore's municipal code provision that established a mandatory retirement age of 55 for firefighters. The Court of Appeals, accepting the city's argument, held that the Federal civil service statute, which requires most Federal firefighters to retire at age 55, constituted a BFOQ for the position of firefighters

employed by the city. The Supreme Court reversed this decision, stating that nothing in the *Wyoming* decision or the ADEA warrants the conclusion that a Federal rule, not found in the ADEA, and by its terms applicable only to Federal employees, necessarily authorizes a State or local government to maintain a mandatory retirement age as a matter of law.

The Court found that it was Congress' indisputable intent to permit deviations from the mandate of the ADEA only in light of a particularized, factual showing. The Court concluded that Congress' decision to retire certain Federal employees at an early age was not based on a BFOQ, but instead dealt with "idiosyncratic" problems of Federal employees in the Federal civil service. Accordingly, the Court ruled that a State or private employer cannot look to exemptions under Federal law as dispositive of BFOQ exemptions under the ADEA. There is a need, the Court said, to consider the actual tasks of the employees and the circumstances of employment to determine when to impose a mandatory retirement age.

The second case, *Western Airlines, Inc.* v. *Criswell,* 472 U.S. 400 (1985), raised a challenge under the ADEA to Western Airlines' requirement that flight engineers, who do not operate flight controls as part of the cockpit's crew unless the pilot and co-pilot become incapacitated, be subject to mandatory retirement at age 60. The Supreme Court upheld a jury verdict for the plaintiffs against an airline defense that the age 60 requirement constituted a BFOQ. The Court confirmed that the BFOQ defense is available only if it is reasonably necessary to the normal operation or essence of a defendant's business. The Court also noted that an employer could establish this defense only by providing that substantially all persons over an age limit would be unable to perform safely and efficiently the duties of the job, or that it would be impossible or highly impractical to deal with older employees on an individualized basis.

In both of these cases, a unanimous Court seemed to look very critically upon attempts to expand the BFOQ defense beyond specific high risk occupations. By adopting a very narrow reading of the BFOQ exemption, the Court appeared to have strongly endorsed individualized determinations.

However, many States and localities with mandatory retirement age policies below age 70 for public safety officers were concerned about the impact of these decisions. As of March 1986, 33 States or localities had been or were being sued by the EEOC for the establishment of mandatory retirement of maximum hiring age laws. In response, a temporary exemption from the law was provided for State and local public safety officers in the 1986 amendments to the ADEA. The provision is in effect for 7 years, until December 31, 1993.

The 1986 amendments also required the Secretary of the Department of Labor and the EEOC to conduct a study and to report to Congress on whether physical and mental fitness tests can be used as a valid measure to determine the competency of police officers and firefighters and to develop recommendations on standards that such tests should satisfy. The study is to be submitted to Congress within 4 years of enactment of the law. The law also requires that within 5 years of enactment, the EEOC propose guidelines for the administration and use of physical and mental fitness tests to

measure the ability and competency of police and firefighters to perform their jobs.

Supporters of a permanent exemption for State and local public safety officers argue that the mental and physical demands and safety considerations for the public, the individual, and co-workers who depend on each other in emergency situations, warrant mandatory retirement ages below 70 for these State and local workers. Also, they contend that it would be difficult to establish that a lower mandatory retirement age for public safety officers is a BFOQ under the ADEA. Because of the conflicting case law on BFOQ, this would entail costly and time consuming litigation. They note that jurisdictions wishing to retain the hiring and retirement standards that they established for public safety officers prior to the *Wyoming* decision are forced to engage in costly medical studies to support their standards. Finally, they question the feasibility of individual employee evaluations, some citing the difficulty involved in administering the tests because of technological limitations concerning what human characteristics can be reliably evaluated, the equivocal nature of test results, and economic costs. They do not believe that individualized testing is a safe and reliable substitute for pre-established age limits for public safety officers.

Those who oppose an exemption contend that there is no justification for applying one standard to Federal public safety personnel and another to State and local public safety personnel. They believe that exempting State and local governments from the hiring and retirement provisions of the ADEA in their employment of public safety officers will give them the same flexibility that Congress granted to Federal agencies that employ law enforcement officers and firefighters.

As an additional argument against exempting safety officers from the ADEA, opponents note that age affects each individual differently. They note that tests can be used to measure the effects of age on individuals, including tests that measure general fitness, cardiovascular condition, and reaction time. In addition, they cite research on the performance of older law enforcement officers and firefighters which supports the conclusion that job performance does not invariably decline with age and that there are accurate and economical ways to test physical fitness and predict levels of performance for public safety occupations. All that the ADEA requires, they argue, is that the employer make individualized assessments where it is possible and practical to do so. The only fair way to determine who is physically qualified to perform police and fire work is to test ability and fitness.

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

based on notions of age-based incapacity and would represent a significant step backward for the rights of older Americans.

For jobs that can affect the public safety but that are not State or local public safety officer occupations, there currently is no blanket exemption from the ADEA. BFOQ remains as the most common defense used by employers who place mandatory age limits on such positions.

In the case of *Tullis* v. *Lear School, Inc.*, 874 F. 2d 1489 (11th Cir. 1989), the court found that Lear School, a private school in Dade County, Florida, was in violation of the ADEA when it terminated a school bus driver who had reached the age of 65. The court disallowed the BFOQ defense because the school failed to prove that as a group, all or most school bus drivers over the age of 65 are unable to perform their jobs safely, and the school failed to show that it was not feasible to conduct individualized assessments of its bus drivers' medical qualifications.

(E) APPRENTICESHIP PROGRAMS

According to EEOC's current interpretation, apprenticeship programs are exempt from the proscriptions of the ADEA. This exemption, in effect, permits employers and labor unions to exclude men and women over age 40 from entering these programs solely because of their age.

The current interpretation has been in effect since 1969, when the DOL published interpretive guidelines which provided that apprenticeship programs are not subject to the requirements of the ADEA. Since then, the DOL has viewed the elimination of the exemption as detrimental to the promotion of such programs in the private sector because they are widely seen as a training program for youth in which the initial investment and training can be recouped over the apprentice's worklife. However, others contend that to exclude older workers from participation in bona fide apprenticeship programs is to deny them needed retraining opportunities. They argue that rapid technological changes often make the skills of older workers obsolete.

Upon receiving responsibility for upholding the ADEA in 1979, the EEOC began to explore the possibility of amending the old DOL interpretation. However, attempts to do so were unsuccessful. Subsequently, a 1983 decision in *Quinn* v. *New York State Electric and Gas Corporation,* 569 F. Supp. 655 (1983), held that neither the language of the ADEA nor its legislative history support a conclusion that Congress intended to exempt apprenticeship programs from the ADEA. Following this decision, the EEOC decided to reconsider the exemption. On June 13, 1984, the Commission unanimously voted to rescind the current exemption and issued proposed regulations which would prohibit arbitrary age discrimination in such programs. The regulations, however, languished before the Office of Management and Budget, apparently because the DOL has opposed the proposed change.

Finally, on July 30, 1987, the Commission reversed itself and voted against changing the old interpretation. According to EEOC Chairman Clarence Thomas, any decision to change that position would be "properly left for the Congress." This was the same day

the Commission cited its broad authority to promulgate regulations in passing its rule (discussed below) permitting employees to waive their ADEA rights without EEOC supervision. By retaining the old DOL interpretation, EEOC has effectively precluded midlife and older workers seeking critical new job skills from receiving needed training through these programs.

(F) APPOINTED STATE JUDGES

Section 11(f) of the ADEA defines the term "employee," and specifically excludes "any person elected to public office in any State or political subdivision . . . or an appointee on the policymaking level. . . ." 29 U.S.C. section 630(f). A number of court cases raised the question whether an appointed State judge is excluded from the protections of the ADEA as "an appointee on the policymaking level."

The U.S. Supreme Court recently settled this issue in the case of *Gregory* v. *Ashcroft,* 111 S. Ct. 2395 (1991). In that case, certain Missouri State court judges were appointed by the Governor, then subsequently retained in office by means of retention elections where they were subject to a "yes or no" vote. The U.S. Supreme Court held that appointed State judges are not covered by the protections of the ADEA.

The Court reasoned that because the Act and its legislative history did not show a clear intention on the part of Congress to cover appointed State judges, they are presumed to come under the Act's exception. Thus, elected and appointed judges may be mandatorily retired under State law.

(G) PENSION ACCRUAL PROVISIONS

In May 1979, the DOL published an interpretive bulletin regarding the 1978 ADEA Amendments. The interpretation allowed employers with pension plans regulated under the Employee Retirement Income Security Act (ERISA) to cease pension contributions and pension credits for active employees who worked beyond the normal retirement age specified in their pension and retirement plans.

The EEOC, which assumed enforcement responsibility of the ADEA shortly after, initiated a review of its pension accrual policy in 1983. After evaluating hundreds of comments from individuals and groups, the majority of whom opposed the interpretive bulletin, EEOC commissioners in 1984 voted to rescind the bulletin and to require employers to continue to post credits to the pensions of workers beyond the normal retirement age. Subsequently, proposed regulations were drafted by the EEOC mandating continued pension accrual, which the Commission in 1985 unanimously approved.

Poised to implement the new policy regarding pension accrual for workers over age 65, the EEOC in 1986 instead reversed directions, abandoning all rulemaking on continued pension accrual and refusing to rescind the bulletin. Although the EEOC also was ordered by the Court to issue a new rule governing continued pension accrual, this portion of the ruling was reversed upon appeal.

After extended debate on this issue, provisions were included in the 1986 ADEA amendments to require employers to continue ac-

crual of pension credits to workers beyond the normal retirement age, effective January 1988. More specifically, the law required pension coverage for all workers without regard to age, excepting (1) defined benefit plans that increase the worker's retirement actuarially to reflect a benefit date that occurs after the month in which the worker turns 65, and (2) plans which limit the amount of benefits or limit the number of years of service or years of participation. Under P.L. 99-509, the Internal Revenue Service (IRS), followed by the EEOC and the DOL, were required to develop regulations in accordance with the new law.

Unfortunately, the new law was vague as to whether the new law was intended to be applied on a retroactive basis. Initially, the EEOC contended that the law did not require employers to take post credits for older workers for years served prior to the law's effective date, a position that was estimated to cost older workers $3 billion in lost pension benefits.

However, a complex rule proposed in April 1988 by the IRS provides that in defined benefit plans—namely, plans which promise a retired worker a set pension based on number of years of employment and a percentage of compensation—all years of service must be taken into account in determining retirement benefits. In contrast, with respect to defined contribution plans—those in which an employer pledges to allocate a certain percentage of compensation each year toward the worker's pension—the law would not be applied retroactively under the IRS ruling.

Thus, under the IRS rule, a worker with a defined benefit plan who turns age 65 prior to 1988 would accrue pension credits for years of service prior to the law's 1988 effective date. However, if the same worker was covered by a defined contribution plan, only employment after January 1988 would be credited. According to the IRS, until a final rule is issued, the proposed regulations are in effect. In early 1989, the EEOC backed away from its earlier opposition and intends to conform to the IRS position.

B. FEDERAL PROGRAMS

The Federal Government provides funds for training disadvantaged and dislocated workers to assist them in becoming more employable. Two important Federal programs designed to promote the employment opportunities of older workers are the Job Training Partnership Act Program and the Senior Community Service Employment Program under Title V of the Older Americans Act.

1. The Job Training Partnership Act

The Job Training Partnership Act (JTPA), enacted in 1982, established a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. $4.1 billion was appropriated for the JTPA program for fiscal year 1991.

JTPA establishes two major training programs: Title II for economically disadvantaged youth and adults, with no upper age limit; and Title III for dislocated workers, including those long-term unemployed older workers for whom age is a barrier to reemployment. Under the Title II-A program, which authorizes training for

disadvantaged youth and adults, funds are allotted among States according to the following three equally weighted factors: (1) number of unemployed individuals living in areas with jobless rates of at least 6.5 percent for the previous year; (2) number of unemployed individuals in excess of 4.5 percent of the State's civilian labor force; and (3) the number of economically disadvantaged individuals. Training under Title II-A can include on-job training, classroom training, remedial education, employability development, and a limited amount of work experience. For the period July 1, 1988, through June 30, 1989, 36,730 persons age 55 and older participated in the Title II-A program, representing 5 percent of total adult participants.

Section 124(a-d) of JTPA also establishes a statewide program of job training and placement for economically disadvantaged workers age 55 or older. Governors are required to set aside 3 percent of their Title II-A allotments for this older workers program. The older workers program under section 124 of JTPA is meant to be operated in conjunction with public agencies, private nonprofit organizations, and private industries. Programs must be designed to assure the training and placement of older workers in jobs with private business concerns. During program year 1988, 38,224 persons age 55 and older were served under this program.

Title III is for workers who have been or are about to be laid off, workers who are eligible for or who have exhausted their entitlement to unemployment compensation, and workers who are unlikely to return to their previous occupation or industry. The dislocated workers program is administered by the States and provides such services as job search assistance, job development, training in job skills which are in demand, relocation assistance, and activities conducted with employers or labor unions to provide early intervention in case of a plant closing. During the period between July 1, 1988, and June 30, 1989, approximately 8,048 persons age 55 and over were served by the Title III program (about 8 percent of total program participants).

In 1988, the Title III program was significantly restructured and further funding was authorized. Under previous law, Title III had been similar to a block grant program, with few specific Federal standards imposed. The new law required States to establish a number of specific subgroups to carry out the program and to place a stronger emphasis on job training. The new program began in July 1989.

The need for services provided under JTPA is underscored by a 1988 DOL study of displaced workers. According to the study, 4.7 million workers lost their jobs due to the decline of an industry or a plant closing between 1983 and 1988. The chance of reemployment for these displaced workers declined significantly with age. Only 51 percent of those workers between 55 and 64 were able to reenter the labor force in any capacity, as compared to 71 percent for those between the ages of 20 and 24. Only 30 percent of those over age 65 became reemployed. Of those who found a job, more than half (55 percent) received lower pay than at their previous job, and more than one-third took salary cuts of more than 20 percent. The study showed that the older an individual was when he or she lost a job, the longer he or she would be unemployed and the

more likely he or she would become discouraged and drop out of the labor force altogether. Overall, there are more than 800,000 "discouraged" workers in the Nation.

During the first session of the 102nd Congress, the Job Training Partnership Act was the subject of much discussion. While most agreed that JTPA has been effective since its enactment in 1983, the Department of Labor and several Members of Congress believed that adjustments to the Act were necessary to meet the changing needs of our Nation's work force.

In particular, much of the discussion centered on the idea of cutting back or eliminating State-level set-asides, including the Title II-A set-aside for training and placement of older workers, and concentrating more resources at the local level through the service delivery areas (SDAs). Supporters of this idea feel that more services are needed at the local level, and specifically more job training services are needed for innercity youth.

Possible elimination of the Title II-A older worker set-aside causes concern among advocates for the elderly, who argue that youth are not the answer to future shortages in the work force. Secretary of Labor Elizabeth Dole recognized the importance of older workers when she stated in the October 1989 edition of "Aging News Network:"

> Experience, maturity, know-how, dependability—these and other positive traits that characterize older workers have always been important to any nation that wants to build and maintain a strong, competitive economy. But as we look to the dawn of a new century, they may be especially critical to our Nation's need to compete in today's global marketplace.
>
> All of this means that we can ill afford policies or practices that discourage skilled, experienced, productive men and women from continuing to work past retirement age if they want to do so.

Supporters of the Title II-A older worker provision contend that while programs funded by the set-aside generally started slowly in the first years, the vast majority of them are now very successful and should not be eliminated.

In the first session of the 102nd Congress, the House passed the Job Training Reform Amendments (H.R. 3033), which would eliminate the 3 percent State-level set-aside for older workers. In lieu of the State-level set-aside, H.R. 3033 would require the SDAs to use 8 percent of their funds to serve older workers.

On November 26, 1991, Senator Simon introduced the Job Training and Basic Skills Act of 1991 (S. 2055). The bills would require a 5-percent State-level set-aside for older workers; the 5 percent would be based on a new, separate adult title and would be approximately equivalent to the current 3-percent State-level set-aside. The Senate adjourned before taking action on this measure, but is expected to address the issue sometime in 1992.

2. Title V of the Older Americans Act

The Senior Community Service Employment Program (SCSEP) was given statutory life under Title IX of the Older Americans Comprehensive Services Amendments of 1973. The program's

stated purpose is "to promote useful part-time opportunities in community service activities for unemployed low income persons." SCSEP provides opportunities for part-time employment and income, serves as a source of labor for various community service activities, and assists unemployed older persons in their search to find permanent unsubsidized employment. Amendments passed in 1978 redesignated the program as Title V of the Older Americans Act.

The Older Americans Act was reauthorized through fiscal year 1987 by P.L. 98-459, the Older Americans Act Amendments of 1984. The Act was again reauthorized in 1987 through fiscal year 1991. (For a discussion of the reauthorization activities during the first session of the 102nd Congress, see Chapter 12—Older Americans Act.)

The SCSEP is administered by the Department of Labor, which awards funds to national sponsoring organizations and to State agencies. Persons eligible under the program must be 55 years of age and older (with priority given to persons 60 years and older), unemployed, and have income levels of not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services. Enrollees are paid the greater of the Federal or State minimum wage, or the local prevailing rate of pay for similar employment. Federal funds may be used to compensate participants for up to 1,300 hours of work per year, including orientation and training. Participants work an average of 20–25 hours per week. In addition to wages, enrollees receive physical examinations, personal and job-related counseling and, under certain circumstances, transportation for employment purposes. Participants may also receive training, which is usually on-the-job training and oriented toward teaching and upgrading job skills.

The SCSEP is one of the few direct job creation programs remaining since the elimination of the Comprehensive Employment and Training Act and the Public Service Employment programs. Nearly 45 percent of enrollees are between the ages of 55 and 64, and almost one-third are age 70 or older. About 70 percent are females, and almost half of all enrolled have not completed high school. Approximately 80 percent have a family income below the poverty line.

The SCSEP has received steady increases in funding and participant enrollment since its inception. In the 1968–69 program year, the first full year of operation in a form similar to the current program, the program's budget was $5.5 million. In program year July 1, 1992 to June 30, 1993, Title V funding appropriations are $395.2 million, which will support an estimated 65,200 job slots. The fiscal year 1992 appropriation represents a slight increase over fiscal year 1991. Increases in the minimum wage raised the cost of each participant in the program from $5,225 in program year 1989 to $5,652 on program year 1990 and $6,061 in program years 1991 and 1992. Although much of this additional cost has been compensated by an increase in Title V funding, budget constraints have prevented Congress from completely offsetting the effect of the minimum wage increase over the past several years.

C. OUR AGING WORK FORCE

In January 1989, the Department of Labor released two new reports on older workers and their impact on our Nation's labor market. These reports analyze current work force and labor market data, and make important and interesting projections for older workers for the future.

The DoL report entitled "Older Worker Taskforce: Key Policy Issues for the Future" projects that by the year 2000, the median age of the labor force will increase from about 36 to 39. Also, by the year 2000, the report projects an increase in the number of workers age 55 and over and a decrease of almost 1 million in the number of workers age 16 to 24. These figures confirm that with the aging of the "baby boomers," the population from which our work force is drawn is also aging.

When these projections are combined with the report's additional projection that labor force participation among individuals age 55 and older will decrease significantly by the year 2000, the result is a potential labor shortage. The report concludes that it is important for the government and employers to remove institutional barriers that discourage older workers from continuing in or re-entering the work force. In addition, incentives to retain or attract older workers should be emphasized, and training should be provided to older workers as a means for enhancing and upgrading their skills.

There has been a decreasing trend in work force participation by older workers. The average age at which people begin to draw Social Security benefits is now 63. However, there is growing concern in some circles about the consequences of early retirement. Many contend that a large number of employees who leave the work force, either voluntarily or due to forced retirement, find themselves ill-prepared for the financial consequences. While many believe that retirees who left the work force too early in life are attempting to return, there is presently little proof.

The 1991 unemployment rates for workers in the age groups of 45 to 54, 55 to 64, and 65 and older were significantly lower than the unemployment rates for younger workers. Because an individual must be out of work and actively seeking employment in order to be counted as unemployed, there are at least two viable explanations for these differences. One explanation is encouraging and the other is not. First, the improved pension system may be making it possible for more workers to leave the labor force and permanently retire. Second, the frustration of older individuals in enduring much longer periods of unemployment than younger individuals may be forcing many of them to give up and leave the labor force altogether.

A DoL report entitled "Labor Market Problems of Older Workers" reiterates the longstanding problems facing older persons seeking employment, concluding that many older workers are pressured into early retirement and that "pension rules and job market realities severely limit their options and opportunities.".The report also points out that a number of financial disincentives to re-entering the job market persist, including the low pay of part-time work and the Social Security earnings limitation. Looking ahead, the report states that the average retirement age, which had been on a

downward trend, has stabilized or gone up slightly in recent years, and that there may be an increased demand for older workers as the general population continues to age. Ultimately, however, the report concludes that the state of the Nation's economy will determine the value accorded to older workers.

D. PROGNOSIS

As the Nation's population ages, there will be additional pressures to maintain an older work force. This will likely result in the eventual conclusion by the business community that it is to their advantage to modify their current employment practices and provide incentives for older workers to remain on the job. As this occurs, there may well be less need for Federal intervention to assure that older Americans are not victimized by age discrimination. However, until the advantages of employing and retaining older workers are widely acknowledged by business, it will remain essential that older persons who desire to work can rely on the EEOC to protect their rights under the ADEA.

In the years to come, Congress will likely address a number of issues affecting the employment of older workers, including: (1) how to solve permanently EEOC's problems in processing ADEA claims; (2) whether to extend ADEA protections to tenured university faculty, public safety officers, and older workers in apprenticeship programs; (3) ways to improve the delivery of services to older workers under the Title V SCSEP Program of the Older Americans Act; and (4) whether to continue to maintain the State-level set-aside for older workers under the JTPA.

Chapter 5

SUPPLEMENTAL SECURITY INCOME

OVERVIEW

In 1972, The Supplemental Security Income (SSI) program was established to help the Nation's poor aged, blind, and disabled meet their most basic needs. The program was designed to supplement the income of those who do not qualify for Social Security benefits or whose Social Security benefits are not adequate for subsistence. The program also provides recipients with opportunities for rehabilitation and incentives to seek employment. In 1992, 5.5 million individuals received assistance under the program.

In 1992, despite continued criticism that benefit levels are inadequate, no changes were enacted by Congress affecting SSI. The major discussions surrounding reform of the SSI program emerged from the SSI Modernization Panel, which was created by then Commissioner Gwendolyn S. King in 1990 to perform a comprehensive examination of the SSI program. It issued its expert report in July 1992, calling for major and costly improvements in the program, as well as a number of smaller technical amendments. In addition, a number of small amendments to SSI were passed by Congress in H.R. 11, the Revenue Act of 1992, which was ultimately vetoed by President Bush and not enacted.

To those who meet SSI's nationwide eligibility standards, the program provides monthly payments. In most States, SSI eligibility automatically qualifies recipients for Medicaid coverage and Food Stamps benefits.

Despite the budget cuts that many programs have suffered in the last decade, SSI benefits have not been lowered. This is in part because the Gramm-Rudman-Hollings Act exempts SSI benefit payments from across-the-board budget cuts. It is also because of widespread support for the program, recognition of the subsistence-level benefit structure, and concern about the program's role as a safety net for the lowest-income Americans.

Although SSI has escaped the budget axe, the lack of funding for benefit increases has meant that the program continues to fall far short of eliminating poverty among the elderly poor. Despite progress in recent years in alleviating poverty, a substantial number remain poor. When the program was started almost two decades ago, some 14.6 percent of the Nation's elderly lived in poverty. In 1991, the elderly poverty rate was 12.4 percent.

The effectiveness of SSI in reducing poverty is hampered by inadequate benefit levels, stringent financial criteria, and a low participation rate. In most States, program benefits do not provide recipients with an income that meets the poverty threshold. Nor have

the program's allowable income and assets level kept pace with inflation. Further, only about half of those elderly persons poor enough to qualify for SSI actually receive program benefits.

In recent years, the gulf between SSI's reality and its potential as an antipoverty weapon has given rise to a desire among advocates and a number of Members of Congress to try and correct the program's inadequacies. Although some proposals have been made to raise the benefit payments to the poverty level and to increase the program's income and assets levels, little progress has been made to enact such changes. Budget constraints, enacted by Congress in the form of a 5-year bipartisan budget agreement in 1990, have limited major reforms. These constraints will continue in the immediate future to inhibit restructuring the program.

Among the issues which provoked recent SSI reform legislation was the lack of oversight of representative payees by the Social Security Administration (SSA), the agency charged with administering the SSI program. Representative payees handle benefit checks on behalf of beneficiaries who, due to age or disability, are unable to handle their own finances. Following intense scrutiny by the Senate Aging Committee and other congressional committees, comprehensive legislation was enacted in 1990 to strengthen investigation and monitoring of representative payees for this vulnerable population. In 1992, SSA established policies and procedures implementing this new system.

Under the leadership of Commissioner King, SSA took steps in 1992 to examine and address problems in the SSI program. The SSI modernization panel issued a comprehensive set of proposals for improving SSI, and SSA has undertaken an outreach effort to inform potential beneficiaries about the program.

A. BACKGROUND

The SSI program, authorized in 1972 by Title XVI of the Social Security Act (P.L. 92-603), began providing a nationally uniform guaranteed minimum income for qualifying elderly, disabled, and blind individuals 2 years later. Underlying the program were three congressionally mandated goals: to construct a coherent, unified income assistance system; to eliminate large disparities between the States in eligibility standards and benefit levels; and to reduce the stigma of welfare through administration of the program by SSA. It was the hope, if not the assumption, of Congress that a central, national system of administration would be more efficient and eliminate the demeaning rules and procedures that had been part of many State-operated public-assistance programs. SSI consolidated three State-administered public-assistance programs: old age assistance; aid to the blind; and aid to the permanently and totally disabled.

Under the SSI program, States play both a required and an optional role. They must maintain the income levels of former public-assistance recipients who were transferred to the SSI program. In addition, States may opt to use State funds to supplement SSI payments for both former public-assistance recipients and subsequent SSI recipients. They have the option of either administering their supplemental payments or transferring the responsibility to SSA.

SSI eligibility rests on definitions of age, blindness, and disability; on residency and citizenship; on levels of income and assets; and, on living arrangements. The basic eligibility requirements of age, blindness, or disability have not changed since 1974. Aged individuals are defined as those 65 or older. Blindness refers to those with 20/200 vision or less with the use of a corrective lens in the person's better eye or those with tunnel vision of 20 degrees or less. Disabled persons are those unable to engage in any substantial gainful activity because of a medically determined physical or mental impairment that is expected to result in death or that can be expected to last, or has lasted, for a continuous period of 12 months.

As a condition of participation, an SSI recipient must reside in the United States or the Northern Mariana Islands and be a U.S. citizen, an alien lawfully admitted for permanent residence, or an alien residing in the United States under color of law. In addition, eligibility is determined by a means test under which two basic conditions must be satisfied. First, after taking into account certain exclusions, monthly income must fall below the benefit standard—$434 for an individual and $652 for a couple in 1993. Second, the value of assets must not exceed a variety of limits.

Under the program, income is defined as earnings, cash, checks, and items received "in kind," such as food and shelter. Not all income is counted in the SSI calculation. For example, the first $20 of monthly income from virtually any source and the first $65 of monthly earned income plus one-half of remaining earnings, are excluded and labeled as "cash income disregards." Also excluded are the value of social services provided by federally assisted or State or local government programs such as nutrition services, food stamps, or housing, weatherization assistance; payments for medical care and services by a third party; and in-kind assistance provided by a nonprofit organization on the basis of need.

In determining eligibility based on assets, the calculation includes real estate, personal belongings, savings and checking accounts, cash, and stocks. In 1992 and years thereafter, the asset limit is $2,000 for an individual and $3,000 for a married couple. The income of an ineligible spouse who lives with an SSI applicant or recipient is included in determining eligibility and amount of benefits. Assets that are not counted include the individual's home; household goods and personal effects with a limit of $2,000 in equity value; $4,500 of the current market value of a car (if it is used for medical treatment or employment it is completely excluded); burial plots for individuals and immediate family members; a maximum of $1,500 cash value of life insurance policies combined with the value of burial funds for an individual.

The Federal SSI benefit standard also factors in a recipient's living arrangements. If an SSI applicant or recipient is living in another person's household and receiving support and maintenance from that person, the value of such in-kind assistance is presumed to equal one-third of the regular SSI benefit standard. This means that the individual receives two-thirds of the benefit. In 1992, that totaled $281 for a single person and $422 for a couple. In 1993, the SSI benefit standard for individuals living in another person's household will increase to $289 for a single person and $434 for a

couple. If the individual owns or rents the living quarters or contributes a pro rata share to the household's expenses, this lower benefit standard does not apply. In March 1992, 5.6 percent, or 293,000 recipients came under this "one-third reduction" standard. Sixty-seven percent of those recipients were receiving benefits on the basis of disability.

When an SSI beneficiary enters a hospital, or nursing home, or other medical institution in which a major portion of the bill is paid by Medicaid, the SSI benefit amount is reduced to $30. This amount is intended to take care of the individual's personal needs, such as haircuts and toiletries, while the costs of maintenance and medical care are provided through Medicaid.

B. ISSUES

1. SSI Modernization Project

SSA Commissioner Gwendolyn King in 1990 established the Supplemental Security Income Modernization Project. In 1992, this important initiative completed a comprehensive examination of the SSI program, reviewing its fundamental structure and purpose. The purpose of the Project is to determine if the SSI program is meeting and will continue to meet the needs of the population it is intended to serve in an efficient and caring manner, while also recognizing the constraints of the current fiscal climate.

As SSA has explained it, the first phase of the Project was intended to create a dialogue to provide a full examination of how well the SSI program serves the needy, aged, blind, and disabled. To begin the dialogue, Commissioner King appointed 21 people who are experts in the SSI program and related public policy fields. The experts include a wide range of representatives of the aged, blind, and disabled from private and nonprofit organizations and Federal and State governments as well as former SSA staff. Dr. Arthur S. Flemming, former Secretary of Health, Education, and Welfare, chairs the Project. Dr. Flemming, and many of the experts serving the Project, are widely recognized as being among the foremost advocates for improving and protecting the SSI program. These choices attest to Commissioner King's commitment to making the Project effective and successful in meeting its goals.

From June 1990 through January 1992, the experts held a series of public meetings across the Nation during which more than 400 individuals and organizations testified. Additionally, approximately 14,600 persons commented on an issues paper which the Project published in the Federal Register on July 31, 1991. The meetings were designed to facilitate the sharing of ideas among attendees' constituencies, including advocacy groups, State and local government officials and academicians. The meetings also informed the public and brought to the Project's attention innovative ideas for change in the SSI program.

The experts considered all of these comments as they determined their individual points of view which were included in their August 24, 1992 final report to the Commissioner of Social Security. This was published in the Federal Register on September 4, 1992, accompanied by a request for comments due by December 3, 1992.

The body of the report addresses more than 50 program improvements which would grant SSI access to truly needy persons who are aged, blind, or disabled and which would improve the quality of care received by people on the rolls. A majority of experts endorse improvements which cover diverse issues, including: Matters relating to the payment of benefits and the adequacy of benefits; the criteria for eligibility (the needs tests—income and resources—and the tests for categorical eligibility—the definitions of age and disability); agency staffing; linkages to the Medicaid and food stamp programs; and the need for periodic reviews of the program. Also included is relevant background information about the current program and specific issues the experts believe need to be addressed, as well as the individual points of view of all the experts, including those whose perspective differs from that of the majority on a given issue.

Most of the experts agreed on four top priorities that need to be addressed. They differed, however, as to how far and how fast to go on the changes. Among the four top priorities is an immediate staffing increase of 6,000 at SSA. The experts consider such an increase to be needed to eliminate growing backlogs and to enable the agency to move toward providing the level of personalized services which are needed by many persons in the SSI population.

Second, and most costly among the proposals, the experts recommended increasing the Federal benefit standard over a period of 5 years so that it reaches 120 percent of the poverty level by the fifth year. In 1992, the standard for an individual is roughly 75 percent of the poverty level.

Third, the experts recommended repeal of the law which requires that receipt of in-kind support and maintenance, such as food, clothing, and shelter, must be considered as income. This would remove a provision which can be harsh, demeaning, and discouraging to charitable endeavors.

Fourth, the Panel advocated increasing the resource test used to determine eligibility from $2,000 for an individual and $3,000 for a couple to $7,000 for an individual and $10,500 for a couple and streamline the exclusions. This would make the rules easier for beneficiaries to understand and give them more flexibility in the use of funds while simplifying program administration.

As the experts completed their review of the SSI program, they recognized that most of their ideas for change would require increased expenditures. Many believed that the identification of potential sources of financing should be under the purview of persons with expertise in public finance. Commissioner King asked Chairman Flemming to chair a group of public finance experts to develop options for financing the improvements identified in the report. Such a group may be convened in 1993.

2. Benefits

Ever since the program's start-up in 1974, benefit levels have fallen below the poverty level. As a result, the program has relieved, but not eliminated, poverty rates among elderly and disabled individuals. The poverty rate among the elderly has declined only marginally from 14.6 percent in 1974 to 12.4 percent in 1991.

For the black elderly, the poverty rate is even greater, at 34 percent. The poverty rate is highest for black elderly women, at 39 percent. The 1992 benefit of $422 left an elderly individual 25 percent below the projected 1992 poverty level of $6,728. For elderly couples, the maximum benefit level of $633 was 11 percent below the projected poverty level of $8,488 in 1992. In 1991, out of a total population of 30.6 million elderly 65 and over, 3.8 million elderly had incomes below the poverty level.

A 1988 study by the National Council of Senior Citizens found that the average low-income elderly household had an annual income of $5,306. Of that amount, housing costs totaled more than 38 percent, food 34 percent, and home energy 17 percent. This left about $493, or $9.38 a week, for discretionary spending.

Under SSI, States also may voluntarily supplement the Federal SSI benefit. Approximately 49 percent of SSI recipients receive such supplementation. Seven States provide no supplement. The median State supplement in 1992 was only $32 for an individual per month. In 1992, only three States—Alaska, California, and Connecticut—supplemented SSI enough to bring benefits up to the poverty level.

In 1992, in an effort to extend the effectiveness of SSI, a majority of experts on the SSI Modernization Panel recommended raising the SSI benefit standard to 120 percent of the poverty level. These experts believe that those who are aged, blind, and disabled should no longer have to live in poverty. The proposed benefit increase would be extremely costly, and will bump up against serious budget constraints in 1993. Unless creative sources of financing can be identified, large increases in SSI will be difficult to achieve in the near future.

3. Income and Assets Limits

Concern has stemmed from the fact that the SSI program's cash income disregards have not been changed since the inception of the program in 1974. If the 1974 values of these disregards had been indexed to reflect price inflation they would have increased from $20 of monthly income from any source and $65 monthly earned income to $55 and $180, respectively. The $20 disregard affects almost 90 percent of elderly beneficiaries. In 1992, the experts on the SSI Modernization Panel recommended increasing the $20 monthly income exclusion to $30, applied only to unearned income.

Compounding the inadequate disregards is the absence of regular indexing for the asset limits individuals must meet to receive SSI benefits. Through the program's first 10 years, the allowable asset limits remained constant at $1,500 for individuals and $2,250 for couples. In 1984, however, the Deficit Reduction Act (P.L. 98-369) raised these limits annually through 1989 by $100 for individuals and by $150 a year for couples to its current level of $2,000 and $3,000 respectively. Even so, antipoverty advocates remain concerned that the asset test is still too stringent and disqualifies otherwise eligible persons.

The results of a 1988 study conducted by the Policy Center on Aging of Brandeis University for the American Association of Retired Persons (AARP), support this contention. The study found

that 34 percent of the income eligible 65-69 age group and 45 percent of the 85 and over age group were ineligible because of assets. The study also reported that a significant number of individuals possessed assets close to the cutoff. For example, about 60,000 elderly persons had countable assets that fell within $750 of the 1984 asset test threshold. The assets held by a majority of the asset ineligible population were interest earning accounts, homes, and automobiles. About half of income eligible/asset ineligible elderly households had modest life insurance policies that contributed to ineligibility.

In addressing these concerns, the SSI Modernization Panel issued a number of recommendations in 1992. Regarding the resource limits, the experts supported raising them to $7,000 for an individual and $10,500 for a couple, while eliminating most of the resource exclusions. The home, an essential car, business property essential for self-support, and household goods and personal effects would continue to be excluded. The experts view these changes as making the program simpler and more equitable. They believe that the increased limits, with fewer exclusions, would more effectively and efficiently identify the truly needy among persons who are aged, blind, or disabled.

4. LOW PARTICIPATION

Since its inception, the SSI program has been plagued with low participation rates. Despite initial projections that over 7 million Americans were eligible for SSI, the caseload has never exceeded 5.5 million. Further, the number of elderly participants has continued to decline. The number of those persons who became eligible for SSI on the basis of age declined from 2.3 million in 1975 to 1.5 million in 1992. A 1986 study by the Commonwealth Fund Commission on Elderly People Living Alone found evidence that those who are eligible but not participating are mostly single elderly women living in poverty.

Over the years, studies have found that only between 40 and 60 percent of those elderly poor enough to qualify for SSI actually receive benefits under the program. A 1988 AARP study prepared under a grant from the Commonwealth Fund Commission on Elderly People Living Alone, found that only 51.1 percent of the eligible elderly were participating in SSI, with rates varying between 30 to 60 percent among the States. A 1980 study, based on 1975 population data, of the Institute for Research on Poverty found a 41 to 47 percent participation rate for the elderly. In the following year, 1981, Urban Systems reported a participation rate of 60 percent, using a nonrepresentative 1979 survey of low-income elderly.

A related 1988 AARP survey, conducted by Lou Harris and Associates, found that over half of the eligible poor who were not participating in SSI had never heard of the program or did not know how to apply for assistance. Less frequently cited reasons for nonparticipation included an inability to deal with the program's application process, language barriers, the stigma of receiving welfare, the loss of privacy, and the perception of low benefits.

The AARP survey identified a number of effective SSI outreach tools. The largest number of elderly respondents, 76 percent, re-

ported that one-on-one assistance with the SSI application process is an effective approach. About 72 percent reported that allowing individuals to set up an appointment time with SSA, rather than spending time waiting in an SSA field office, would further program participation. Slightly fewer, 68 percent, said that informing individuals that SSI eligibility confers access to health care through Medicaid would make a difference, followed closely by increasing benefits (67 percent) and allowing individuals to apply for SSI at some location other than an SSA field office (66 percent).

Aware of these problems, the SSI Modernization Panel in 1992 advocated increasing SSA staff by 6,000 and ensuring a specific funding stream to ensure SSA continues outreach activities. In the report, the experts argued that Congress would need to increase appropriations for administrative expenses in order to enable SSA to conduct outreach.

The findings of an April 1989 report of Families U.S.A. confirm that the major obstacle toward greater SSI participation among the elderly is a lack of information and understanding about the program. Based on a survey of over 6,000 low-income elderly, the study found that only one-third of the respondents knew that SSI could raise an eligible's person's income and one-fourth were aware that SSI eligibility could lead to health care under Medicaid. The study also reported that the perceived complexity of the SSI application process and the lack of assistance in completing the application forms serves to keep many eligible individuals off the rolls. Finally, the report concluded that SSI outreach efforts on the part of SSA were limited, sporadic, and untargeted, and that a nationwide effort was critical to ensure that eligible individuals are able to receive the benefits under the program.

On a demonstration basis, AARP and the Commonwealth Fund Commission on Elderly Living Alone worked in 1988 with dozens of local agencies in three cities to develop and test ways to increase participation in the SSI program. The projects pioneered a number of innovative strategies, making extensive use of the media, community education, and one-on-one counseling of potential SSI applicants. In the three cities—El Paso, Pittsburgh, and Oklahoma City—SSA reported an average increase of about 97 percent in applications and about 58 percent in awards. In 1989, these projects served as templates for SSI outreach programs in ten additional locations.

In recent years, SSA itself has undertaken some outreach activities with congressional support. In 1984, for example, a congressionally mandated effort by SSA to inform 7.6 million potential SSI recipients by mail of possible eligibility resulted in 79,000 applications—representing 1 percent of potential recipients who were alerted. A total of 58,000 of those who applied were awarded benefits. An appropriation in 1990 resulted in SSA awarding grants to 25 groups and organizations throughout the country to conduct SSI outreach demonstration projects. In 1991, SSA continues to work with these projects as they test various methods of getting people to apply for SSI that can be duplicated elsewhere.

The chronic low rates of program participation have prompted Congress to urge and SSA to adopt a more aggressive approach to this problem and to provide better training to SSA staff. At the

same time, many voice strong concern over the impact of the agency's closing of field offices, staff reductions in field offices, particularly field representatives and those with bilingual capability, and the lack of outreach efforts in minority communities.

Over the last several years, SSA resources most critical to the agency's outreach efforts—field representatives and contact stations—have been scaled back significantly. Between 1986 and 1989, the number of field representatives dropped by 28 percent and the number of contact stations by 22 percent.

Adding to the barriers to increased SSI participation was the problems plaguing the nationwide implementation of an SSA toll-free line. Under the system, calls to SSA bypass SSA field offices and were rerouted to a small number of SSA telephone centers. In its first years of operation the toll-free line persistently suffered from high rates of busy signals and incomplete or erroneous answers, particularly with respect to the SSI program. One SSA study, for example, revealed that nearly one in four callers (24 percent) with questions about SSI were given incorrect answers. Senator Pryor introduced a bill, S. 2158, which was enacted in 1990 requiring SSA to provide telephone access to local offices. In 1992, SSA implemented a part of that legislation, although phone lines which had been disconnected were not restored in many cases. (For a fuller discussion of SSA's toll-free line, please see chapter 1.)

5. Representative Payees

Under SSA's representative payee program, an individual other than the beneficiary is appointed to handle checks from the Social Security and SSI programs when the beneficiaries are deemed unable to manage their own finances. The monthly payments to approximately 1 million SSI beneficiaries are handled by representative payees. By definition, beneficiaries in need of a payee are vulnerable.

Senator Pryor chaired a hearing to investigate the lack of safeguards to protect beneficiaries from abuse by representative payees and lapses by SSA. The findings led him to introduce a bill to intensify oversight of the program which was enacted in 1990, strengthening SSA's procedures. In response to that legislation and congressional concern, SSA moved to address some of the weaknesses that had been identified in its representative payee program. In 1992, SSA established a number of policies and procedures to implement the new law, consulting with a variety of experts to ensure the new system protects the vulnerable beneficiary population. As a result, advocates and Members of Congress were reassured that beneficiaries were adequately protected. Final regulations implementing the bill are due to be completed in 1993.

6. Employment and Rehabilitation for SSI Recipients

Section 1619 and related provisions of SSI law provide that SSI recipients who are able to work in spite of their impairments can continue to be eligible for reduced SSI benefits and Medicaid. The number of SSI disabled and blind with earnings has increased from 87,000 in 1980 to 211,000 in 1992. In addition, 27,000 aged SSI recipients had earnings in 1992.

Before 1980, a disabled SSI recipient who found employment faced a substantial risk of losing both SSI and Medicaid benefits. The result was a disincentive for disabled individuals to attempt to work.

The Social Security Disability Amendments of 1980 (P.L. 96-265) established a temporary demonstration program aimed at removing work disincentives for a 3-year period beginning in January 1981. This program, which became Section 1619 of the Social Security Act, was meant to encourage SSI recipients to seek and engage in employment. Disabled individuals who lost their eligibility status for SSI because they worked were provided with special SSI cash benefits and assured Medicaid eligibility.

The Social Security Disability Benefits Reform Act of 1984 (P.L. 98-460), which extended the Section 1619 program through June 30, 1987, represented a major push by Congress to make work incentives more effective. The original Section 1619 program preserved SSI and Medicaid eligibility for disabled persons who worked even though two provisions that set limits on earnings were still in effect. These provisions required that after a trial work period, work at the "substantial gainful activity level" (then counted as over $300 a month earnings, which has since been raised to $500) led to the loss of disability status and eventually benefits even if the individual's total income and resources were within the SSI criteria for benefits.

Moreover, when an individual completed 9 months of trial work and was determined to be performing work constituting substantial gainful activity, he or she lost eligibility for regular SSI benefits 3 months after the 9-month period. At this point, the person went into section 1619 status. After the close of the trial work period, there was, however, an additional one-time 15 month period during which an individual who had not been receiving a regular SSI payment because of work activities above the substantial gainful activities level could be reinstated to regular SSI benefit status without having his or her medical condition reevaluated.

The Employment Opportunities for Disabled Americans Act of 1986 (P.L. 99-643) eliminated the trial work period and the 15 month extension period provisions. Because a determination of substantial gainful activity was no longer a factor in retaining SSI eligibility status, the trial work period was recognized as serving no purpose. The law replaced these provisions with a new one that allowed use of a "suspended eligibility status" that resulted in protection of disability status of disabled persons who attempt to work.

The 1986 law also made Section 1619 permanent. The result has been a program that is much more useful to disabled SSI recipients. The congressional intent was to ensure ongoing assistance to the severely disabled who are able to do some work but who often have fluctuating levels of income and whose ability to work changes for health reasons or the availability of special support services.

This is of particular importance to elderly parents of adult mentally retarded or mentally ill children. At issue is the continued availability of income assistance, medical care, housing, and social services for their children. Such services are often provided by the parents themselves, both the financial costs associated with these

services and the day-to-day care and supervision of their adult disabled children. Many of these aging parents would like to set up trust accounts to provide for the children's care following their death. However, the income from, and resources of, such a trust may cause a child to be ineligible for SSI and therefore unable to utilize the work incentive provisions of Section 1619.

Under present law, an individual must have 1 month of regular SSI benefits before they qualify for the work incentive provisions of Section 1619. The result is that an individual who is only receiving SSDI, when losing their disability status due to work activity, cannot move into the SSI Section 1619 program. The House of Representatives approved a provision in 1989 which allows an SSDI recipient who becomes ineligible for SSDI as a result of earnings to participate in Section 1619 without first being required to receive at least 1 month of SSI benefits. This proposal, which was not enacted in 1991, will remain on the agenda for 1993.

Congress and advocates for individuals with disabilities remain highly interested in work incentives, and are impressed with the progress of the 1619 program. More refinements, and possibly more broad-based expansions of the program, can be expected in the future.

C. PROGNOSIS

Over the last several years, in recognition of SSI's role as the major element in the Nation's safety net for poor elderly and disabled individuals, the Congress has exempted the program from budget cuts. Nevertheless, Federal spending constraints have precluded any program expansion and, as a result, the SSI eligibility criteria have lost ground to the effects of inflation. At the same time, program benefits continue to lag behind the amount needed to pull recipients out of poverty.

In 1992, budgetary pressures continued to preclude congressional efforts to correct these program deficiencies. No doubt in coming years the obstacles to achieving significant SSI expansion will remain difficult to overcome.

In this context, the most important development in many years in the SSI program was the establishment and report of the SSI Modernization Panel. Although the experts' report it issued in 1992 was not unanimous on all counts, there was substantial agreement by a majority of panelists to make major improvements in the program. While these were reported and received with little fanfare in 1992, they land on the desk of a new Commissioner under a new President in 1993, increasing optimism that a fresh look will be given at the program. Nevertheless, despite an expectation that a Clinton Administration will show a greater concern for this population, it will be operating under a legacy of debt and deficit spending it will inherit. Funding program improvements will remain highly difficult, and will pit SSI in competition with other urgent national needs.

To the extent that additional Federal resources are directed toward expanding SSI, they likely will be achieved on a basis that is incremental rather than sweeping. Some of the less-costly recommendations of the SSI Modernization Panel stand a better chance

of being adopted by the new Administration or approved by Congress. The goal of Chairman Flemming to convene a panel to decide on options for financing SSI improvements should help pave the way for congressional action.

Congressional oversight of SSA is likely to ensure that administrative problems do not undermine the SSI program, and that SSI recipients and others can get accurate and timely answers to questions over the agency's new toll-free line. In that regard, one of the greatest challenges for 1993 will be ensuring an adequate appropriation for SSA's administrative expenses.

Chapter 6

FOOD STAMPS

OVERVIEW

During the 1980's, Congress enacted laws that both restricted and liberalized the Food Stamp Program. In 1981 and 1982, eligibility was greatly limited and benefit increases were delayed or eliminated. Later, following passage of the 1985 Farm Bill and the 1988 Hunger Prevention Act, many of the major restrictions enacted in the early 1980's were removed and new provisions liberalizing the program were added. Today's Food Stamp Program looks much like that in place at the beginning of the decade.

In 1992, Congress faced several food stamp issues. A surge in food stamp enrollment, and the likelihood that increases would continue, led Congress with the Administration's support, to raise fiscal year 1993 appropriations by some 20 percent over 1992 spending. Food stamp enrollment went from a fiscal year 1991 monthly average of 22.6 million persons to 25.4 million people in 1992; it is expected to surpass 26 million people in 1993. Participation in Puerto Rico's special nutrition assistance program has remained stable at about 1.5 million persons a month. The prospect of a decrease in food stamp benefits beginning in October 1992 because of lower food prices brought enactment of a law barring a reduction in basic food stamp benefit levels for fiscal year 1993 (P.L. 102-351). Responding to calls for new measures to help children and their families, the House approved the "Children's Initiative" (H.R. 3603), including child welfare, foster care, and adoption assistance provisions, and major amendments increasing food stamp benefits (the Mickey Leland Childhood Hunger Relief Act).

In 1993, advocates, possibly with Administration support, are likely to seek enactment of the Mickey Leland Childhood Hunger Relief Act. This measure includes provisions similar to those reported by both the House and Senate Agriculture Committees in 1991 and approved by the House in 1992. The major amendments would increase benefits to those with high shelter costs, liberalize the treatment of child support payments and the way vehicles are counted as an asset, and grant an across-the-board 2-percent increase in basic benefits.

A. BACKGROUND

The Food Stamp Program works to alleviate malnutrition and hunger among low-income persons by increasing their food purchasing power. State welfare agencies, following Federal regulations established by the U.S. Department of Agriculture (USDA), issue food coupons that eligible households may use in combination

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with the other income to purchase a more nutritious diet than would otherwise be possible.

In 1992, an average of 25.4 million low-income persons participated in the program, with an average monthly benefit of $68.50 per person. In addition, about 1.5 million people a month were enrolled in Puerto Rico under its Nutrition Assistance Program (NAP), a block grant authorized under the Food Stamp Act that has replaced the Food Stamp Program in the Commonwealth. Food stamps are available to households meeting certain federally established income and asset tests, or who already receive Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or State/local general assistance. It is estimated that a minimum of 35 million persons in the United States may actually be eligible to receive food stamps. Over the past decade, average monthly participation has ranged from a low of 18.6 million people in fiscal year 1988 to an all-time high in 1992.

The origins of the Food Stamp Program can be traced to an eight-county, experimental antihunger project established by Executive Order in 1961. A national expansion of the project concept followed passage of the Food Stamp Act of 1964. After 1964, all States were given the option to offer a coupon distribution program in lieu of their existing commodity donation projects. By 1975, the program was available nationwide. In 1977, Congress enacted the Food Stamp Act of 1977, fundamentally revising the program's benefit structure, eligibility criteria, and administrative scheme. Since then, Congress has enacted amendments intended to improve the Food Stamp Program and strengthen its integrity.

Eligible applicants receive monthly food stamp allotments to buy food through standard market channels, usually authorized grocery stores. These stores then forward them to the commercial banks for cash or credit. The stamps flow through the banking system to the Federal Reserve Bank where they are redeemed out of a special account maintained by the U.S. Treasury Department. In a few pilot projects, benefits are issued in cash rather than coupons. The Food Stamp Program serves as an income security program by supplementing family income. It also contributes to farm and retail food sales and helps reduce surplus stocks by encouraging increased food purchases.

Recent studies confirm the correlation between nutritional status and health, especially for the young and the old, underscoring the true significance of the Food Stamp Program. The program recognizes that elderly people with high medical bills may have total incomes higher than the poverty level, but less money actually available for food than others with lower incomes and no medical bills. To address these and other unique circumstances of the elderly, the program provides for more liberal treatment of shelter costs, medical expenses, and assets. For the 14 percent of elders who take the medical deduction for the elderly, the average deduction is nearly $90 per month, providing an increase in benefits of about $25 per month.

Although 20 percent of food stamp households have at least one elderly member (age 60 or older), they make up only 11 percent of food stamp recipients and receive 8 percent of food stamp benefits because elderly households are typically smaller (an average of 1.5

persons) and have relatively higher incomes than recipient households of the same size. Ninety percent of all elderly participants live alone or with one other person, usually elderly as well. Seventy percent live alone, of which 80 percent are single elderly females. Almost 10 percent of elderly households also include children. Eighty-seven percent of elderly recipients have liquid assets of $500 or less, with an average of $184 per household. Elderly food stamp recipients (age 60 or over) tend to depend on Social Security and SSI. Some 60 percent of food stamp households with elderly members receive SSI, 70 percent get Social Security payments, and 40 percent benefit from both.

The Federal Government pays 100 percent of all food stamp benefits and 50 percent of most State and local administrative costs. State and local costs for expanding computer capability and fraud control activities are eligible for up to 75 percent Federal funding. The Food and Nutrition Service of the Department of Agriculture is responsible for administering and supervising the Food Stamp Program and for developing program policies and regulations. At State and local levels, the Food Stamp Program is administered by State welfare departments.

The elderly may qualify for special assistance in applying for food stamps though Social Security offices if they are applicants for, or recipients of, Social Security or SSI benefits. Many advocacy groups, however, contend that Social Security offices are not providing needed assistance in many cases. In order to evaluate how effectively these offices are assisting potential food stamp beneficiaries, in 1989, Congress passed a measure, sponsored by Chairman Pryor, which directed the Comptroller General to comprehensively examine this issue.

State and local welfare offices are also required to establish and implement special procedures for those who have difficulty applying for food stamps at the welfare offices and for those with extremely low incomes who need food stamps quickly, e.g., out-of-office application procedures, permission to use "authorized representatives" to apply for and use food stamps, and "expedited service" for those in extreme need. Benefits must be provided to eligible households within 30 days of application, or within 5 days for those in extreme need.

Uniform national household eligibility standards for program participation are established by the Secretary of Agriculture. All households must meet a liquid assets test and, except for those with an elderly or disabled member, a two-tiered income test to be eligible for benefits. Recipients of two primary Federal-State categorical cash welfare programs—AFDC and SSI—are automatically eligible for food stamps, although in California increased SSI benefits replace food stamp assistance. An eligible household's monthly gross income must not exceed 130 percent of the income poverty levels set annually by the Office of Management and Budget (OMB), and its monthly income (after deducting amounts for such things as medical and dependent care, shelter, utilities, and work-related expenses) must be equal to or less than 100 percent of the OMB poverty level. Only the second test, monthly income after deductions, is applied to households with elderly or disabled members.

To be eligible, a household cannot have liquid assets exceeding $2,000, or $3,000, if the household has an elderly member. The value of a residence, personal property and household belongings, business assets, burial plots, a portion of the value of a vehicle, and certain other resources are excluded from the liquid assets limit.

Certain able-bodied household members (older than 16–18 years of age, depending upon their school and family status, and younger than 60 years) who are not working must register for employment and accept a suitable job, if offered one, to maintain eligibility. States are required to operate Employment and Training (E&T) programs under which adults who are registered for work and not subject to certain exemptions must fulfill State work program requirements. These may include workfare obligations, supervised job search requirements, participation in a training program, or other employment or training activities designed by the State.

Applicant households certified as eligible are entitled to a monthly benefit amount calculated from their income and size. A food stamp household is expected to contribute 30 percent of its monthly cash income after expense deductions (or about 15–20 percent of its gross income) to food purchases. Food Stamp benefits then make up the difference between that expected contribution and the amount needed to buy a low-cost, adequate diet; this amount is the maximum monthly benefit and is equal to the cost of USDA's "Thrifty Food Plan," adjusted for household size and inflation and increased by a special 3-percent "add on." In fiscal year 1993, the maximum food stamp benefit is $111 a month for a one-person household and $203 for a two-person household. Average monthly benefits in 1992 were $68.50 per person and about $50 among elderly recipients. However, about one-quarter of elderly households receive only the minimum $10 a month benefit.

B. ISSUES

In 1993, Congress may take further action on the proposed Mickey Leland Childhood Hunger Prevention Act, approved in 1991 by the House and Senate Agriculture Committees, to the extent money can be found in the budget. In light of this possibility, it may be useful to review some of the studies released during the 1970's and 1980's demonstrating the need for an expanded program.

1. Studies Documenting Prevalence of Hunger in America

Hunger in America captured congressional attention soon after a visit to the rural South in April 1967 by members of the Senate Subcommittee on Employment, Manpower and Poverty. The subcommittee held hearings on the effectiveness of the so-called "war on poverty" and was told of widespread hunger and poverty. Later that year, a team of physicians found severe nutritional problems in various areas of the country. These and other reports of hunger and malnutrition in America led to an expansion of Federal food assistance programs. In 1977, physicians returned to evaluate progress made in combating hunger in these same communities and found dramatic improvements in the nutritional status of their

residents. These gains were attributed to the expansion of Federal food programs in the 1970's.

Throughout the 1980's considerable attention was focused on the re-emergence of widespread hunger in the United States. Since 1981, at least 32 national and 43 States and local studies on hunger have been published by a variety of government agencies, universities, and religious and policy organizations. They all suggest that hunger in America is widespread and entrenched, despite national economic growth.

In 1981, news accounts of bread lines and crowded soup kitchens began to appear in papers in various cities around the country. In 1982, the U.S. Conference of Mayors reported that in most cities surveyed, the need for food represented a true emergency. In 1983, the Conference issued a report which detailed a significant increase in requests for emergency food assistance citing unemployment as a primary cause.

Closely following that report, the General Accounting Office found significant increases in the number of persons seeking food assistance during the early 1980's, including substantial numbers of persons who had recently been financially stable. In 1983, Senator Edward Kennedy issued to the Senate Committee on Labor and Human Resources a report based on a field investigation undertaken the week before Thanksgiving, 1983. Senator Kennedy found that hunger was on the rise in America and indicated that Congress should act to improve assistance to the hungry.

The Center on Budget and Policy Priorities surveyed private nonprofit agencies which operate emergency food programs across the Nation and reported in 1983 that more than half of the 181 programs surveyed increased the number of free meals or food baskets they provided by 50 percent or more from 1982 to 1983. Nearly one-third of the programs also doubled in size over that time.

Later that year, President Reagan appointed a commission to investigate allegations of rampant hunger in the United States. At the end of 1984, the President's Task Force of Food Assistance concluded that there was little evidence of widespread hunger in the United States and that reductions in Federal spending for food assistance had not injured the poor. Several modest recommendations to make the Food Stamp Program more accessible to the hungry were outlined in the report, including:

(1) Raising asset limits;

(2) Increasing the food stamp benefit to 100 percent of the Thrifty Food Plan;

(3) Categorical eligibility for AFDC and SSI households;

(4) Targeted benefit increases to beneficiaries with high medical or shelter expenses (particularly the elderly and disabled); and

(5) Modification of the permanent residence requirement so benefits would be made available to the homeless.

These liberalizations, however, were offset by cost-reduction measures which included increasing the State responsibility for erroneous payments and an optional State block grant for food assistance.

The Food Research and Action Center (FRAC) also surveyed nationally the use of emergency food programs during the early

1980's. In 1983, FRAC found that food stamp recipients were the majority users of emergency food programs, mostly because they ran out of stamps by the second or third week of the month. It was reported that those who did not receive food stamps either did not know they were eligible, had applied and been turned down, or did not know how or where to apply. FRAC also reported that between 1983 and 1984, there was an average monthly increase of 20.4 percent of the number of households served nationally by emergency food providers and a 17 percent per month increase between 1984 and 1985. As a result of budget cuts and changes in the law, FRAC concluded that the Food Stamp Program was neither assisting the eligible poor in an adequate fashion nor reaching the population most at risk of hunger.

The Harvard School of Public Health, after 15 months of research into the problem of hunger in New England, concluded in 1984 that:

(1) Substantial hunger exists in every State in the region;

(2) Hunger is far more widespread than generally has been realized; and

(3) Hunger in the region had been growing at a steady pace for at least 3 years and was not diminishing.

The researchers found that greater numbers of elderly persons were using emergency food programs and that many were suffering quietly in the privacy of their homes. The staff also expressed concern over what had been noted in medical clinical practice: Increasing numbers of malnourished children and greater hunger among their patients, including the elderly. The staff also cited the impact of malnutrition on health and stated that children and elderly people are likely to suffer the greatest harm when food is inadequate.

The Physicians' Task Force on Hunger in America, established in 1984, has issued periodic reports on the nature and scope of the hunger problem, including regional and group variations. Through the Harvard School of Public Health, it also has assessed the health effects of hunger and made recommendations to remedy the problem. The group's 1984 report concluded: (1) That hunger was reaching epidemic proportions across the Nation, (2) that hunger was worsening, and (3) that increasing hunger could be attributed to the Federal policies. The report estimated that up to 20 million Americans were hungry at least some period of time each month.

In 1986, the Task Force identified 150 "hunger counties" in the United States with high poverty levels and low food stamp participation. A high concentration of "hunger counties" was identified in the Midwest and North Central States. The report concluded that the level of participation in the Food Stamp Program appeared to be most closely related to a county's efforts to enroll the poor in the Program rather than the county's poverty rate.

Later that year, the Task Force issued another report examining barriers to participation in the Food Stamp Program to determine why food stamp coverage was declining when hunger was increasing. It concluded that, while poverty had increased between 1980 and 1985, food stamp participation by those eligible had decreased because of conscious Federal policy changes that resulted in barriers to food stamp participation, keeping State and local food

stamp programs from reaching more needy people. Many recommendations were made to provide outreach, increase access, and liberalize the program.

In 1987, the Physicians' Task Force on Hunger issued a report which noted that, despite 5 years of economic growth, hunger in America had not been reduced significantly. More people were living in poverty, many of them the working poor and the long-term unemployed, the report found. The Task Force cited a strong downward pressure on wages, with the share of after-tax household income dropping for every income category since 1980 except the highest 20 percent. Furthermore, new persons were entering the hunger ranks, including former oil workers in the South, farm families in the Midwest, service workers of California, and miners and steelworkers in the East and Midwest. The report also noted the several factors that may contribute to increased hunger: (1) 25 percent of the population lived at the poverty level at some time during the year, (2) the income gap between rich and poor families had reached its widest point in four decades, and (3) government programs designed to assist the poor had less impact in the mid-1980's than in 1979.

A study released in 1986 by Public Voice for Food and Health Policy found that the rural poor were less likely to consume adequate nutrients than were the nonpoor and that rural poor children experienced stunted growth at an alarming rate. Low birth weights and high infant mortality rates were found to be significantly higher in poor rural counties than in the rest of the Nation. Also, while many poor elderly persons live in rural areas, only 31 percent of these households receive food stamp benefits. The study also concluded that the rural poor were significantly less likely to participate in any public assistance programs.

In 1990, preliminary results of the Community Childhood Hunger Identification Project (CCHIP), a major ongoing scientific study of hunger among families with children, became available. Four CCHIP sites reported disturbing statistics regarding the prevalence of hunger among low-income families (ranging from 29 percent in Pontiac, MI, to 42 percent in Seattle, WA) and the number of poor families at risk of hunger (ranging from 67 percent in Pontiac to 80 percent in Hennepin County, MN).

Also in 1990, the U.S. Conference of Mayors released a 30-city survey of hunger and homelessness in urban areas. Local officials reported a 22 percent average increase in requests for food assistance. The vast majority of surveyed cities were forced to turn away needy persons due to inadequate resources. When asked to identify the principal causes of hunger, city officials most frequently cited employment-related problems which reduced household income and food purchasing power.

(A) STUDIES FOCUSING SPECIFICALLY ON HUNGER AMONG THE ELDERLY

According to medical experts on aging, malnutrition may account for substantially more illness among elderly Americans than has been assumed. The concern about malnutrition is rising fast as the numbers of elderly grow and as surveys reveal how poorly millions of them eat. The New York Times reported in 1985 that scien-

tists estimate that from 15 to 50 percent of Americans over the age of 65 consume fewer calories, proteins, essential vitamins, and minerals than are required for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in resistance to disease seen in elderly patients—a weakening in immunological defenses that commonly has been blamed on the aging process. Experts say that many elderly fall into a spiral of undereating, illness, physical inactivity, and depression. Recent findings suggest that much illness among the elderly could be prevented through more aggressive nutritional aid. In the view of some physicians, immunological studies hold promise that many individuals may lighten the disease burden of old age by eating better. Being poor also greatly exacerbates the effect of nutrition problems. Low participation in the Food Stamp Program leaves large numbers of Americans without enough to eat and the problems exist largely because many people who are eligible for food stamps are not receiving them.

A 1987 National Survey of Nutritional Risk Among the Elderly by the Food Research and Action Center found that 18 percent of the low-income elderly who responded said they did not have enough money to buy the food they needed, 35 percent usually ate less than three meals a day, and 5.4 percent were without food for more than 3 days in the last month. Yet about a third of this sample seldom or never participated in congregate meal programs and only about 25 percent participated in the Food Stamp Program.

A 1985 report by the GAO, based on research conducted by private organizations, USDA, and the President's Task Force on Food Assistance concluded that nonparticipation in the Food Stamp Program by many low-income households was attributed to factors including:

(1) Lack of awareness regarding household eligibility for the program;

(2) Relatively low benefit payments may provide little incentive for eligible elderly to apply;

(3) Administrative requirements such as complex application forms and required documentation;

(4) Physical access problems such as transportation or the physical condition of the applicant; and

(5) Attitudinal factors, including sensitivity to the social stigma associated with receiving food assistance.

Our 1982 study estimated that only 50 percent of the eligible elderly in the United States participate in the Food Stamp Program. Participation was especially low among elderly people who live alone, and the older people were, the less likely they were to participate. This may have been due to a lack of awareness of the household's eligibility for the program. Thirty-three percent of eligible nonparticipants believed they were not eligible for food stamps and another 36 percent were not sure.

(B) FOOD STAMP PARTICIPATION STUDIES

A November 1988 study by the Congressional Budget Office again indicates the low rate of participation in the Food Stamp Program by those eligible. According to then current census data, only 41 percent of eligible households and 51 percent of eligible individuals received food stamps in 1984. Eligibility conditions were, however, more strict at that time. Participation levels were the highest for very-low income households and individuals. Participation rates ranged from 67 to 90 percent for those who were eligible to receive over $100 in benefits per month. Eligible families with children also had higher participation rates, as many also participated in AFDC. Households with elderly members had lower participation rates of 34 to 44 percent. The lowest participation rates were for households without children or elderly members.

Studies released by GAO, in July and October 1988, examined and analyzed data regarding nonparticipation in the Food Stamp Program. Lack of information about the program and problems with administrative barriers were cited as the most common reasons for not taking advantage of the program. GAO examined eight, all of which found that the likelihood of household participation rates in the Food Stamp Program decreases as the age of the head of household increases, or as the number of the people aged 65 or older in the household increases. The GAO cited several administrative procedures which discouraged participation including: limited office hours and restricted interviewing schedules, requirements that households complete screening forms before filling out food stamp applications or being interviewed, failure of some offices to consider applicants for expedited benefits, and the lack of assistance in obtaining needed documents for applications.

In 1989, USDA's Food and Nutrition Service released two studies examining Food Stamp Program participation rates. USDA found that participation rates were not as low as some earlier studies had suggested. Nevertheless, it concluded that some vulnerable populations, including the elderly, experience very low participation rates. USDA findings included the following: (1) 66 percent of eligible individuals and 60 percent of eligible households participated in the Food Stamp Program in 1984; (2) participating households received 80 percent of all benefits that would have been paid, if all eligible households had participated; (3) 74–82 percent of eligible persons who had income to or below the poverty line were participating in the Food Stamp Program; and (4) only 33 percent of eligible elderly individuals participated in the Food Stamp Program.

2. PAST ENACTED AND PROPOSED RESPONSES TO HUNGER IN AMERICA

Drawing on the findings of these studies of the 1970's and 1980's, a number of recommendations for improvement and expansion of the Food Stamp Program were put forward in Congress, many of which were enacted into law in 1985 and 1988. In addition to amendments that reversed cut-backs made in the early 1980's, other improvements included a 3 percent add-on to food stamp benefit levels, additional benefits for those with high shelter and child care expenses, new employment and training programs for food stamp recipients, and restructuring the program's "quality control"

system (where States are subject to fiscal sanctions when they have very high rates of erroneous benefit and eligibility determinations).

Major proposals to increase participation and improve benefits in the Food Stamp Program were considered by Congress in 1990, but not enacted. These proposals included: increasing the current 3 percent add-on to 5 percent (an across-the-board increase in all recipients' benefits); targeted benefit increases for those with higher shelter or dependent care expenses and those receiving child support payments; provision for continued, unreduced benefits when eligibility lapses briefly during reapplication; greater protection for recipients suffering hardships, such as large rent increases; a reduction in the degree to which vehicles are counted as liquid assets; less restrictive rules for relatives sharing housing; and an increase in the asset limit for the disabled. Added Federal support for employment and training programs, automated date processing computerization, and outreach activities also fell by the wayside. Taken together, these proposals would have increased food stamp spending by some $4.5 billion over the next 5 years.

C. CONGRESSIONAL RESPONSE

1. APPROPRIATIONS

The Agriculture appropriations act for fiscal year 1993 (P.L. 102-341) provides $27.1 billion for food stamps, including a $2.5 billion "contingency" fund in case of unexpected increase in enrollment; it also grants $1.051 billion to Puerto Rico's NAP. In fiscal year 1992, Federal food stamp spending was $22.5 billion, and Puerto Rico was granted $1.013 billion.

2. 1992 LEGISLATION

The Senate Agriculture, Nutrition, and Forestry Committee approved its version of the Mickey Leland Childhood Hunger Relief Act (S. 757) and reported it on November 26, 1991 (S. Rept. 102-252). The bill would have made major changes in the Food Stamp Program at a cost of more than $6 billion over the next 5 years. The major amendments in this measure included provisions that would:

(1) Allow siblings and adult children living at home to apply for food stamps as separate households under the same terms applied to other relatives and unrelated persons living together;

(2) Raise the current 3-percent "add-on" to maximum food stamp benefits to 5 percent, providing an across-the-board increase to all recipients;

(3) Limit the degree to which amounts paid or received as child support are considered in determining food stamp eligibility and benefits;

(4) Eliminate the ceiling on the amount of shelter expenses households without an elderly or disabled member may have deducted when their benefits are determined, thereby increasing benefits to those with very high shelter expenses;

(5) Allow disabled households to have liquid assets of up to $3,000, as is now the case for the elderly; and

(6) Further limit the degree to which the value of a household is counted as an asset in judging eligibility.

The House Committee on Agriculture approved a similar measure (H.R. 1202) and reported it on November 27, 1991 (H. Rept. 102-396). Primarily because of differences in the timing of implementation under the House version of the Mickey Leland Childhood Hunger Relief Act, the House bill had somewhat lower costs.

With one major exception (the increase in the 3-percent add-on), the provisions of the Mickey Leland Act were approved by the House on August 6, 1992, as part of H.R. 3603, the "Children's Initiative." But the measure was not taken up by the Senate and died with the end of the 102d Congress.

Food stamp benefits are indexed for food price inflation every October. Each October's adjustment is based on food costs measured in the previous June. In late July 1992, June food prices were announced to be 1.3 percent lower than June 1991, thus requiring an October 1992 reduction in benefits. With no opposition from the Administration, legislation was enacted in August 1992 (P.L. 102-351) that prevented an October benefit reduction by freezing basic benefit levels through fiscal year 1993, although changes in individual household circumstances can still cause benefit increases or decreases.

D. REGULATORY AND JUDICIAL ACTION

The only major regulatory action in 1992 was the issuance of final regulations permitting States to change the way in which they issue food stamp benefits—from paper coupons to "electric benefit transfer" (EBT) systems. These systems, already in place in a number of pilot projects, provide benefits through the use of "ATM-like" cards that are issued to recipients. The cards are then used in grocery stores linked to a central computer and recipients' food purchases are deducted from their food stamp "account."

Because of the massive influx of new applicants in 1992, a number of State welfare offices fell behind schedule in processing applications in a timely fashion. This led to a number of court suits and judicial decisions forcing States to speed up their processing of food stamp applications.

E. PROGNOSIS

Given the large ($2.5 billion) contingency fund provided for fiscal year 1993, it is unlikely that major food stamp appropriations issues will come before Congress in 1993, although continued growth in participation could force another big increase in food stamp funding for 1994. It also appears unlikely that the Clinton Administration will come forward with substantial new food stamp amendments. Instead, Congress will probably re-visit the Mickey Leland initiatives that have been "on hold" since 1990, proposals for change in the food stamp "quality control" system, rules for approving retail grocery stores for participation. Congress may also move to integrate rules generated for the Food Stamp Program and other welfare programs.

Chapter 7

HEALTH CARE

OVERVIEW

This chapter is composed of five parts: (A) Health Care Costs and Utilization; (B) Medicare; (C) Medicaid and Long-Term Care; (D) Health Research and Training; and (E) Retiree Health Care.

Health care is one of the most pressing domestic issues facing the Congress and the new Clinton Administration, and the American public will be closely watching their elected representatives in 1993 with respect to their activities on this issue. In the next several months, the Congress and the Administration will undoubtedly begin to enact viable solutions to our health care system. These reforms will likely focus on making health care more readily available to the under- and uninsured, although the depth and breadth of these reforms is impossible to predict. The only relative certainty with respect to health care reform is that with health care costs climbing out-of-control, any changes would have to incorporate stringent cost-containment provisions to be considered true reform.

Two health care reform issues of particular interest and concern to the elderly are the costs of prescription drugs and the access and affordability of long-term care. For too long, we have ignored the impact that skyrocketing prescription drug prices are having on the ability of American citizens, especially the elderly, to afford life-saving medications. They are the highest out-of-pocket expenditure for three out of four elderly. Over 5 million Americans age 55 and older say that they have to make choices between buying food and paying for medications. To illustrate just how much drug prices have risen over the past 10 years, it is useful to compare the general inflation rate with the increase in prescription drug prices. Between 1982 and 1992, the general inflation rate was 46 percent, compared to a 143 percent increase in prescription drug prices in that same time period.

Unfortunately, long-term care threatens to become the forgotten issue. Between 9 and 11 million older Americans of all ages need some type of long-term care. Two-thirds of them are elderly, and the other third are under age 65. Most of these people are living at home, being cared for by families and friends. Access to affordable home and community-based long-term care is nearly nonexistent for most people. However, because of the enormous costs of providing these services to so many people, as well as a perception that access for the uninsured is the more pressing problem, fundamental changes to our long-term care delivery system are not likely to occur in the foreseeable future.

A. HEALTH CARE COSTS AND UTILIZATION

1. BACKGROUND

Prior to the mid-1970's, the cost of health care was not a major issue. Instead, expansion of access and the improvement of quality of care were foremost on the nation's health policy agenda. As costs began to skyrocket, however, policymakers began to realize that controlling these increases had to become a priority, and much more attention was focused on the adequacy of the return the Nation was getting for its enormous investment. Between 1965 and 1991, national health expenditures increased from nearly $41.6 billion (5.9 percent of gross national product) to $666.2 billion (12.2 percent of GNP).[1] Health care costs increased 10.5 percent from 1989 to 1991, and the rate of growth continues to increase. The U.S. Department of Commerce estimates that health care spending in 1992 will total $838.5 billion (an increase of 12 percent over the previous year), accounting for 14 percent of the Nation's economy. The Commerce Department also estimates that health care spending will increase 12 to 15 percent over the next five years unless significant changes in the health care system occur.

The role of the Federal Government in funding national health expenditures grew very rapidly in the 1960's. Between 1965 and 1967, Federal spending nearly doubled, rising from not quite 12 percent to nearly 24 percent of national health care spending. From 1967 to 1980, Federal spending rose gradually, reaching 29 percent in 1980. Since then, the Federal share of national health expenditures has remained very steady. The Federal Government paid $195.4 billion or 29.3 percent of the Nation's health bill in 1991.

Hospital care costs continue to be the largest component of the Nation's health care bill. In 1992, an estimated 38.5 percent ($323 billion) of national health care expenditures was paid to hospitals. Physicians were paid $157 billion for 19 percent of national health expenditures.[2]

Americans of all ages are healthier today than they were 10 to 20 years ago. While most older people report themselves to be in good to excellent health, many tend not to report specific health problems and mistakenly think they are caused by old age rather than disease. Yet age does affect a person's health, particularly the way the body reacts to disease and drugs.

Individual assessment of a person's own health is often the most important measure of health status. More than 70 percent of those over 65 report that they are in good, very good or excellent health. Family income is an important indicator of health status. For example, while 26 percent of those over 65 with family incomes of $35,000 and over report excellent health, only 10 percent of those with incomes under $10,000 do. The converse is also true; 15.6 per-

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[1] Levit, Katherine, Helen C. Lazenby, Cathy A. Cowan and Suzanne W. Letsch. "National Health Expenditures, 1990," *Health Care Financing Review*, Fall, 1991, Vol. 13, No. 1, p. 29.

[2] U.S. Department of Commerce, *1993 Industrial Outlook Report*.

cent of the poor elderly report poor health compared to 5.1 percent of their wealthy counterparts.[3]

Chronic diseases are a major threat to the independence of older persons. More than four out of five elderly have at least one chronic condition, and multiple conditions are commonplace among older people, especially older women. The five leading chronic conditions for the elderly in 1989 were arthritis, hypertension, hearing impairment, heart disease, and cataracts. Hospitalization of most older persons is caused by an acute episode of a chronic illness. Diseases of the circulatory, digestive, and respiratory systems, and cancer are the leading causes of hospitalization. Visits to the doctor also are most often for treatment of chronic conditions.[4]

The dimensions of the current health services use by the elderly only hint at future needs. Health services usage by the elderly is growing because of absolute increases in the total aged population, greater numbers of individuals in the eldest subgroup, and an increased number of services provided per person. Greater expectation of good health, the availability of third-party financing and increased access to medical advances such as renal dialysis and radiation therapy also are leading reasons for greater use of health services by the elderly.

Persons 65 and older, 12 percent of the population, account for more than one-third of the Nation's total personal health care expenditures. These expenditures represent total health care investment from all sources exclusive of research. In 1987 (the latest data currently available), total personal health care expenditures for the elderly were estimated at $162 billion and per capita spending reached $5,360. That represented a 13.6 percent average annual growth rate since 1977. It is particularly notable that older Americans spend as large a percentage of their income on health care needs (15 percent) as they did prior to the existence of Medicare.

Throughout the last two decades, the structure and delivery of health care have been plagued by perverse incentives, resulting in the over-utilization of services, inefficiency and waste. Led by the Federal Government, which faced major funding increases each year to pay for Medicare, Medicaid, and other health programs, third-party payers began to question whether large scale reform of health care was needed. In 1983, Congress and the administration created the prospective payment system (PPS) for Medicare reimbursement of hospitals, at the time the most dramatic change in Medicare reimbursement policy since its enactment.

Since the 1983 Medicare PPS reform, States have moved to adopt prospective payment methodologies for their Medicaid programs. Private payers, too, are supporting a hybrid of reimbursement reforms, ranging from prospective rate setting to innovative capitation schemes.

Facing continuing increases in payments to physicians, Congress in 1989 established a new payment system for physician services. Under this system, payments are to be made under a fee schedule

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[3] *Aging America: Trends and Projections, 1991.* Prepared by the U.S. Senate Special Committee on Aging, American Association of Retired Persons, Federal Council on the Aging, and the U.S. Administration on Aging. Department of Health and Human Services Publication No. (FCoA) 91-28001, p. 108.

[4] *Aging America,* p. 114.

based on a relative value scale (RVS) (a method of valuing individual services in relationship to each other). The RVS will be coupled with annual volume performance standards which are target rates of increase in physician expenditures. As with PPS, States and private payers are expected to adopt similar methods of reimbursement.

The health care arena is changing so rapidly on so many fronts that any broad characterization of it today is likely to be outdated tomorrow. Nevertheless, there is no question that the overriding concern influencing the Nation's health care system is cost containment.

(A) HOSPITALS

Hospital care for the aged cost $68 billion in 1987 (the most recent data available); this is an amount equal to $2,248 per capita. Medicare reimbursed about 70 percent of that total while other public funds paid about 15 percent of the bill. Private health insurance covered the remaining 15 percent.

Short hospital stays by the elderly increased by more than 57 percent between 1965 and 1986. In 1987, a survey of non-Federal short-stay hospitals revealed that 10.5 million elderly patients were discharged from hospitals, comprising 31.3 percent of all short-stay hospital patient stays. Those 75 and older accounted for 16.5 percent of short stays. According to the American Hospital Association national hospital survey, the average length of stay for elderly patients has declined, from 10.8 days in 1977 to an estimated 8.6 days in 1991.

Older persons tend to stay in the hospital approximately 50 percent longer than and twice as often as the general population. The average hospital stay for persons 65–74 was about 8.2 days in 1987 compared with 9.1 days for the 85 and older group.

The aging of the population will increase the demand for physician care. Projections show that demand will increase by 22 percent from 1986 from 250 million physician contacts to 304 million contacts by the year 2000 and by 129 percent (more than 570 million visits) by 2030.[5]

Because chronic conditions are likely to increase with age, the health care needs of the elderly are broad in scope and require the participation of a number of health care professionals who specialize in geriatrics and gerontology. In addition, nurses have substantial responsibilities for providing services to the elderly in a wide range of settings such as hospitals, long-term care settings, ambulatory care programs and day care programs. Dentists, social workers, and allied health care professionals also can actively contribute to the care of the elderly when they understand the needs of older patients. Available data, however, indicate that only a small fraction of professional health care schools have programs in geriatrics and gerontology.

[5] Ibid.

(B) PHYSICIANS' SERVICES

Utilization of physicians' services increases with age. Approximately 85 percent of the elderly living in the community had at least one contact with a physician in 1987. On average, the elderly are more likely than younger persons to make frequent visits to a physician. Persons 65 and older visit a physician nine times for every five times by the general population. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and older reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.[6]

Approximately 60 percent of physician visits by the elderly are made to a doctor's office. The remaining visits are divided among hospital emergency rooms, outpatient departments, and home and telephone consultations.

Spending for physician services to the elderly grew an average of 16 percent per year from 1977 to 1987, reaching a level of $33.5 billion in 1987.[7] Medicare spending accounted for an estimated 57.8 percent of the per capital expenditures (for the aged) for physician services in 1984 ($504 out of a total $868). During the period from 1980–83, Medicare physician expenditures increased (adjusted for inflation) at an average annual rate of 12 percent, compared to 6.5 percent for all physician expenditures. From 1983 to 1986, expenditures increased at an average annual rate of 9.1 percent and 7.2 percent, respectively.[8] The different rates of increase in expenditures suggest that Medicare beneficiaries receive a higher volume of physician services than the rest of the population.

(C) PRESCRIPTION DRUGS

Significant attention continued to be focused in 1992 on the ability of older Americans to afford prescription medications. Studies released throughout the year by the AARP, Families USA, and the Senate Special Committee on Aging suggested that millions of older Americans were going without medications that they needed to take every day to maintain life. The report released by AARP in July was entitled "A Survey on the need for an Outpatient Prescription Drug Program Under Medicare." The report released by the Senate Aging Committee in August was entitled "Accessibility and Affordability of Prescription Drugs for Older Americans." The Families USA report, released in September, was called "Prescription Costs: America's Other Drug Crisis."

These reports concluded that many older Americans are unable to obtain their prescription drugs because of woefully inadequate public and private prescription drug insurance for this population group, and continuing levels of excessive prescription drug price inflation at the manufacturers' level.

Two other reports were also released by the General Accounting Office (GAO) in 1992 concerning prescription drug prices. One

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[6] U.S. Senate Special Committee on Aging, America in Transition: An Aging Society. Washington, D.C., U.S. Govt. Print. Off., Sept. 1989, p. 96.

[7] Waldo, Daniel R., et al. Health Expenditures by Age Group, 1977 and 1987. Health Care Financing Review, Vol. 10, No. 4, Summer, 1989, page 114.

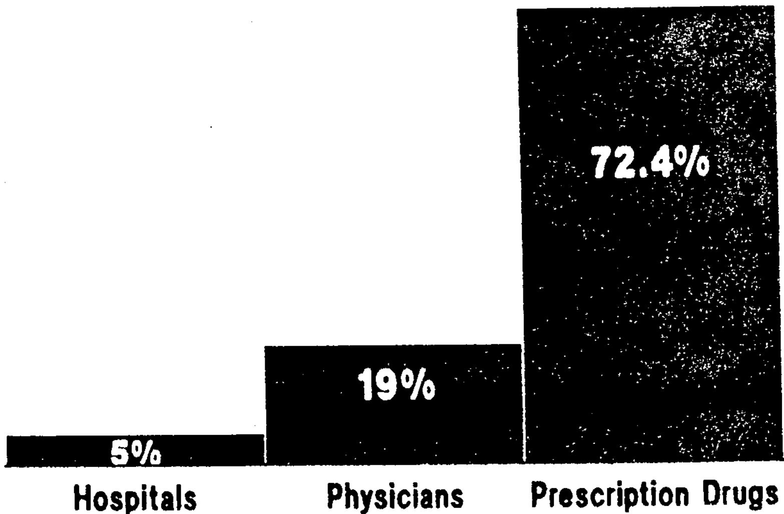
[8] Ibid., p. 112.

report analyzed the reasons that manufacturers reported were responsible for the high cost of the top-29 most widely prescribed medications in the United States. The other report compared prices for prescription drugs in the United States with the prices for the same drugs in Canada. The results of these reports are described later in this section.

It is not surprising that millions of older Americans have been affected by prescription drug costs and escalating prescription drug prices. In the United States, most hospital and physician service costs are paid for either by private health care insurance or publicly funded health care programs, such as Medicare and Medicaid. Because of extensive insurance coverage for these health care services, only 5 percent of hospital costs are paid out-of-pocket, and only 19 percent of physician service costs are paid out-of-pocket in the United States (Chart 1).

Chart 1

More Than 70% Of All Prescription Drug Costs Are Paid Out Of Pocket



However, according to the AARP report, for Americans 65 and under, about 54 percent of all prescription drug costs are paid out-of-pocket. Private insurance plans cover only 32 percent of prescription drug costs for this population group, while government programs, such as Medicaid, cover only about 10 percent. The percentage of out-of-pocket drug costs paid by older Americans—those over 65—is even higher, rising to 64 percent. Only 22 percent of this group's drug costs are paid by private insurance, and Medicaid covers only about 9 percent of drug costs for this population group.

As a result of escalating prescription drug prices, the high percentage of drug costs paid out-of-pocket, and the lack of adequate drug insurance coverage, the AARP report found that about 8 million Americans over 45 now say that they have to cut back on necessary items such as food or fuel to pay for their medications. The report also found that about 18.4 million older Americans over 65 report that they have trouble paying for their medications.

Most Americans under 65 usually take prescription medicines for an acute, short-term condition, such as an infection or cough. However, most older Americans have to take multiple prescription drugs to treat chronic, long-term medical conditions such as hypertension, arthritis, glaucoma, or diabetes. For this reason, not only are prescription drugs the highest out-of-pocket medical cost for older Americans, they are also the highest out-of-pocket long-term care medical cost for most older Americans. Every drug included in the list of top 20 drugs taken by older Americans, as reported in the Families USA study, is used to treat chronic, long-term medical conditions.

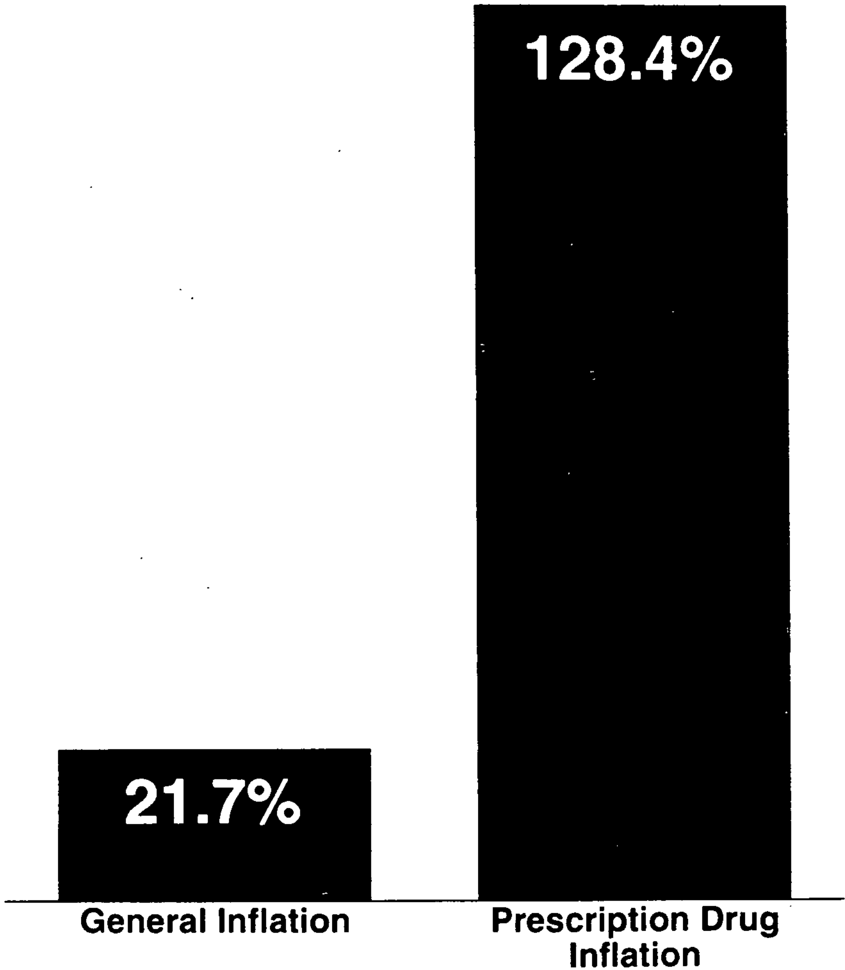
The reasons that older Americans are having an increasingly difficult time obtaining the medications that they need can be summarized as follows:

(1) Drug Price Inflation Has Been Significant

In general, drug prices have increased three times the rate of general inflation over the last 12 years. From 1980 through 1992, while the general inflation rate in the economy was 22 percent, drug prices increased at the retail level by 128 percent (Chart 2); more than six times the amount.

CHART 2

Prescription Drug Inflation Increased Six Times General Inflation 1980-1992



Source: Bureau of Labor Statistics

The data reported above reflect the overall average inflation rate for a specific marketbasket of prescription drugs during the period of time specified. However, the report released by Families USA found that, from 1985 through 1991, prices increased by 79 percent on the top 20 most widely prescribed drugs taken by older Americans, while the overall inflation rate during this time was just 21 percent, one-fourth the amount. Many of these drug products in the top-20 group were still on patent, meaning that older Americans could not ask their physician to prescribe lower-priced generic substitutes.

Many brand-name prescription drugs most frequently prescribed for older Americans have increased in price significantly over the past 6 years, and lower-priced generic alternatives are not yet available on the market (Table 1). Although not all drugs in the Families USA top-20 prescription drugs are still on patent, it is widely known that the generic equivalents of some of these drugs may not work as well as the brand name. This effectively means that, in many cases, there are no choices for older Americans when one of these drugs are prescribed, even if generics are available. Examples of these drugs which are not on patent, but which are still inflating at significant rates include Synthroid and Persantine.

TABLE 1.—MAJOR BRAND NAME PRESCRIPTION DRUGS COMING OFF PATENT, 1992–95

Brand Name, Manufacturer & Use	Generic Name	Month of Patent Expiry	1991 U.S. Sales (Estimated) [In Millions]
	1992		
Dolobid (Merck) [antiarthritic]	diflunisal	January	$40
Feldene (Pfizer) [antiarthritic]	piroxicam	April	$295
Procardia XL (Pfizer) [heart medication]	nifedepine	September	$808
Cardizem SR (Marion) [heart medication]	diltiazem	November	$350
Ceclor (Eli Lilly) [antibiotic]	cefaclor	December	$550
	1993		
Voltaren (Ciba-Geigy) [antiarthritic]	diclofenac	January	$355
Lopid (Parke-Davis) [cholesterol]	gemfibrozil	January	$350
Ansaid (Upjohn) [antiarthritic]	flubiprofen	February	$140
Corgard (Bristol-Myers) [heart medication]	naldolol	September	$130
Xanax (Upjohn) [antianxiety]	alprazolam	October	$465

TABLE 1.—MAJOR BRAND NAME PRESCRIPTION DRUGS COMING OFF PATENT, 1992-95—Continued

Brand Name, Manufacturer & Use	Generic Name	Month of Patent Expiry	1991 U.S. Sales (Estimated) [In Millions]
Halcion (Upjohn) [antianxiety]	triazolam	October	$100
Lopressor (Ciba-Geigy) [heart medication]	metoprolol	December	$250
Naprosyn (Syntex) [antiarthritic]	naproxen	December	$480
Anaprox (Syntex) [antiarthritic]	naproxen sodium	December	$185
	1994		
Diabeta (Hoechst) [antidiabetic]	glyburide	January	$135
Seldane (Marion) [antihistamine]	terfenadine	March	$530
Tagamet (SmithKline) [antiulcer]	cimetidine	May	$640
Micronase (Upjohn) [antidiabetic]	glyburide	May	$215
Vancenase (Schering) [antiasthma]	beclomethasone	August	$110
Vanceril (Schering) [antiasthma]	beclomethasone	August	$50
Clozaril (Sandoz) [schizophrenia]	clozapine	September	$40
	1995		
Capoten (Bristol-Myers) [heart medication]	captopril	August	$580
Zantac (Glaxo) [antiulcer]	ranitidine	December	$1,530
Sandimmune (Sandoz) [transplant rejection]	cyclosporin	September	$250

Source: Generic Pharmaceutical Industry Association and C.J. Lawrence, March 23, 1992, Number 92-3.

(2) Older Americans Have High Out-of-Pocket Drug Costs

The median household income of an older American is estimated to be about $8,781. With an average prescription price of about $20, prescription drug bills readily mount for an older American taking 10 to 15 prescriptions each year. In fact, if an older person took just 10 prescriptions a year, and had no insurance coverage, that individual would spend 27 percent of his/her income ($2,400/$8,781) on prescription drugs. In reality, it is estimated that the average older American takes 15 prescriptions each year, four times more than the average Americans (Chart 3).

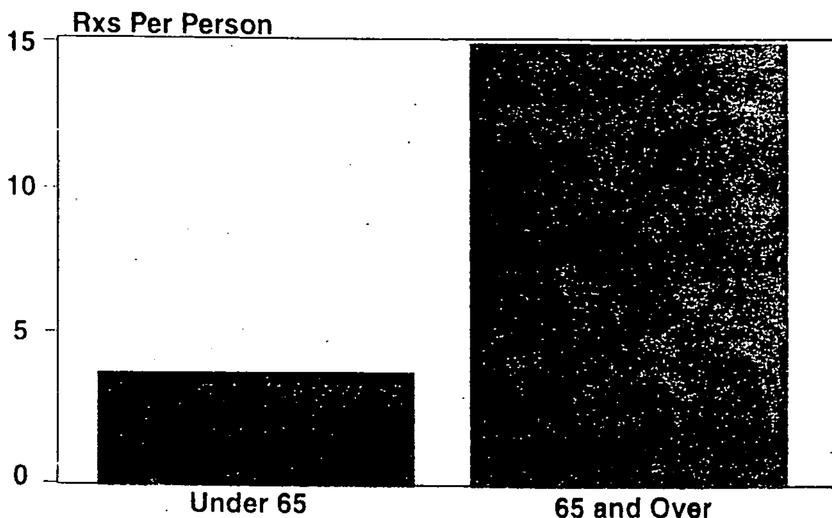
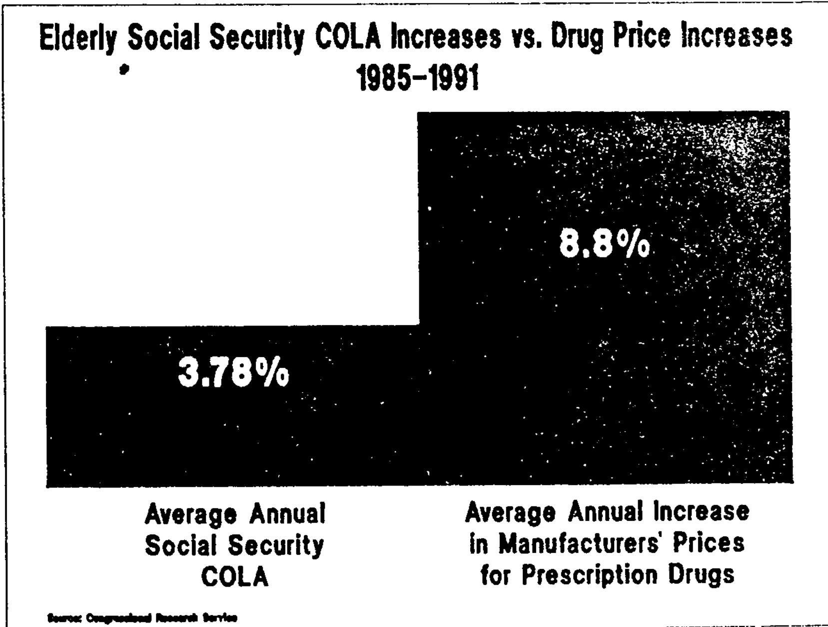


Chart 3

In addition, prescription drug price increases have far outpaced the increases in the average older American's buying power. For example, while the average annual Social Security Cost-of-Living Adjustment (COLA), was about 3.78 percent from 1985 through 1991, prescription drug prices have increased by an annual average rate of 8.8 percent over the same period (Chart 4). Because of this, data from the AARP leads to the conclusion that over 5 million older Americans now say that they have to make choices between buying food and paying for their prescription drugs.

Chart 4



The report released by Families USA used data from the 1987 National Medical Expenditures Survey (NMES) to estimate out-of-pocket spending among older Americans for prescription drugs. The report found that the average annual prescription drug expenditures among those older Americans that used prescription drugs in 1987 was $588. When this is updated to 1992, the average increases to $879.

However, hardest hit by outpatient prescription drug costs are older Americans in the two lowest income quintiles. For example, the average annual prescription drug expenditure among those older Americans in the lowest income quintile (median income=$3,826) that used prescription drugs was $614 in 1987, or $917 if updated to 1992. Prescription drug expenditures represented 16.1 percent of the total median income of this group of older Americans in 1987, or 20.7 percent if updated to 1992. Because many older Americans in the lowest income quintile may not qualify for Medicaid or do not have the means to afford outpatient prescription drug insurance, it is assumed that most of these drug expenses are paid out-of-pocket.

For the second lowest income quintile, with a median income of $10,280, average annual out-of-pocket costs among prescription drug users was $597, and $891 if updated to 1992. As a percentage of median income, these amounts represent 5.8 percent in 1987 and 7.5 percent in 1992.

It is clear that, while many older Americans are having a tough time paying for their drugs, it is the poorest older Americans who are not covered by the Medicaid "safety-net" or private health insurance that are having to make the tough choices between buying drugs and other necessities of life.

(3) Private and Public Drug Insurance Coverage for Older Americans Is Inadequate

Contributing to the prescription drug access problem afflicting older Americans is the paucity of public and private insurance coverage for medications. Over 50 million Americans—including 16 million elderly—have no insurance coverage whatsoever for prescription drugs.

The AARP report found that about 43 percent of older Americans age 55 and over have no prescription drug coverage. That means 23 million older Americans are left exposed to potential financial catastrophe from exorbitant medication bills.

The problem is worse for older Americans over age 75. Only 40 percent of this population group has drug insurance coverage, leaving 8 million older Americans in this age group without drug coverage. In general, more older Americans have prescription drug coverage from private insurance sources rather than public or government-financed prescription drug insurance.

(a) Status of Private Insurance for Drug Coverage

On the private insurance side, many insurers do not include prescription drug coverage in their plans because of the rapidly escalating costs of prescription drugs. An exception to this is employer-based health insurance plans, which frequently do cover the cost of prescription drugs for older Americans that are either currently employed by or retired from the company.

Some Medigap plans, which many older Americans purchase to supplement their Medicare insurance, include coverage for outpatient prescription drugs. However, even if these Medigap plans do cover drugs, they often provided little financial relief because of high deductibles and copayments requirements that a patient has to incur to realize the full benefit of the coverage.

In the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508, OBRA 1990) Congress required that all States comply with new standards for Medigap insurance plans by July 1992. The new law simplifies the multitude of current Medigap policies by limiting the types of plans that can be sold and by specifying the minimum benefits that each plan can contain. All new Medigap policies must match 1 of 10 standardized benefit plans. Under these reforms, 3 of the 10 plans require that outpatient prescription drug coverage be provided as a benefit. Two of the plans require "basic" outpatient prescription drug coverage; the other requires "extended" coverage.[9]

Basic Coverage.—Under the basic coverage option, the patient would pay an annual $250 deductible, after which the plan would pay 50 percent of outpatient prescription drug

[9] 1992 Medicare and Medigap Update, United Seniors Health Cooperative, Washington, DC.

charges up to $1,250 in any calendar year. Under this coverage option, a patient would have to incur prescription drug costs of $2,750 to receive the maximum benefit of $1,250.

Extended Coverage.—Under the extended coverage option, the patient would pay an annual $250 deductible, after which the plan would pay 50 percent of outpatient prescription drug charges up to $3,000 in any calendar year. Under this coverage option, a patient would have to incur prescription drug costs of $6,250 to receive the maximum benefit of $3,000.

Unfortunately, many older Americans are unable to afford the additional premiums needed to pay for Medigap drug coverage. In addition, many older Americans do not have thousands of dollars in drug costs each year, but still have a very difficult time paying for their prescription drugs because their medication bills are a high percentage of their overall income. These older Americans would incur significant costs for this Medigap coverage, but would rarely realize the full benefit of the coverage. In the final analysis, Medigap plans cannot be relied on to fill the prescription drug coverage void for many older Americans that have significant out-of-pocket prescription drug costs relative to their income levels.

(b) Status of Public Prescription Drug Coverage

In contrast to the United States, publicly funded (government) health care programs in other industrialized nations pay for the majority—if not all—of outpatient prescription drug costs. For example, 100 percent of prescription drug costs are paid for by publicly funded programs in Australia, Japan, and Italy; 99 percent in Austria; 98 percent in France; 92 percent in Germany; but only 12 percent in the United States, primarily through the State-based Medicaid programs for the poor.

The report of the Senate Aging Committee found that Medicaid covers the cost of prescription drugs for only about 16 percent—or 1.9 million older Americans—that are classified as poor or near poor. About 10 million poor or near poor older Americans do not qualify for Medicaid and its prescription drug program. Therefore, while Medicaid can help to pay for the medication costs of some of the poorest of the poor, many poor Americans that are not eligible for Medicaid have high prescription drug bills and no means to pay for them.

There are 10 States that have established pharmaceutical assistance programs (PAPs) for the elderly. These programs help to provide drug coverage to older Americans that have high out-of-pocket drug costs relative to their income, but are ineligible for Medicaid or do not have private insurance. A more indepth description of the Medicaid outpatient prescription drug program and the State-based PAP programs is included in the Medicaid section of this report.

Taken together, these factors mean that while pharmaceuticals remain the most frequently used medical intervention in the health care system, they are often inaccessible or are used inappropriately by older Americans due to their high cost and poor insurance coverage. Some older Americans taking multiple medications at the same time are not able to fill or refill all the prescriptions they need because they simply can not afford them. Other older

Americans reduce their drug costs by only taking half the dose they need, while others cut tablets in half. Clearly, the cost of drugs has jeopardized the health of many older Americans who are unable to afford them.

(4) GAO Report on Prescription Drug Price Increases

Another report about the high cost of medications was released in August by the GAO. The report, entitled "Prescription Drugs: Changes in Prices for Selected Drugs" was requested by Congressman Byron Dorgan (D–ND) and Congressman Pete Stark (D–CA). In that report, manufacturers of 29 widely used prescription drugs were asked to explain the reasons for the significant price increases on these products over the last few years. The most often-stated reasons by drug manufacturers for their price increases included: increased research and development costs; the need to pay for expanded manufacturing capabilities; and an increased value to the drug due to the FDA approving a new use for the product.

Some of the drugs most commonly used by older Americans were among those drugs whose prices increased fastest during the 6-year period ending December 31, 1991. For example, the price of Parke-Davis' Dilantin, a popular drug used to treat epilepsy, increased in price almost 350 percent during that time. Another drug made by this manufacturer, Nitrostat, used to treat angina, increased in price 274 percent. Coumadin, made by DuPont Merck, used to prevent blood clotting, increased in price 218 percent. The manufacturers did not provide sufficient information to the GAO to determine whether the stated reasons for the price increases were justified.

(5) GAO Report on United States/Canada Drug Price Comparisons

In October, the GAO released a report comparing the differences in prices for prescription medications between the United States and Canada. The report was entitled "Prescription Drugs: Companies Typically Charge More in the United States Than in Canada." It found that, on average, prescription drug prices in the United States are 32 percent higher than those in Canada. Four of the top ten selling drugs in the United States cost between 59 and 278 percent more in the United States than Canada. These were Synthroid (278 percent), Xanax (183 percent), Premarin (162 percent), and Ceclor (59 percent).

Many of the widest price differentials between the two countries were for drugs commonly taken by the elderly. For example, the price of Ativan, a popular anti-anxiety medication made by Upjohn, was 702 percent higher in price than in Canada. Inderal, made by Wyeth-Ayerst and used to treat angina and hypertension, was 251 percent higher in price than in Canada.

The differences in prices, the report concluded, are not related to manufacturers' cost, but rather are largely attributable to actions taken by Canada's federal and provincial governments to contain the cost of drugs. First, Canada has established a Patent Medicines Prices Review Board (PMPRB) which sets guidelines for manufacturers to follow in pricing their products. Since the establishment of the Board in 1987, prescription drug price increases have

dropped sharply, and are now increasing at about the same rate as the general rate of inflation in that country.

In addition, the various provincial governments—all of which have some type of publicly funded drug benefit—use their significant buying power to lower the prices of drugs to the various drug plans. Provincial officials can remove drugs from the list of reimbursable drugs if the price of the drug is considered excessive, or if the manufacturers refuse to bargain over the price of the drug.

The data in the new GAO report have confirmed earlier studies of significant drug price differences between the United States and Canada.

(6) Drug Manufacturer Indigent Patient Programs

To increase access to drugs for Americans that cannot afford their medications, a number of pharmaceutical manufacturers have developed programs to help make medications more available free of charge. The programs are commonly referred to as "indigent patient programs." It is laudable that pharmaceutical manufacturers have, for several years, voluntarily offered programs to assist some of the poorest Americans obtain life-saving medications. However, the level of awareness of these manufacturers' programs appeared to be minimal among older Americans and the agencies that have been established to provide social services to this population group. The programs are usually promoted to the physician through word-of-mouth by the local sales representative of the pharmaceutical manufacturer, and are rarely promoted to the indigent patients who need them the most. As a result, only a very small number of indigent patients are benefiting from the programs at this time.

To make older Americans and other indigent vulnerable populations more aware of these programs, the U.S. Senate Special Committee on Aging surveyed pharmaceutical manufacturers for information about their indigent patient programs. The Committee then published a Directory of these manufacturers' programs. Information from each manufacturer that responded to the survey is included in the Appendix part of this report. The manufacturers and their programs are listed in alphabetical order by manufacturer.

While the level of awareness of these programs certainly needs to be increased, it is encouraging to note that almost all major, brand name pharmaceutical manufacturers reported that they have programs that provide prescription drugs free of charge to indigent patients. A brief summary of how these programs operate is provided below.

(a) Drugs Covered Under the Programs

Drug companies generally make all their prescription products available free of charge to indigent patients through these programs. In general, some drug manufacturers reported that they have well-defined, well-structured indigent patient programs, while other manufacturers reported that they have programs that make drugs available to indigent patients on an informal ad hoc basis through the request of the physician. The programs generally do not make controlled substances available, such as narcotic drugs.

Some companies have established special programs for certain drugs that may be very expensive, or treat particular populations, such as cancer or AIDS patients.

Because many indigent patients receive fragmented health care—that is, they see multiple physicians or pharmacists, or receive care in a busy clinic or emergency room—samples may not always be available, or the samples that were dispensed may not be properly recorded on the patient's chart. This makes it much more difficult to track a patient's drug therapy. In the final analysis, drug samples are primarily expensive marketing tools for pharmaceutical manufacturers and are not a substitute for an indigent patient program that provides a full course of therapy for the patient's condition at the time of need.

(b) Patient Eligibility

Many of the programs simply require that the physician determine that the patient is indigent and cannot afford the drugs prescribed. Some programs require the physician to write a letter to the company stating that the patient is indigent, and include a prescription for the products requested. Other programs, especially for those drugs that are expensive, require either the physician or patient to enroll in a program, or qualify for a program by meeting certain income and asset criteria. Some companies have established toll-free numbers that patients and physicians can call to enroll in these programs.

Many of the programs require that the patient be ineligible for private health insurance, third party coverage, Medicaid, or Medicare before they qualify for an indigent patient program. Unfortunately, as was described in the first section of this report, while some indigent patients—especially older and disabled Americans—may qualify for Medicare, outpatient prescription drugs are not covered under Medicare. Therefore, it would be unfair to deny indigent patients access to any of these programs simply because they qualify for Medicare. Of course, because of their financial status, most indigent patients would be unlikely to purchase supplemental insurance coverage that would cover the cost of outpatient prescription drugs. However, if an indigent patient has some form of health care insurance that does not cover prescription drugs, then that patient should be eligible to receive drugs under a drug manufacturer's indigent patient program.

A few programs require that the physician treat the patient as indigent before the drug manufacturer will provide the drugs free of charge to that patient. That is, the physician is also required to waive his or her fee for treating the indigent patient. These programs, however, indicate that they usually honor the physician's determination that the patient is indigent even if the physician does not waive his or her fee.

(c) How the Indigent Patient Obtains the Drugs

Most of the programs require that the physician make initial contact with the company either directly or through the local sales representative to obtain the drugs for the indigent patient. The drugs are then delivered to the physicians' office, and then distrib-

uted to the patients. In some cases, injectable drugs and hospital-only drugs are delivered to the hospital if they are administered in that setting to a patient that is uninsured.

Even if there is increased awareness of indigent patient programs among patients and health care professionals, the mechanism by which almost every company delivers drugs to the indigent patient is through the physician's office. Unfortunately, this does not allow patients to get their drugs in a timely manner. This distribution system significantly reduces the goal of providing access to drugs to indigent patients which the companies say that they are committed to doing. It may take several weeks to get the drugs to the patient through the physician. In addition, indigent patients may not have a regular physician if they are receiving care through clinics or emergency rooms. In these cases, patients may never receive their medications.

A better way to provide prescription drugs to indigent patients under these programs is to have them dispensed to patients by pharmacists. Such an approach would allow the patient to receive the drug in a timely fashion. It would also help the pharmacist monitor the patient's drug therapy if the indigent patient is seeing multiple physicians and taking multiple medications. Pharmaceutical manufacturers should then reimburse the pharmacists for the cost of the product and provide a dispensing fee based on the pharmacist's usual and customary dispensing fee, as one drug manufacturer does in its indigent patient program.

(d) Number of Patients Covered

In general, the data reported by the companies about the number of indigent Americans that are participating in these programs leads to the conclusion that only a small number of Americans that qualify for these programs are actually taking advantage of them. This may be the case for many reasons. First, indigent patients may often receive care in emergency rooms or other facilities in which they see multiple physicians. Thus, the fragmented care that they receive often times does not allow them to establish a professional relationship with a health professional who can provide continuity of care. Many of the physicians may therefore be unaware of the patient's financial situation, or the patient's drug history.

Second, many indigent patients themselves are unaware that these programs exist, and do not ask physicians or pharmacists about them. Even if patients do know about these programs, many may feel uncomfortable asking for "free drugs," and may feel too "proud" to admit that they are unable to afford their drugs. Finally, drug manufacturers need to do a much better job of promoting these programs to the public at large—including the medical and pharmacy profession—and improving the operation of these programs to make them more accessible and practical for patients.

A primary target for publicizing these programs should be community-based health clinics, organizations such as Area Agencies on Aging, and other home-care agencies, that provide services to older Americans. Often times, caregivers of older Americans are the first ones to recognize that drugs are not taken properly be-

cause older Americans do not know how to take them, or because they cannot afford to take the drugs as prescribed.

On October 5th, the CBS Evening News ran a special segment on drug manufacturer indigent patient programs and the availability of the directory from the Aging Committee. Since that time, the Aging Committee has received over 60,000 requests for the publication. The overwhelming response to the directory developed by the Committee is testimony to the number of Americans of all ages that are having a tough time paying for their medications.

In response to the survey done by the Aging Committee, the Pharmaceutical Manufacturers Association (PMA) did a similar survey of its member companies' indigent patient programs. Shortly before the Aging Committee released its directory, the PMA distributed its directory of indigent patient programs to physicians. The PMA established a toll-free hot line that physicians could call to obtain more information about individual manufacturer indigent patient programs. The toll free number is 1-800-PMA-INFO. Indigent individuals should not call this number or any manufacturer's number on their own, but should work with their physician to determine if they are eligible for a particular program.

B. MEDICARE

1. BACKGROUND

Medicare was enacted in 1965 to insure older Americans for the cost of acute health care. Over the past two decades, Medicare has provided millions of older Americans with access to quality hospital care and physician services at affordable costs. In fiscal year 1992, Medicare insured approximately 35.8 million aged disabled individuals at an estimated cost of $130.9 billion ($145.9 billion in gross outlays offset by $15 billion in beneficiary premium payments). Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

Medicare (authorized under title XVIII of the Social Security Act) provides health insurance protection to most individuals 65 and older, to persons who have been entitled to Social Security or railroad retirement benefits because they are disabled, and to certain workers and their dependents who need kidney transplantation or dialysis. Medicare is a Federal program with a uniform eligibility and benefit structure throughout the United States. Protection is available to insured persons without regard to their income or assets. Medicare is composed of two parts—the Hospital Insurance (HI) Program (Part A), and the Supplementary Medical Insurance (SMI) Program (Part B).

As insurance for short-term acute illness, Medicare covers most of the costs of hospitalization and a substantial share of the costs for physician services. However, Medicare does not cover all of the hospital costs of extended acute illnesses and does not protect beneficiaries against potentially large copayments or charges above the Medicare payment rate for physician services. Approximately 70 percent of aged Medicare beneficiaries have private supplemental coverage, often referred to as Medigap insurance.

One of the greatest challenges in the area of Medicare policy in the 1990's will be the need to rein in program costs while assuring that elderly and disabled Americans have access to affordable, high quality health care. As a result, the development of Medicare policy has been marked with a number of both achievements and frustrations over the past few years.

Most notable among the achievements are physician payment reform and major rural health care initiatives, including the elimination over 5 years of the urban-rural hospital payment differential. The 5-year budget agreement that became the Omnibus Budget Reconciliation Act of 1990 or (OBRA 1990), included some Medicare program expansions, such as coverage for mammography screening and hospitalization services in a community mental health center. There was also a successful effort to keep increases in beneficiary out-of-pocket costs to a minimum.

The frustrations included the repeal of the Medicare Catastrophic Coverage Act (MCCA) in 1989, the lack of enthusiasm surrounding the release of the Pepper Commission report, and the Medicare provider cuts of $34 billion over 5 years included in OBRA 1990. Because OBRA 1990 was a 5-year agreement, no substantive changes to the Medicare program are expected during that period. Most Members of Congress considered the agreement made under OBRA 1990 with regard to the Medicare program to be ironclad—in other words, few, if any major cuts would be made during this period, and program expansions would occur only if an equal reduction were made elsewhere.

In the 102nd Congress, no Medicare-related legislation was passed. In fact, although the Congress was able to include some relatively noncontroversial technical corrections provisions in the Urban Aid bill (H.R. 11) in late 1992, the President vetoed it. As a result, the Medicare program was neither weakened nor strengthened. While this was the case in the 102nd Congress, it remains to be seen if Medicare will be changed in 1993 and beyond. It is conceivable, however, that the varying interests to improve the program, cut its costs, and to score potential points in an election year will produce a stalemate that will provide little more than relatively modest changes to the program.

(A) HOSPITAL INSURANCE PROGRAM (PART A)

Most Americans age 65 and older are automatically entitled to benefits under Part A. For those who are not automatically entitled (that is, not eligible for monthly Social Security or railroad retirement cash benefits), they may obtain Part A coverage providing they pay the full actuarial cost of such coverage. The monthly premium for those persons is $221 in 1993. Also eligible for Part A coverage are those persons receiving monthly Social Security benefits on the basis of disability and disabled railroad retirement system annuitants who received such benefits for 2 years.

Part A is financed principally through a special hospital insurance (HI) payroll tax levied on employees, employers, and the self-employed. In 1993, each worker and employee will pay a tax of 1.45 percent on the first $135,000 of covered earnings. The self-employed pay both the employer and employee shares. In fiscal year 1993,

payroll taxes for the HI Trust Fund will amount to an estimated $87.3 billion, accounting for 87.8 percent of total HI financing. Interest payments, transfers from the Railroad Retirement Account and the general fund along with premiums paid by voluntary enrollees equal the remaining 12.2 percent. An estimated $84.4 billion in Part A benefit payments will be made in fiscal year 1993.

Benefits included under Part A, in addition to inpatient hospital care, are skilled nursing facility care, home health care, and hospice care. For inpatient hospital care, the beneficiary is subject to a deductible ($676 in 1993) for the first 60 days of care in each benefit period. For days 61–90, a coinsurance of $169 is required. For hospital stays longer than 90 days, the beneficiary may elect to draw upon a 60-day "lifetime reserve;" a coinsurance of $338 is required for each lifetime reserve day. (Please see Section C of this chapter for a more detailed discussion of the other Part A benefits.)

Hospitals are reimbursed for their Medicare patients on a prospective basis, which has been an issue of great debate on Capitol Hill for several years. The Medicare prospective payment system (PPS) pays hospitals fixed amounts that correspond to the average costs for a specific diagnosis. PPS uses a set of 487 diagnosis related groups (DRG's) to categorize patients for reimbursement. The amount a hospital receives from Medicare no longer depends on the amount or type of services delivered to the patient, so there no longer are incentives to overuse services. If a hospital can treat a patient for less than the DRG amount, it can keep the savings. If the treatment for the patient costs more, the hospital must absorb the loss. Hospitals are not allowed to charge beneficiaries any difference between hospital costs and the Medicare DRG payment.

(B) SUPPLEMENTAL MEDICAL INSURANCE (PART B)

Part B of Medicare, also called supplemental medical insurance, is a voluntary, non-means tested program. Anyone eligible for Part A and anyone over age 65 can obtain Part B coverage by paying a monthly premium ($31.80 in 1992 and $36.60 in 1993). Part B covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, durable medical equipment and certain other services. Part B is financed by a combination of beneficiary premiums, deductibles, and copayments, general revenues, and Part B trust fund interest. Under current law, premiums must cover 25 percent of program costs (i.e., actual program outlays); the remaining 75 percent are funded from general revenues.

In 1991, approximately 32.8 million people were covered under Part B. General revenue contributions totaled $33 billion, accounting for 72 percent of all income. Another 24.7 percent of all income was derived from premiums paid by participants, with interest payments accounting for the remaining 3.3 percent. Of the $44 billion in disbursements, $42.5 billion (96 percent) was for benefit payments while the remaining $1.5 billion (4 percent) was for administrative expenses.

When Congress created Medicare in 1965, it established reimbursement principles for physicians' services on the basis of reasonable charges. Under reasonable charge reimbursement principles, payment is equal to the lowest of these three elements: a physi-

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cian's actual charge for a service; what the physician usually charges for that service; and what other physicians practicing in the same community generally charge for that service. Under that payment system, phased out in January 1992, a separate payment was made for each individual service rendered.

The Omnibus Budget Reconciliation Act of 1989 made substantial changes in the way Medicare will pay physicians. The new law provides for the establishment of a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. The RVS is coupled with annual volume performance standards which are target rates of increase in physician expenditures. Also included in the reform were limits on actual charges to provide protection to beneficiaries from large extra-billing amounts and a program of outcomes and effectiveness research.

To provide beneficiaries with the opportunity to select a physician who has agreed to accept Medicare's "assigned" rate, the Deficit Reduction Act of 1984 (DEFRA, P.L. 98-369) established the concept of the participating physician. A participating physician voluntarily enters into an agreement with the Secretary of the Department of Health and Human Services to accept assignment (Medicare's allowable reimbursement rate) for all services provided to all Medicare patients for a 12-month period. If assignment is accepted, beneficiaries are not liable for any out-of-pocket costs other than standard deductible and coinsurance payments. In 1989, 40.2 percent of doctors were participating physicians.

(C) PEER REVIEW ORGANIZATIONS

Hospitals are required to enter into agreements with peer review organizations (PROs) as a condition for receiving payments under Medicare's prospective payment system for inpatient hospital services. PRO's review the services provided to Medicare patients to assure that services are medically necessary, provided in the appropriate setting, and meet professionally recognized standards of quality health care.

The Secretary of the Department of Health and Human Services (HHS) is required to contract with PROs. Organizations eligible for PRO contracts include physician-sponsored organizations, physician-access organizations, and health benefit payer organizations. PROs are expected to serve the dual role of curtailing unnecessary costs and assuring the quality of health care. However, in recent years, Aging Committee investigations have found that PRO's primary emphasis has been on controlling costs, rather than on assuring quality care.

There are 53 PRO contract areas. Each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands are designated as separate PRO areas.

The PRO review process begins after a Medicare beneficiary is discharged from the hospital and payment is made. Paid bill data is sent to the PRO, which selects a sample for review and requests the relevant medical records from the hospital. PRO reviewers (usually nurses) use criteria that contain the generally recognized reasons justifying a patient's hospital admission or surgical proce-

dure. If the PRO reviewer determines that the care was not medically necessary or that it should have been provided in another setting (e.g., an outpatient facility), the PRO will issue a payment denial. A payment denial can only be made after the attending physician has been given an opportunity to discuss the case with a PRO physician. For the latest contract period, which began in October 1988 and continues through the present, 1.72 percent of all reviewed discharges were denied on the basis of care being noncovered, inappropriate, or not medically necessary. To help ensure Medicare reimbursement, some States require physicians to call the PRO for pre-admission and extended stay approval.

(D) SUPPLEMENTAL HEALTH COVERAGE

At its inception, Medicare was not designed to cover its beneficiaries' total health care expenditures. Several types of services, such as long-term care for chronic illnesses and outpatient prescription drugs, are not covered at all, while others are partially covered and require the beneficiary to pay deductibles, copayments, and coinsurance. Medicare covers approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered directly out-of-pocket, private supplemental health insurance, such as Medigap, by Medicaid, and other sources.

The term "Medigap" is commonly used to describe a private health insurance policy that is designed to supplement Medicare's coverage. There currently exists no survey that collects, on an ongoing basis, information about Medigap coverage. Several studies on this issue are discussed below. In general, one can conclude from them that approximately 65 percent of those with Medicare (about 20 million persons) have some type of private supplemental health insurance coverage, although not all of it is Medigap. Approximately 35 percent of aged Medicare beneficiaries purchase private insurance; another 30 percent have employment-based coverage.

The Current Population Survey, (CPS) conducted by the Census Bureau, collects information on other health insurance coverage held by Medicare beneficiaries. The survey does not collect information on Medigap insurance specifically, but rather on any type of health insurance that a Medicare beneficiary might hold, whether purchased privately or provided by an employer. According to preliminary data from the Congressional Research Service, the March 1991 CPS found that approximately 65 percent of noninstitutionalized aged Medicare beneficiaries (19.7 million persons) had some type of private coverage in 1991. About 36 percent of these beneficiaries (10.9 million) had individually purchased, nonemployment-based private coverage. It is reasonable to assume that most of this coverage is through Medigap policies, although the survey does not provide this information.

Medigap premiums vary depending on the extent of benefits covered (and the allowable charges made by health care providers to provide those benefits), and other factors such as the extent of utilization of health care services by the covered population, administrative costs, insurance company profit, and reserve requirements.

In addition, the cost of a plan can vary depending on the age and geographic location of the enrollee. A 1989 HIAA telephone survey found that the mean 1989 annual Medigap premium was $718 and the median was $640. However, it is important to note that 1989 Medigap policies offered fewer benefits in prior or subsequent years because of the more extensive coverage offered by the MCCA.

It is also important to note that the repeal of the MCCA brought sharp increases in Medigap premiums. In preparation for hearing testimony before the Senate Special Committee on Aging, GAO contacted 29 commercial Medigap insurers to obtain their current estimate of their premium changes. The average increase in the 1990 premiums over 1989 was estimated to be 19.5 percent, or $11.44 per month. The increases ranged from 5 percent to 51.6 percent. The average monthly premium in 1989 was $58.52 ($702.24 per year); in 1990, it was $69.96, or $839.52 per year.[10]

The regulation of private insurance has traditionally been a State responsibility. However, the National Association of Insurance Commissioners (NAIC) has developed model standards which can be adopted by States. These standards specify, among other things, the minimum benefits that a policy must cover. These were adopted by NAIC in the mid-1970's, and have been amended several times since then.

Despite the NAIC model law and regulations, abuses in the sale of Medigap policies persisted, leading Congress to include in the Social Security Disability Amendments (P.L. 96–265, enacted June 1980) a new Section 1882 entitled "Voluntary Certification of Medicare Supplemental Health Insurance Policies," also known as the Baucus Amendment, after the chief sponsor of the amendment, Senator Max Baucus. Section 1882 established standards for Medigap policies based primarily on the June 1979, NAIC model standards. It establishes loss ratio requirements for group and individual Medigap policies. It also provides criminal penalties for certain abusive Medigap sales practices, including making false statements and misrepresentations, and selling policies that duplicate Medicare's benefits.

Under the Baucus amendments, the Federal Medigap standards were implemented in two ways. Individual insurers could voluntarily submit their policies to the Voluntary Certification Program to be certified. Or, recognizing the traditional role of States in regulating insurance, States could adopt the Federal Medigap standards as part of their regulatory program. If the State programs meet or exceed the Federal standards, then policies approved in those States are deemed to have met the Federal requirements, and the Voluntary Certification Program does not apply.

Although Section 1882 of the Social Security Act was enacted in response to abusive sales practices in Medigap policies sold to the elderly, the Congress continued to hear about abusive practices. Testimony by consumer groups and others before the House Committee on Energy and Commerce in April 1989 and before the Senate Special Committee on Aging in March 1990 and the Senate

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[10] U.S. General Accounting Office. *Medigap Insurance: Expected 1990 Premiums after Repeal of the Medicare Catastrophic Coverage Act.* Testimony of Janet Shikles before the U.S. Senate Special Committee on Aging. Harrisburg, PA, Jan. 8, 1990. p. 5-6.

Finance Committee in June 1989 and February 1990 cited variety of abusive sales practices, including: selling policies which duplicate coverage that the customer already has; generating lists of names to sell to insurance agents through ads offering information about Medicare; and "twisting" which occurs when the customer is encouraged to switch or twist old policies for new ones because of higher commissions on new policies.

At a March 1990 Aging Committee hearing, the Committee heard about how some of the most vulnerable of our society—the elderly—are victimized by insurance marketing abuses. Also, the Committee received testimony about the use of slick, misleading come-ons that are used to scare or trick vulnerable consumers into buying something of questionable value that they do not need and cannot afford.

These concerns were addressed in the 101st Congress by a number of hearings as well as legislation introduced by a number of Members. Senators Pryor, Heinz, Kohl, Baucus, Daschle, Durenberger, Riegle, and Rockefeller were instrumental in pushing for Medigap reform. In addition, Congressmen Wyden, Dingell and Stark played leadership roles. The final outcome of this attention was a comprehensive Medigap reform package included in the budget reconciliation bill.

Given the understandable confusion many older persons have about their health insurance needs and coverage, as well as their vulnerability to high pressure, and sometimes unscrupulous, sales practices, Senators Pryor, Heinz and other members of the Aging Committee introduced S. 2189, the Health Insurance Counseling and Assistance Act. This bill was incorporated in OBRA 1990, and requires the Secretary to make grants to States to support or establish health insurance counseling programs. Health insurance counseling was heralded by some as the most significant aspect of the Medigap reform. Other significant provisions of Medigap reform are outlined below.

Simplification of Policies.—Benefit options will be simplified to provide for a core group of benefits, and up to maximum of nine other groups of defined Medigap packages. The defined core group of benefits will be common to all defined Medigap benefit packages, and all Medigap insurers will be required to offer the core group of benefits. Noncompliance with simplification standards will be subject to a civil monetary penalty not to exceed $25,000.

Uniform Policy Description.—Using uniform language and format, insurers will be required to provide an outline of coverage to facilitate comparisons among Medigap policies and comparisons with Medicare benefits.

Prevention of Duplicate Medigap Coverage.—It will be unlawful for a Medigap policy to be issued unless the seller obtains from the applicant a written, signed statement stating what type of health insurance the applicant has, the source of the health insurance, and whether the applicant is entitled to Medicaid. Also, it will be unlawful to sell or issue a Medigap policy, or health insurance that duplicates a Medigap policy to an individual who has a Medigap policy, unless the individual indicates in writing that the policy replaces an existing policy which will be terminated.

The direct sale of Medigap policies to Medicaid beneficiaries will be prohibited, except in cases where States pay the Medigap premiums for beneficiaries. Noncompliance with these provisions will be subject to civil monetary penalties.

Loss Ratios.—Minimum loss ratios will be increased to 65 percent for individually sold Medigap policies and will be 75 percent for group policies. NAIC will develop a methodology for uniform calculation of actual and projected loss ratios as well as uniform reporting requirements. Policy issuers will be required to provide a refund or a credit against future premiums to assure that loss ratios comply with requirements. Noncompliance with these requirements will be subject to civil monetary penalties.

Renewability, Replacement, and Coverage Continuation, Preexisting Condition and Medical Underwriting Limitations.—Medigap policies will be required to be guaranteed renewable. The issuer will not be permitted to cancel or non-renew the policy solely on the grounds of the health status of the policyholder. If the Medigap policy is terminated by the group policyholder and is not replaced, the issuer will be required to offer an individual Medigap policy which provides for the continuation of benefits contained in the group policy.

Medigap insurers will be required to offer coverage to individuals, regardless of medical history, for the 6-month period will commence after an applicant turns 65. For the working aged, for a 6-month period when they first enroll in Medicare Part B. Also, insurers are prohibited from discriminating in the price of the policy, based upon the medical or health status of the policyholder. Violations of medical underwriting provisions will be subject to civil monetary penalties.

Premium Increases.—States must have a process for approving or disapproving proposed premium increases, and establish a policy for holding public hearings prior to approval of premium increases.

Enforcement of Standards.—No policy may be sold or issued unless the policy is sold or issued in a State with an approved regulatory program, or is certified by the Secretary. The previously inactive Supplemental Health Insurance Panel will be abolished, and the Secretary will be required to review State regulatory programs. States will be required to report to the Secretary on the implementation and enforcement of standards.

If the Secretary finds that a State program no longer meets the standards, the Secretary must provide the State with an opportunity to adopt a plan of correction. If the Secretary makes a final determination that the State program fails to meet the standards, policies sold in such a State are required to be certified by the Secretary.

State Approval of Policies Sold in the State.—All policies sold in a State, including policies sold through the mail, must be approved by the State in which the policy is issued.

Medicare Select.—The Secretary will be authorized to establish a 3-year demonstration project in up to 15 States which will allow benefits under a lower-cost policy to be restricted to items and services furnished by certain providers, if a policy otherwise complies with Medigap standards.

2. Issues and Congressional Response

(A) Shortcomings of Current Medicare Coverage

Until the late 1980's, the major gaps in Medicare coverage for the elderly and disabled had not been seriously examined. An attempt was made with the passage of the Medicare Catastrophic Care Act in 1988 to cover some of the so-called catastrophic costs that many Medicare beneficiaries may encounter. That law, however, was repealed in late 1989, largely because of the dissatisfaction of many elderly persons with the financing of the law, as well as some of the new benefits that the law contained. Many policymakers consider the repeal of MCCA a step backward for Medicare beneficiaries. Although the bill did contain some benefits that were already covered by many beneficiaries' supplemental insurance policies, there were significant new benefits, such as prescription drug coverage and expanded home health and SNF care that are not covered by most supplemental policies.

Medicare provides excellent hospital benefits for short-term stays; however, coverage for long-term hospital stays (more than 60 days) is limited and leaves elderly patients without Medigap insurance vulnerable to catastrophic out-of-pocket expenses. Other non-Medicare-covered expenses that can be catastrophic costs are the expenses associated with long-term care, including nursing home and home health care for the treatment of chronic illness, outpatient prescription drugs, and physician charges above the Medicare allowable charge. In addition, expenses incurred from optical, dental, and hearing services and products continue to represent a significant out-of-pocket cost burden that are not covered by Medicare.

Without question, the greatest catastrophic health care expense is that associated with the provision of long-term nursing home care. At an average annual cost of $30,000 a year, nursing home expenses dwarf all other non-Medicare-covered services. One study has estimated that one-third of elderly households would be financially ruined if one family member were to spend 13 weeks in a nursing home. The beneficiary will qualify for Medicaid assistance only after becoming, for all practical purposes, impoverished. (Further discussion of this problem can be found in Section C of this chapter.)

Although long-term nursing home care is extremely expensive, and despite the fact that one in four elderly can be expected to require nursing home care at some point in their lives, the likelihood of needing such care pales in comparison to the likelihood of requiring prescription drugs. Every year, 75 percent of all older Americans consume prescription drugs. For many elderly, the cost of these non-Medicare-covered outpatient prescription drugs can run into the hundreds, and even thousands, of dollars per year. In fact, one in five elderly incur medication costs that exceed $500 a year and, as mentioned previously, for three out of four older Americans it represents their highest out-of-pocket costs.

Further, because prescription drug prices have increased at a rate that has almost tripled the general inflation rate in the last 10 years, few insurers offer coverage of prescription drug costs in their

Medigap policies. Most, if not all of those policies that continue to offer the benefit have significantly increased their premiums, making it extremely difficult for many elderly to afford the coverage.

Right behind prescription drug expenses, non-Medicare-covered physician charges represent the next highest out-of-pocket liability. Although Medicare reimburses 80 percent of what the program considers a reasonable charge, physicians who do not accept assignment can and do charge more than the program-determined reasonable charge. As a result, Medicare beneficiaries not only are liable for the additional 20 percent of the charge Medicare deems reasonable, but also are liable for any amount over and above the Medicare assigned rate. Per enrollee payments copayments and balance billing for Part B services rose from $194 in 1980 to an estimated $476 in 1990.

Private insurers offering supplemental insurance (Medigap) coverage to the elderly have been hesitant to offer policies that do more than provide protection against the copayments for the limited services that Medicare covers. Consequently, many elderly have found it particularly difficult and/or unaffordable to find policies that cover long-term nursing home and home health care, prescription drugs, and physician costs that are more than the Medicare approved rate. It appears, therefore, that until a significant private and/or public insurance initiative is developed to address these and other shortcomings, the elderly—particularly the low- to middle-income elderly—will continue to live in fear of incurring catastrophic health care costs.

(B) MEDICARE SOLVENCY AND COST CONTAINMENT

Controlling expenditures within the Medicare program and looking for ways to assure the program's solvency continue to be among the highest priority issues for both the Congress and the administration. A driving force for Medicare cost containment is the need to assure solvency of the Medicare trust funds. The Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) fund are maintained by the Treasury and evaluated each year by a board of trustees.

Recent trustees' projections show financial problems ahead for Medicare. Long-range deficits in the HI trust fund have been projected by the trustees since 1975. Concern was heightened early in 1982 when the trustees warned that the trust fund could become insolvent in 1987. Congress responded by enacting many changes over the following few years, mostly in conjunction with its efforts to deal with the Federal budget deficits, which, when coupled with better economic conditions, pushed the projected point of insolvency into the next century. However, since 1987, the situation has not improved. The trustees repeatedly have projected the point of insolvency occurring sometime between 2002 to 2005, even though the Congress continued to enact cost-saving measures. In their latest report, the point of insolvency moved up from 2005 to 2002. While SMI's financing is not constrained by a fixed tax rate, its steeply rising costs place a strain on the general resources of the Govern-

ment since only one-fourth of its costs are financed by enrollee premiums.

The (SMI) program is basically term insurance financed from premiums paid by enrollees and from general revenues. When Medicare was established in 1965, the Part B premium was set at an amount that would cover 50 percent of program costs. Today, less that 25 percent of program costs are paid for by the premium, even though the premium has grown quite rapidly.

Since 1983, Congress repeatedly passed measures to slow the increases in SMI payments to physicians through across-the-board limits on fees and selective constraints on services considered to be overvalued. However, the program's growth rate has shown little signs of abating. To a large extent, it reflects the enormous price and cost pressures being exerted by the medical sector of the economy, notably for physician and outpatient hospital services. The number of people served by the program has been growing by about 600,000 or about 2 percent annually, resulting in a 23-percent increase since 1980. In contrast, per capita expenditures in the economy at large for physician services rose by 157 percent in the 1980–89 period. Those financed by SMI rose by 177 percent. Per capita physician expenditures have been projected to more than double again between 1987 and the year 2000, and SMI is projected to follow suit, with its expenditures rising from 0.86 percent of gross domestic product in 1991 to 1.69 percent in the year 2001.

While 75-year SMI projections are not made by the trustees, SMI's costs will be influenced by many factors, including inflation and an aging society. Unlike the Medicare Hospital Insurance Fund, SMI does not having to confront a potential financing shortfall by having to rely on a fixed payroll tax rate. However, rising SMI costs exert pressure on Congress in other ways: (1) through program enrollees who complain about premium increases, and (2) through a budget process strained by the existence of large deficits. While SMI does not have an explicit limit imposed on its financial resources, the prospect of continuing large premium hikes and an expanding draw on the Government's general resources are likely to impose implicit limits on the future financing of the program.

The Hospital Insurance (HI) program is primarily financed by payroll taxes. Taxes paid by current workers are used to pay benefits for current workers. The introduction of the Prospective Payment System, along with other factors slowing inflation in the medical marketplace, has given new life to the trust fund.

In the 1991 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund, the trustees reported that with intermediate economic projections, the present financing schedule for the HI program is sufficient to ensure the payment of benefits until 2005. Again, with pessimistic assumptions, they predicted the trust fund would be bankrupt by 2001.

The inadequacy of the present financing schedule of the HI Trust Fund to ensure its long-term health remains a legitimate concern. Although recent efforts to reduce the costs of health care paid for the HI program have been successful, the actuarial deficit in the HI program and the probability of exhaustion of the trust fund projected by the trustees are cause for Congressional concern.

Moreover, because of changing demographics, fewer workers will be available to support each Medicare beneficiary. Today, over four covered workers support each Medicare enrollee. By the middle of the next century, only slightly more than two covered workers will support each enrollee. According to the trustees, however, all but the most optimistic assumptions indicate that there will be insufficient reserves in the HI program even before this major demographic change begins to occur. Therefore, a need to find ways to ensure the same level of benefits to future generations of the elderly continues.

Prior to the enactment of OBRA 1990, the Medicare payroll tax was 1.45 percent for both the employee and the employer up to a maximum level of $51,300 in 1990. OBRA 1990 increased the maximum level subjected to the payroll tax to $125,000. This change, effective in 1991, significantly increased revenue coming into the Medicare HI trust fund. However, the primary reason for this legislative modification was to reduce the Federal deficit—not to strengthen the HI trust fund.

(C) BUDGET ISSUES

(1) FY 1993 Budget Proposal

The President's FY 1993 budget included legislative proposals that, according to the Administration, would reduce FY 1993 Medicare outlays by $1.5 billion ($630 million for Part A, $430 million for Part B, increased revenues of $313 million in Part B, and $156 million in administrative savings). If these proposals were enacted, the President estimated that Medicare outlays would be $129.3 billion in FY 1993. The President's budget also included a proposal to increase HI trust fund revenues by $1.7 billion. From FY 1992 through FY 1997, revenues of $9 billion would be generated from implementing this proposal.

Part A.—The President's budget proposed to delay the implementation date for the annual hospital update factor under the prospective payment system from October 1 to January 1. According to the Administration, the proposal would conform the effective date of the update factor with the actual effective date that has been enacted for Medicare in recent years. Hospitals were generally opposed to this provision because it would delay the date of the regularly scheduled update and result in lower payment to them. The Administration estimated that the proposal would save $630 million in FY 1993 and a total of 5.4 billion from FY 1993 through FY 1997.

Under current law, Medicare coverage and payment of HI taxes are mandatory for State and local government employees hired on or after April 1, 1986. OBRA 1990 required State and local governments to extend Social Security and Medicare HI coverage to employees not under a State and local retirement plan, except for students, effective July 1, 1991. State and local government employees covered under a retirement plan were not affected by this provision; State and local governments can still choose whether to offer HI coverage to them.

The President's FY 1993 budget proposed mandating Medicare coverage (and payment of HI taxes) for State and local government

employees hired before April 1, 1986, who are covered under a retirement plan. The Administration estimated that this proposal would increase revenues by $1.7 billion in FY 1993 and $9 billion from FY 1992 through FY 1997 (if the proposal had been implemented on April 1, 1992).

Support for this proposal stems from the belief that many State and local government employees will ultimately receive Medicare benefits through their spouses or short periods of work in employment covered by Social Security. Supporters contend that it is inequitable for these employees to receive benefits if they have not contributed to the system. Opponents argue that it would add to the financial and administrative burdens of State and local governments, many of whom are already facing fiscal crises.

Part B.—The budget contained proposals to reduce FY 1993 Part B outlays by $430 million and to generate increased revenue of $313 million. Among these proposals were significant changes in the way Medicare pays for anesthesia services, durable medical equipment, and clinical laboratory services.

A proposal to implement an income-related premium for Part B received a lot of attention from aging advocates. The President's proposal would have required single beneficiaries with adjusted gross incomes over $100,000 and couples whose incomes exceed $125,000 to pay 75 percent of their Part B premium costs ($95.40 in 1992). In the Administration's view, government subsidies should be reduced for those who are clearly not needy. Opponents maintain that means-testing weakens the fundamental entitlement structure of Medicare.

According to the Administration, this proposal would have affected 2 percent of Medicare beneficiaries, or approximately 700,000 individuals. The Administration estimated that it would generate revenue of $313 million in FY 1993, and a total of $3.1 billion from FY 1992 through FY 1997.

(2) Revenue Act of 1992

OBRA 1990 includes a 5-year deficit reduction plan and a new enforcement mechanism to assure that the deficit reduction plan is carried out. Title XIII of OBRA 1990, the Budget Enforcement Act (BEA) of 1990 established the new budget enforcement rules which have important implications for proposals to expand Medicare benefits or to cut Medicare outlays to help finance tax cuts.

Largely because of the 5-year agreement as well as the new budget rules, in 1991 the Congress adhered to the terms of the 1990 deficit reduction agreement. Later, fueled by concerns about a variety of expiring health and tax provisions, the Congress passed the Revenue Act of 1992 (H.R. 11). This bill included a number of changes to the Medicare program, including restoration of separate payments for physicians who interpret electrocardiograms, full payment for new physicians, and provisions that would extend special payment rules for small rural hospitals.

Amid conflicting opinions about whether the bill contained tax increases, President Bush vetoed H.R. 11 on November 4, 1992. Many expect that the health provisions contained in the bill will be acted on again early in the 103rd Congress.

(3) OBRA 1990 Budget Agreement

On September 30, 1990, the President and congressional leaders announced a budget summit agreement for FY 1991–95. The agreement proposed a reduction of projected Medicare outlays of at least $4.6 billion (with $2.85 billion from providers and $1.75 billion from beneficiaries) for FY 1991 and $60 billion over 5 years. Roughly half of the proposed $60 billion in cuts would come from beneficiaries. The budget summit proposal contained increases in the Part B premium and deductible as well as a new clinical lab copayment. Particularly because over 50 percent of older Americans fall below 200 percent of poverty, many Members of Congress were concerned about the increased out-of-pocket expenditures the provisions of the budget summit would require.

Amidst much controversy over the budget summit, on October 5 the House defeated a budget resolution that would have set the framework for implementation of the budget summit agreement. Many saw Medicare cuts as the driving force behind Members' reluctance to support the summit agreement. Subsequently, the Congress passed a new budget resolution that outlined comparable amounts of cuts, but allowed the committees of jurisdiction to craft the specific entitlement and tax changes.

On October 16, the House passed H.R. 5835, the Omnibus Budget Reconciliation Act of 1990. An amended version was passed by the Senate 2 days later. Finally, days before the election, H.R. 5835 was approved by both the House and the Senate. The law was a 5-year deficit reduction plan designed to reduce Medicare outlays by $3.6 billion in FY 1991 and $44.1 over 5 years.

Part A cuts in payments to hospitals totaled $13.7 billion over 5 years and $1.6 billion in FY 1991. Payments to physicians and other under Part B were reduced by $1.6 billion in FY 1991 and total $14.2 billion over 5 years. Medicare as Secondary Payer provisions are expected to save $95 million in FY 1991 and $6.3 billion over 5 years. In spite of a lengthy budget debate and deep Medicare cuts, the Congress made some substantial legislative accomplishments in health care.

(D) QUALITY OF CARE ISSUES/PEER REVIEW ORGANIZATIONS

When Congress enacted Public Law 98–21 establishing Medicare's PPS, there was a general recognition that inherent in the newly structured payment system were incentives to underserve patients and discharge patients prematurely. To ensure against these outcomes, Congress charged peer review organizations (PROs) with monitoring quality of care as well as utilization outcomes.

The Senate Special Committee on Aging has been actively involved in investigating problems regarding the delivery of quality health care under Medicare. The Committee's efforts uncovered serious deficiencies related to earlier hospital discharges, denial of access to needed services, inadequate rights of appeal, pressures on physicians to provide care at a lower level than that which would be considered sound medical practice, limited focus of PRO activities, inadequate post-hospital care, and the lack of adequate data regarding the quality of health care provided under PPS. Related Committee activities uncovered serious limitations on the part of

the Federal Government to protect beneficiaries from incompetent and dangerous medical practitioners.

As part of the OBRA 1986, the Congress enacted a number of quality of care reforms. Among the new reforms enacted were the written notice to patients of hospital discharge rights, an improved discharge planning process, a study of payments for administratively necessary days, allowance for provider representation of beneficiaries during certain benefit appeals, and a number of PRO improvements including the requirement that PROs review the quality of care provided.

The Medicare and Medicaid Patient and Program Protection Act was signed into law on August 18, 1987. This law mandatorily excluded from participation in Medicare, Medicaid, Maternal and Child Health Block Grant, and the Social Services Block Grant any medical practitioner (whether an individual or entity) convicted of a criminal offense for neglect or abuse of a patient in connection with the delivery of a health care item or service or a criminal offense relating to delivery of a service under Medicare or a State health care program. Among it other provisions, the law specifies a number of circumstances under which the Secretary of HHS is granted the discretion to exclude providers from participation in State and Federal health care programs, makes provisions for the duration and appeal of such exclusions, allows for civil monetary and criminal penalties, and requires States to develop a system for maintaining statistics on and reporting of action taken against sanctioned providers.

During 1987, congressional interest in the PRO system and its objective of ensuring the delivery of quality health care continued. OBRA 1987 included a number of changes affecting contracting and other aspects of the PRO system. Specifically, the legislation extends initial and renewal PRO contract periods from 2 years to 3 years, and allows the Secretary of HHS to stagger the contract renewal periods.

These changes are expected to foster greater stability in PRO operations, allow for more accurate evaluation of a PRO's performance, and reduce administrative contracting costs. In addition, the 1987 law requires that each PRO offer educational sessions several times each year to hospital staffs regarding review of the hospital's Medicare services, directs PROs (to the extent possible) to provide initial review of psychiatric and physical rehabilitation services by a physician trained in the appropriate field, and requires PROs to consider special problems of delivering care in remote rural areas.

Also included in the OBRA 1987 were PRO provisions which require that: (1) PROs provide reasonable notice and opportunity for discussion of denied claims and that the provider be given 20 days (for discussion and review) before the payment denial would be effective, (2) the HHS Secretary publish in the Federal Register (30 days before the date on which the change takes effect) any new policy or procedure that affects the performance of PRO contract obligations, (3) general criteria and standards used in evaluating PRO fulfillment of contract obligations be published in the Federal Register, and (4) the Secretary of HHS provide documentation to each PRO on its performance in relation to other PROs.

Several PRO provisions were considered by Congress during deliberations on the FY 1990 budget. Two major provisions passed by the Congress as part of OBRA 1989 relate to denial of payment for substandard care. The peer review community was concerned about the requirement to simultaneously notify practitioners/providers and patients of denials of payment for substandard care prior to a reconsideration opportunity for providers/practitioners. The new provision allows practitioners and providers the opportunity for reconsideration of a PROs quality denial determination prior to patient notification. Such reconsideration would be in lieu of any subsequent reconsideration. Also included in the legislation is language specifying the content of the patient notice on quality denials, which will state: "In the judgment of the peer review organization, the medical care received was not acceptable under the Medicare program. The reasons for the denial have been discussed with your physician and hospital."

Another provision included in the 1989 budget reconciliation, advanced by the American Nurses Association, requires that PROs establish procedures for the involvement of health care practitioners who are not doctors of medicine in the review of services provided by members of their profession.

In 1990, some long debated PRO issues were resolved by the Congress. OBRA 1990 changes to the PRO program included: clarification of the willing and able standard; providing for the exchange of information and coordination of review activities between PROs and Medicare carriers; assuring the confidentiality of PRO deliberations; and clarifying the limits on liability for PROs. Also, the involvement of optometrists and podiatrists in the review of their services was increased.

Also in 1990, the Institute of Medicine released a report outlining the results of 2-year congressionally mandated study on quality review and assurance in Medicare. The report outlined a redirection for a Medicare quality assurance program. The report recommended to move toward clinical evaluations and patient outcomes, broaden the range of assessments to include services provided in practitioners' offices and other settings in addition to hospitals, and expand the emphasis on professional self-monitoring and internal organizational improvement. In the last 2 years, Congress has held hearings on these recommendations but has made no legislative changes to Medicare's quality assurance program.

(E) ISSUES AFFECTING PHYSICIANS AND OTHER PART B PROVIDERS

Part B supplemental medical insurance (SMI) of the Medicare program has experienced tremendous growth since its inception, in terms of both services delivered and program expenditures. Between FY 1978 and FY 1987, Medicare spending for physicians' services increased at an average annual rate of 16 percent. SMI accounts for about one-third of total Medicare spending, and physician services make up about 75 percent of SMI expenditures. Although their services comprise less than 25 percent of all Medicare

spending, physicians actually may influence more than 70 percent of other medical services used by Medicare beneficiaries.[11]

Between 1980 and 1983, Medicare expenditures for physician services increased at an average annual rate (adjusted for inflation) of 12 percent, compared to 6.5 percent for all physician expenditures.[12] In response, Congress froze Medicare fees for participating physicians from 1984 to 1986; the fee freeze was lifted in December 1986 for nonparticipating physicians. The freeze was a qualified success. While the average annual increase in Medicare expenditures for physician services was lower between 1983 and 1986 (9.1 percent) than in previous years, it nonetheless was higher than the annual increase of 7.2 percent for all physician expenditures.

(1) Physician Payment Reform

From 1984-87 Congress made a number of legislative adjustments to the way Medicare pays physicians. Despite the adjustments, the physician payment system remained relatively intact, with payments made for each service rendered. These adjustments, designed to stem the dramatic expenditure increases within Part B, were not successful in slowing the increases.

These increases have been the focus of a great deal of attention. Many have suggested that both the individual prices and the unit of payment are inflationary and create price distortions. Others believe that these imbalances created financial incentives that inappropriately influence physicians' decisions about what services to provide, location of their practices, and specialty choice.

As part of the OBRA 1989, the Congress established a new payment system for physician services paid for by Medicare. Because of the magnitude of the reforms, the physician payment reform package was the most significant health care legislation enacted in 1989. Its enactment clearly reflected the work of Senators Rockefeller and Durenberger, as well as Congressmen Stark and Waxman, who pushed hard for its passage in 1989. The Administration's support was also crucial.

Under the new system, payments will be made under a fee schedule based on a relative value scale (RVS). An RVS is a method of valuing individual services in relationship to each other. Also included in the new system are annual volume performance standards which are target rates of increase in physician expenditures.

Impetus for Reform.—The reasonable charge payment system governed Medicare physician payments from the inception of Medicare in 1966 to the implementation of the fee schedule in 1992. When Medicare was implemented, reasonable charges were derived from physicians' historical charges for services. Although fees were updated nearly every year, the payment structure remained basically the same. Many analysts criticized the reasonable charge reimbursement system. One of the most persistent criticisms was that it generally resulted in substantially higher payments for more specialized procedures, such as surgery and diagnostic tests,

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[11] Physician Payment Review Commission. Medicare Physician Payment: An Agenda for Reform. Washington, DC, U.S. Govt. Print. Office, 1987, p. 13.

[12] Anderson, Gerald F. and Jane E. Erickson. National Medical Care Spending. Health Affairs, v. 6, no. 3, Fall, 1987. p. 101.

than for primary care services. The magnitude of the difference in payments was thought to be greater than justified by the skill and training required for performing more specialized procedures. A related concern was that while a high price may initially be justified for a new procedure, prices do not generally decline over time, even when the procedure becomes part of the usual pattern of care. Further, payments varied widely for the same service performed by different physician specialties.

Significant variations were found among the geographic areas used to administer the system. These payment areas are called localities. There were 240 localities, which were not consistent in terms of size, population, or type of area (urban or rural). Prevailing charges across localities did not necessarily reflect differences in the costs of practicing medicine in those areas. In some cases, there were large differences in prevailing charges between urban and rural areas, among similar urban and rural areas, and even between contiguous localities with similar demographic characteristics.

In addition to concerns about payment distortions and geographic inequities in the reasonable charge reimbursement system, criticism was also focused on the inflationary effects of fee-for-service reimbursement. Because physicians are paid for each service they render, this system could encourage physicians to increase the volume of services they provide. It could also encourage them to provide more intensive or high technology services because these services were generally better reimbursed than primary care services. It did not create incentives for physicians to provide less expensive rather than more expensive services, even if the less expensive services might be equally effective.

Policymakers also expressed dissatisfaction with the rapid rate of growth in Medicare expenditures for physicians' services. Total Medicare spending for physicians' services was expected to reach $30 billion in FY 1992. From 1980 to 1989, Medicare charges per aged (as distinct from disabled) enrollee for physicians' services increased from $376 to $1,040, an increase of 176 percent. After accounting for the effects of inflation, Medicare real spending for physicians' services increased 83 percent during this period. Among other things, increases in real spending reflect factors such as increased volume and intensity of services.

New Fee Schedule.—The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) establishes an entirely new system for calculating Medicare payments for physician services. Instead of basing payments on reasonable charges, payments are made on the basis of a fee schedule. The fee schedule has three components: the relative value for the service; a geographic adjustment; and a national dollar conversion factor. The system is being phased in over 5 years, beginning in January 1992.

The relative value for a service compares the relative physician work involved in performing one service with the work involved in providing other physicians' services. It also reflects average practice expenses and malpractice expenses associated with the particular service. Each physician service is assigned its own relative value. The scale used to compare the value of one service with another is known as a resource-based relative value scale (RBRVS).

The relative value for each service is the sum of three components: the physician work component; the practice expense component, which measures average practice expenses such as office rents and employee wages; and the malpractice expense component, which reflects average insurance costs.

The geographic adjustment is designed to account for variations in the costs of practicing medicine. Three separate adjustments are made for each of the three components of the relative value unit, a work adjustment, a practice expense adjustment, and a malpractice adjustment. These are added together to produce an indexed relative value unit for the service for the locality.

A separate geographic adjustment applies to services performed in each service area. With the exception of three new statewide localities, the localities used under the old system are also used under the new system.

The conversion factor is a dollar figure that converts the geographically adjusted relative value for a service into a dollar payment amount. In 1992, one national conversion factor applies to all physician services (except anesthesia services). The 1992 conversion factor is $31.

The law establishes specific transition rules for how payments are to be phased in to the fee schedule during the 5-year transition period. In 1992, services whose fees are within 15 percent of the 1992 fee schedule payment amount are paid at the fee schedule amount. HHS estimated that approximately one-third of payments will be for services paid at the fee schedule amount in 1992. The remaining two-thirds of payments will be for services considered to be overvalued (previous payments were too high) or undervalued (previous payments were too low). Over the 5-year transition, payments for these services will be gradually increased or decreased. By 1996, payments for all services will be made solely on the basis of the fee schedule.

The new physician fee schedule reflects many of the recommendations made by the Physician Payment Review Commission (PPRC), a congressionally established advisory body. PPRC continues to advise the Congress concerning implementation issues.

Beneficiary Protections.—Medicare pays 80 percent of the fee schedule amount for physicians' services after beneficiaries have paid the $100 annual deductible. Beneficiaries are responsible for the remaining 20 percent, which is referred to as coinsurance. A physician may choose whether or not to accept assignment on a claim. In the case of an assigned claim, Medicare pays the physician 80 percent of the approved amount. The physician can only bill the beneficiary the 20 percent coinsurance plus any unmet deductible. When a physician agrees to accept assignment of all Medicare claims in a given year, the physician is referred to as a participating physician.

Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as nonparticipating physicians. There are a number of incentives for physicians to become participating physicians, chief of which is that the fee schedule payment amount for nonparticipating physicians is only 95 percent of the recognized amount paid to participating physicians.

Nonparticipating physicians may charge beneficiaries more than the fee schedule amount on nonassigned claims; these balance billing charges are subject to certain limits. OBRA 1989 permitted nonparticipating physicians to charge up to 125 percent of the approved Medicare payment amount in 1991. If their 1990 charges were more than 125 percent of the 1989 approved payment amount, then their limit in 1991 was 125 percent. Physicians whose 1990 charges exceeded the 1990 approved Medicare payment amount by less than 125 percent could not increase their charges to the 125 percent limit in 1991. Evaluation and management services were subject to a higher limit of 140 percent in 1991 only. Similarly, the 1992 limit is up to 120 percent of the approved (fee schedule) amount. In 1993 and subsequent years, the limit is 115 percent of the fee schedule amount, without regard to charges in previous years.

In early 1992, considerable attention focused on the fact that some nonparticipating physicians billed patients in excess of the limiting charges. An Aging Committee hearing illustrated problems with the way HCFA implemented these limits. In part, these excess balance billing charges occurred because of physician confusion regarding the limit that applied.

Questions were also raised as to whether the statute protects beneficiaries from excess charges. The statute specifically prohibits physicians from balance billing in excess of the limiting charges (and includes sanctions for physicians who do so knowingly, willfully, and on a repeated basis). However, no specific provision is made for a refund of any excess balance billing charges.

Aging Committee Chairman Senator David Pryor, along with Senator William Cohen and others, introduced legislation to address the concerns of Medicare beneficiaries. The legislation clarifies that the beneficiary is not liable for charges on unassigned claims that exceed the limiting charge; requires increased monitoring and enforcement efforts by HCFA; and adds intermediate sanctions through notification when an overcharge has occurred. This bill was included in H.R. 11 which was vetoed by the President.

In response to congressional and beneficiary concerns, HHS has taken a number of steps designed to improve implementation of the limiting charge provision. These included improved monitoring of claims and improved beneficiary and physician information. Carriers have been instructed to train inquiry staff to provide beneficiaries the specific charge limit for the specific case and to suggest that the beneficiary contact the physician in the case of an overpayment. Further, an improved Explanation of Medicare Benefits form is being phased in which will eliminate confusing information and signal when the limiting charge is exceeded.

Monitoring.—The Secretary is required to monitor actual charges of nonparticipating physicians after January 1, 1991. Also, the Secretary is to monitor and report to Congress on any changes in the proportion of services provided by participating physicians, the proportion of services paid on assignment, and the amounts charged above recognized payment amounts. If the Secretary finds that a significant reduction in participation or assignment rates or an increase in balance billing charges, he is required to develop a plan to address the problem and submit recommendations to the Con-

gress. The Secretary is also required to monitor: changes in utilization and access within geographic, population, and service related categories; possible sources of inappropriate utilization which contribute to the overall expenditure level; and factors underlying these changes and their interrelationship.

Medical Care Outcomes and Effectiveness Research.—The Agency for Health Care Policy and Research was created by OBRA 1989. One function of this agency, which will have impact on the implementation of physician payment reform, is to coordinate and expand the outcomes and effectiveness research program. This program promotes research with respect to patient outcomes for selected medical treatments and surgical procedures for purposes of assessing their appropriateness, necessity, and effectiveness. The findings emerging from this research will help physicians more appropriately and cost-effectively treat patients. In addition, the availability of at least some medical practice standards will hopefully protect physicians against inappropriate malpractice suits and awards by potentially serving as an affirmative defense.

Impact.—Simulations of the fee schedule suggest that Medicare payments would, on average, increase for medical specialties and decrease for surgical specialties. Also, the fee schedule is expected to change the distribution of payments among geographic areas with physicians in urban areas facing reductions in payments and those in rural areas generally receiving more. Also, with limits on balance billing, beneficiaries' out-of-pocket costs will decrease. Over time, implementation of volume performance standards will stem increases in Medicare expenditures.

Medicare Volume Performance Standard (MVPS).—Recently, some physicians have expressed concerns about the way the annual update to the fee schedule is calculated. As noted earlier, a dollar conversion factor converts the geographically indexed relative value for a service into a payment amount. The conversion factor is updated each January 1.

The law establishes a formula for updating the conversion factor. Part of the calculation is based on a comparison of actual expenditures with an expenditure goal for a prior period. The expenditure goal is known as the Medicare Volume Performance Standard (MVPS). Thus, the conversion factor update for 1993 is determined in part by comparing the actual increase in outlays for 1991 with the 1991 MVPS. If actual 1991 expenditures fall below the 1991 MVPS, the 1993 increase will exceed the general inflation adjustment. Conversely, if actual 1991 expenditures exceed the 1991 MVPS, the 1993 increase will be less than the general inflation adjustment. A separate MVPS is established for surgical services and for nonsurgical services.

The 1991 expenditure data indicates that expenditures for surgical services fell below the 1991 surgical MVPS, while expenditures for nonsurgical services exceeded the 1991 nonsurgical MVPS. The update for surgical services is 3.3 percent, while the update for nonsurgical services is 0.8 percent. This is the first time that two updates, and therefore two conversion factors, will be used.

Some view the larger update for surgical services as contrary to the goal of the new payment system which was intended to increase payments for primary care services. Some also question the

assumptions used to establish the 1991 MVPS. The PPRC has recommended that the 1993 differential updates not be included in the base for future updates and that in the future, only one MVPS and one update be used. This may be an issue considered by the 103rd Congress.

(2) Durable Medical Equipment

Under current law, durable medical equipment (DME) is reimbursed on the basis of a fee schedule that delineates six categories of equipment. OBRA 1990 contains a number of provisions primarily intended to control growth in spending for DME. These provisions include the following: reducing fee schedule reimbursement for transcutaneous electrical nerve stimulators (TENS) by 15 percent and limiting payment for seatlift chairs to only the seatlift mechanism; repealing existing regional limits on fees and replacing them with phased in national "floors" and upper limits; and prohibiting suppliers from distributing partially completed or completed medical necessity forms to beneficiaries and requiring suppliers to obtain prior approval from carriers for items frequently used unnecessarily.

Senator Cohen, ranking member of the Aging Committee, and Budget Committee Chairman Senator Sasser, along with Senator David Pryor, introduced legislation addressing concerns about fraud and abuse in the DME industry. The intent of the legislation is to deter the incidence of abusive practices with respect to supplying DME, and to establish more rational DME administrative and payment policy. Their bill, the "Durable Medical Equipment Fraud and Abuse Prevention Act of 1992" saved the Federal Government over $200 million and was included in H.R. 11, which was eventually vetoed by President Bush.

(F) HEALTH MAINTENANCE ORGANIZATIONS

During 1982 and 1983, HHS awarded 26 Medicare demonstration program contracts to develop Medicare Health Maintenance Organizations (HMOs). These demonstration projects, which were operational in 21 cities across the country, were implemented to test whether the HMO concept would be effective in holding down Medicare expenditures. HCFA initiated a nationwide program in 1985 providing for the expanded use of HMO's by Medicare.

Two kinds of organizations are eligible to contract with Medicare: federally qualified HMO's under the 1973 HMO Act and competitive medical plans (CMPs) as defined in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). For Medicare purposes, the standards that these two kinds of entities must meet to participate in the program are essentially identical. The difference between them is in the way they operate in the private market. The CMP was created to broaden participation and stimulate competition in the medical marketplace.

Under TEFRA, risk-contract HMOs and CMPs receive a fixed, monthly capitation payment for each enrolled beneficiary, and are fully at risk for all Medicare-covered services. In other words, the HMO is responsible for any cost overruns. The beneficiary who enrolls in a risk-contract HMO must receive all medical treatment,

except for emergency or urgently needed services, from that HMO. This feature is referred to as the "lock-in" provision. Beneficiaries must pay for services received outside of the plan as well as any services that have not been authorized by the HMO. Neither the HMOs nor Medicare are responsible for the payment of nonemergency out-of-plan services.

The formula used to determine the monthly payment per HMO beneficiary is based on the average adjusted per capita cost (AAPCC), the fee Medicare estimates it would have paid traditional providers (hospitals and fee-for-service physicians) in the same community. HMOs receive 95 percent of the AAPCC, thereby saving Medicare 5 percent on each Medicare HMO enrollee. HMOs also are permitted to charge beneficiaries the usual Medicare deductibles and coinsurance or HMOs may collect an equivalent sum from the beneficiaries in the form of a monthly premium.

Enrolled beneficiaries may receive a portion of the savings achieved by an HMO under its risk contract in the form of additional benefits not otherwise covered by Medicare. Whether savings are available to share with beneficiaries depends on if the HMOs' AAPCC exceeds its average community rate (ACR). The ACR is the HMOs' estimate of what it would charge similar private enrollees for the same set of benefits it will be providing to Medicare beneficiaries under its contract. The ACR is a payment safeguard built into Medicare law to help ensure that HMOs do not retain excessive profits from Medicare's payments. If an HMOs ACR is less than its estimated average Medicare payment rate, it must use the difference to provide additional benefits to beneficiaries or return the funds to Medicare through reduced premiums.

In November 1991, there were 1,507,173 Medicare beneficiaries enrolled in TEFRA risk or cost contracts with HMOs or CMPs. At that time, 93 risk contracts and 25 cost contracts were in effect. (An additional 637,836 beneficiaries were enrolled in prepaid plans under arrangements other than TEFRA contracts.) Although the number of Medicare HMOs has declined substantially over the past few years, the percentage of Medicare beneficiaries enrolled in a risk or cost contract with HMOs or CMPs has remained steady, at about 4 percent.

The participation of HMOs in the Medicare program represents yet another attempt by the Federal Government to stem rising health care costs. Like all health care cost containment strategies, the challenge facing the Medicare HMO program is to achieve this objective without compromising health care quality. Along those lines, OBRA 1987 contains provisions addressing problems related to post-contract protection of Medicare beneficiaries against health costs not covered by Medicare, quality of care, physician incentive arrangements, and HMO capitation rates. The latter two were further addressed in the budget reconciliation legislation of 1990.

(1) Post-Contract Protection

An attractive feature of many HMOs is the availability of health care coverage which is more generous than that provided under the combination of Medicare and most supplemental, or Medigap, insurance policies. Accordingly, many beneficiaries join HMOs as an

alternative to traditional Medigap policies. However, if an HMO closes or ceases participation in Medicare, a beneficiary may be left facing unanticipated, uncovered health costs. This is a particular problem for beneficiaries with existing health problems because they are unlikely to find alternative Medigap coverage that does not exclude such conditions for a period of several months. As a result, a member of an HMO which has closed may be left totally vulnerable to health care expenditures not covered by Medicare.

In 1987, two events highlighted this potential problem. First, the Florida-based International Medical Corporation, Inc. (IMC), one of the Nation's largest HMOs with about 150,000 Medicare beneficiaries, declared bankruptcy. Second, 29 Medicare HMOs—18 percent of the total—pulled out of the Medicare HMO program.

In the case of IMC, another health care corporation (Humana) assumed responsibility for providing roughly similar services to the IMC enrollees. This arrangement prevented Medicare enrollees from suffering any adverse financial consequences arising from lack of supplemental health insurance. With respect to the HMO withdrawals from the Medicare program, few beneficiaries were involved due to the small size of the contracts in question.

While these two events could have been much worse in terms of beneficiary impact, they both drive home the point that Medicare enrollees in an HMO are at some risk of sudden supplemental health care costs. To guard against this, Congress included provisions in OBRA 1987 requiring HMOs to ensure that Medicare enrollees are provided with supplemental coverage in the event the HMO ceases to serve such beneficiaries. Additional provisions require HMO's to inform Medicare enrollees of the possibility that its Medicare contract may be canceled at some future time.

(2) Quality of Care

Following a year-long Senate Special Committee on Aging investigation, Senator Heinz released a report in 1987 on HMOs with Medicare risk contracts. It found cases of questionable marketing and biased enrollment practices, involuntary disenrollments, and inadequate medical care, and concluded that HCFA was not fulfilling its monitoring responsibilities. While the findings were preliminary and not intended to be representative of the industry as a whole, groups representing the HMO industry criticized the report for focusing only on grievances within a limited number of HMOs, thereby unfairly and inaccurately magnifying the problems within the Medicare HMO program.

To prevent wrongful practices among HMOs, Congress included provisions in OBRA 1987 to broaden and increase monetary sanctions against HMOs which selectively deny enrollment to a Medicare beneficiary or health care to a Medicare enrollee. A penalty of up to $100,000 was established for engaging in biased enrollment, and existing fines were increased from $10,000 to $25,000 for denying a beneficiary medically necessary services. Similar sanctions were set for charging premiums in excess of the legal amount, involuntarily disenrolling or refusing to re-enroll a beneficiary on the basis of health status.

Despite these beneficiary protections, problems appear to persist in at least some aspects of the Medicare HMO program. A November 1990 series in the *Florida Sun* about the Humana Gold Plus Plan in Florida (the former IMC) prompted Senator Heinz to request an investigation by the Inspector General of allegations that the plan failed to inform some beneficiaries of the plan's restrictions, used improper enrollment and disenrollment procedures, and improperly denied payment for some members' bills.

Senator Heinz requested a GAO study as follow-up to some of the findings from the 1987 study. GAO's study was released at a March 1991 Aging Committee hearing, "Medicare HMOs and Quality Assurance: Unfulfilled Promises." GAO's study revealed many problems with HCFA's oversight of these HMOs. Of 204 Medicare risk contract HMOs, 57 were reviewed. Of those 57, only 21 received a passing grade. More than 60 percent of the quality assurance programs could not show the ability to either identify or correct quality of care problems. The GAO also found that the congressionally required PRO review of the quality of care provided by risk HMOs has been hampered by inadequate data and unreliable sampling.

(3) Physician Incentives

HMO contracts with physicians often contain financial incentives to control the volume and cost of services used by enrollees. Such incentives range from limited profit sharing to paying the physician a fixed monthly amount to assume financial responsibility for all of the services used by a group of assigned enrollees. In some contracts, physicians accept financial risk, not only for their own services, but for the services used by their assigned patients when treated by other providers.

Physician incentive arrangements are common in the private sector and have long been used by HMOs and prepaid arrangements as a means to control the volume and costs of services. Although the incentive is clearly to provide less rather than more care under such an arrangement, there are no substantive data to suggest that HMO members have received lower quality care because of these incentives. Nonetheless, critics of physician incentive arrangements believe that in some cases physicians may respond to financial pressure by delaying or denying treatment.

To respond to these concerns, OBRA 1986 banned the use of physician incentive payments by HMOs for their Medicare patients, effective April 1, 1989, and at the same time required a HHS report on acceptable incentive payment systems. OBRA 1987 postponed the effective date of the ban to April 1, 1990, to allow time to fully consider any recommendations in the HHS report, which was subsequently released at the end of 1988.

Most recently, OBRA 1990 lifted the ban on the use of physician incentive arrangements by Medicare HMOs provided that the physician incentive plan used by the HMO does not provide specific payments, directly or indirectly, as an inducement to withhold or limit medically necessary services to a specific patient. In addition, the physician incentive plan cannot place physicians at substantial financial risk (as determined by the Secretary) for services not pro-

vided by the physician or by the physician group unless there are appropriate safeguards in place.

(4) HMO-capitation rates

A continuing controversy in the Medicare HMO program surrounds the methodology used to establish the premium rates Medicare pays to risk-contract HMO's. These rates are based on the average adjusted per capita cost (AAPCC)—the Secretary's projection for the coming year of the average Medicare expenditure for providing covered services to beneficiaries who are not enrolled in an HMO or CMP (i.e., those who remain in the fee-for-service Medicare program). The AAPCC accounts for a number of variables, including beneficiary age and sex, disability status, eligibility for welfare benefits, institutional status, and location of the HMO.

Extensive concerns have been expressed by HMOs that the AAPCC is not an accurate reflection of their costs for treating Medicare enrollees, and HMOs have argued vociferously for premium payments set at 100 percent of the AAPCC rather than 95 percent. On the other side of the equation, however, are concerns that Medicare may be overpaying the HMO's because the Medicare beneficiaries that select HMO coverage may be healthier than average.

To develop a payment system which more accurately reflects utilization and costs, Congress included provisions in OBRA 1987 which authorized the Secretary of HHS to establish demonstration projects to test alternative rate-setting methods. The General Accounting Office also was called upon to study the AAPCC and any preferred alternatives. More recently, OBRA 1990 required the Secretary of HHS, in consultation with the HMO industry, to develop a payment system that is a better predictor of future utilization and costs of services. This may involve adjustments for health status or prior use rates or a new payment methodology and should be in place for 1993 rates.

(G) ISSUES AFFECTING HOME HEALTH CARE

After Medicare changed to the PPS system in 1983, Medicare patients have been sent home from the hospital after shorter stays and in greater need of follow-up health care. At the same time the PPS system was being introduced, HCFA targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit. For example, the number of visits per 1,000 enrollees declined from 1,344 in 1984 to 1,143 in 1988, a decrease of 15 percent. As a result, more Medicare beneficiaries needed home health care at a time when less care was available.

TABLE 1.—MEDICARE HOME HEALTH SERVICES

Year	Persons served (thousands)	No. of persons served per 1,000 enrollees	Total reimbursements (millions)	Total visits (millions)	No. of visits per 1,000 enrollees
1975	500	22	$215	11	431
1980	957	34	662	22	788
1983	1,351	45	1,398	37	1,227
1984	1,516	50	1,666	40	1,324
1985	1,589	51	1,773	40	1,279
1986	1,600	50	1,796	38	1,208
1987	1,565	48	1,792	36	1,113
1988	1,565	48	1,792	36	1,113
1989			2,556		1,313
1990					
1991					
1992					
1993					

Source: Health Care Financing Administration.

Fortunately, many of the problems facing the Medicare home health benefit were addressed through both the legislative and regulatory process in the late 1980's. Until recently, the home health benefit was the fastest growing part of the Medicare program. Visits per 1,000 enrollees will increase an estimated 122 percent between 1988 and 1993 (from 1,143 to 2,551).

HCFA, however, continues to make occasional attempts to restrict the use of the home health benefit. HCFA has repeatedly tried to eliminate the "waiver of liability" which home health agencies critical flexibility in interpreting Medicare rules and regulations so they are not forced to deny access in cases where eligibility is in question. OBRA 1990 included an extension of the waiver of liability to December 31, 1995, for home health agencies, SNFs, and hospices.

Another issue of more recent concern to home health agencies is the use of so-called "sampling audits" by HCFA. Medicare fiscal intermediaries have used sampling techniques (i.e., they audit a very small percentage of the agency's claims) to audit home health agency claims. This is done in lieu of auditing all the claims, and the results of the sampling audit are then applied to the agency as a whole. As a result, any errors in the audit are exponentially multiplied, with possibly serious consequences for the affected home health agency. Current law does not specifically authorize the use of sampling techniques in claims coverage audits. Rather, the law refers to individual coverage determinations, based on the principle that each patient under the Medicare home health benefit presents unique health care needs. In October 1991, Senators Pryor and Mitchell introduced legislation (S. 1838) that would bar HCFA from using sampling audits on Medicare providers. Unfortunately, no action was taken on this legislation in the 102nd Congress; it re-

mains to be seen what will occur with regard to the Medicare home health benefit in 1993 and beyond.

(H) ISSUES AFFECTING HOSPITALS

In 1990, as in previous years, Medicare hospital payments became a major target for budget cutting efforts as the Congress sought to meet the deficit reduction targets of the Gramm-Rudman-Hollings law. This, combined with efforts to refine the Medicare hospital prospective payment system, created a challenging setting within which the Congress and the administration sought to resolve health policy and deficit reduction demands. Throughout the budget debate, priority was placed on consideration of those hospitals which would be particularly vulnerable to further cuts, and in preserving the largest possible hospital payment update within the tight budget constraints. As mentioned previously, there were no legislative changes to Medicare Part A in 1991 or 1992. As a result, for the first time in years, hospitals received a respite from legislative budget-cutting action that went beyond what was already in law.

(1) The Prospective Payment System

Under PPS, hospitals are paid a predetermined rate based on a physician's diagnosis rather than the former cost-based reimbursement system. Medicare-eligible hospital inpatients are classified into 1 of 487 diagnosis related groups (DRGs), which are based on the patient's diagnosis. DRGs represent the national average cost per case for treating a patient with that particular diagnosis. Until fiscal year 1995, separate PPS rates apply depending on whether a hospital is located in a large urban area (over 1 million people, or 970,000 in New England), other urban area, or rural area, as determined by the Metropolitan Statistical Area (MSA) system maintained by the Office of Management and Budget. These rates are adjusted to account for differences in hospital wage levels. An area wage index is calculated for each MSA; a single wage index is established for all the rural areas in each state.

The national PPS payments rates were phased in over a 4-year period, which was completed in FY 1988. During the transition period, payment rates were based in part on historical, hospital-specific costs and in part on the Federal DRG payment amount. Payments are now based on the Federal DRG amount, with no hospital-specific component. In most areas, the Federal amount is a fully national rate. Although in a few regions with historically higher costs, the Federal amounts will be based in part on regional rates until September 30, 1990. This final transition provision is known as the regional floor. This was extended for 3 years to September 30, 1993, by OBRA 1990. HHS is to report to Congress by June 1993 on a new index to adjust payments for variations in nonlabor inputs. This extension of the regional floor was somewhat controversial in that it mostly benefits hospitals in 11 northeastern and midwestern States.

To determine the total payment to a hospital for a particular DRG, the applicable Federal payment amount is multiplied by the relative weight for that particular DRG. Each of the approximately

487 DRGs has been assigned its own weight which reflects the relative costliness of treating a patient in that DRG compared to the average Medicare patient.

PPS rates are updated each year by the use of an "update factor." The annual update factor is determined, in part, by the projected increase in the hospital marketbasket index (MBI). The marketbasket index measures the cost of goods and services purchased by hospitals, yielding one price inflator for hospitals in a given year. The update factor also includes adjustments for increases in hospital productivity, technological change, and other factors that affect the level of operating cost per discharge. It is also adjusted to include increases in average payments per case attributable to increases in case mix due to changes in coding and reporting accuracy.

Before FY 1988, the same factor was used for all hospitals. However, in subsequent years, separate factors have applied to hospitals according to location. Hospital payments comprise such a large share of the Medicare program that they were the major focus of congressional efforts to trim Medicare in 1990. Under the 5-year budget agreement in OBRA 1990, hospitals will be cut by a total of $13.7 billion. The largest portion of that savings comes from changes in the update factor. The update factor for large and other urban hospitals after January 1, 1991, is equal to the MBI minus 2 percent; for FY 1992, MBI minus 1.6 percent; for FY 1993, MBI minus 1.55 percent, and for FY 1994–95, the full MBI increase. For rural hospitals, the update factors are: after January 1, 1991, the MBI minus 0.7 percentage points; for fiscal year 1992, the MBI minus 0.6 percentage points; for fiscal year 1993, MBI plus 0.55 percentage points; for fiscal year 1994, the MBI plus 1.5 percentage points, and for fiscal year 1995, the amount necessary to provide rural hospitals with an average standardized amount equal to that of other urban hospitals.

(2) Capital Reform

Capital-related costs (including depreciation, leases and rentals, interest, and a separate return on equity payment for proprietary hospitals) are excluded from PPS and are paid on a reasonable cost basis. The passthrough of capital costs has encouraged hospitals to make capital investments whether or not they are justified in terms of the needs of their communities. Moreover, as ProPAC has noted, the passthrough encourages early retirement of assets, promotes insensitivity to interest rates and financing methods, and favors the use of capital over labor resources. In fiscal year 1991, Medicare paid about $6.2 billion for capital-related costs.

In establishing PPS, the Secretary of HHS was originally authorized to develop a method for including capital costs in PPS. Congress repeatedly postponed this authority. OBRA 87 required the Secretary to provide payment for capital-related costs in accordance with a prospective payment system, effective for hospital cost reporting periods beginning on or after October 1, 1991, and repealed the Secretary's authority to establish prospective payments for capital before that date.

OBRA 1990 continued the 15-percent reduction in capital payments to all PPS hospitals for FY 1991. It also requires the Secretary, in developing the prospective payment system for capital costs to take effect in FY 1992, to make payments in such a way as to reduce aggregate capital spending by 10 percent in fiscal years 1992 through 1995. Sole Community Hospitals (SCHs), Essential Access Community Hospitals, and Rural Primary Care Hospitals were exempt from this reduction.

HHS published their initial proposal for prospective capital payment in the Federal Register on February 28, 1991; final rules were published on August 30, 1991. This implementation of this system, scheduled to take place over a 10-year period, began on October 1, 1991. Once fully-implemented, capital payments will be made on the basis of systemwide average costs, rather than the particular costs incurred by each individual hospital. This means that hospitals with above-average capital costs will receive lower payments while those with lower capital costs will receive higher payments.

Not surprisingly, the new system raised a great outcry from the providers. Hospitals felt that there were already sufficient incentives for restraint and that a prospective payment system for capital could deprive some hospitals of payment for necessary spending. ProPAC generally accepted the proposal, although it expressed some reservations about some of the specific features of the system. Most of the debate on the proposal centered on the approaches to particular issues, including: the method for establishing basic rates and for increasing those rates in future years; transition rules and other exceptions to protect the hospitals most severely affected by the change in payment methods; and the extent to which capital payment rates should be adjusted to reflect hospital or patient characteristics or other factors that could affect relative levels of capital spending. HHS attempted to address some of these concerns in the final rule.

Similar to the PPS system, in which payment rates are based on a base year (1981) and increased each year through an "update factor," the proposal will base initial capital payment rates on average capital costs per case in FY 1989, updated for inflation and other cost changes. The base will have to be adjusted over the next 4 fiscal years in accordance with the requirements of OBRA 1990 that the rates achieve an aggregate savings of 10 percent relative to what would be paid under a full cost system.

The hospital industry is concerned about what happens after the first 4 years with respect to payment updates. They are fearful that the experience may be similar to that of annual updates in the PPS rate. The Secretary was originally supposed to establish the PPS update factors, taking into account inflation and other important factors. However, largely because of interest in deficit reduction, Congress has usually established update factors directly in legislation, and often below the rate of inflation. Hospitals are concerned that the same situation with respect to capital payments could have a serious effect on their ability to make capital investments for two reasons. First, because hospitals may have difficulty borrowing funds if lenders cannot be sure of the hospital's future income and their ability to meet their debt; and second, because of the nature of capital investments, which are fixed over a number

of years, it is more difficult for hospitals to respond to restraints on payment. ProPAC has recommended that a single update be used for both capital and operating expenses. The hospital industry would like to see a distinct capital update factor, based solely on actual increases in capital spending.

The transition period to the new payment system has also been difficult to address. The Secretary's final rule uses three options: (1) the use of blended rates to provide a gradual shift from hospital-specific to industrywide payment rates; (2) "grandfathering," under which hospitals with above average capital costs may continue to be paid on a cost basis for their existing capital commitments; and (3) special protections for the "outlier" hospitals most seriously affected.

The issue of adjusting capital payments to reflect those factors included in the DRG payment, such as diagnosis, location, presence of graduate medical education programs, and the proportion of low-income patients has also been raised. HHS' system uses six basic adjustments, including a higher payment rate for hospitals located in large urban areas. The American Hospital Association contends that some additional adjustment factors could improve the relationship between payment and costs. In particular, they propose adjustments for the age of a hospital's facilities and the degree of the hospital's dependence on debt.

(3) Medical Education

Since its enactment in 1965, Medicare has reimbursed hospitals for its share for the direct costs of approved health professions education programs conducted in hospitals. These direct costs include: (1) Salaries and fringe benefits for residents, faculty, and support staff; (2) the cost of conference and classroom space in the hospital; (3) any costs of additional equipment and supplies; and (4) allocated overhead costs. Physician graduate medical education (residency training) is the most costly component of health professions education paid under Medicare.[13] In addition, Medicare pays teaching hospitals an additional amount, called the indirect adjustment, to cover factors (including indirect teaching costs such as additional tests ordered by residents) that are believed to result in higher costs in teaching hospitals then in nonteaching hospitals.

When the Medicare program was established, Congress made clear its intent that Medicare should support the clinical training of health personnel at least until alternative community-based systems of support were developed. As a result of Medicare payment policies, as well as additional Federal support of the health professions through the National Institutes of Health and Title VII of the Public Health Service Act, a vast network of medical and health profession schools developed throughout the country.

The resulting growth in medical education has helped ease what was once a substantial physician shortage to the point where many now argue that we are in danger of having too many physicians. However, while in the aggregate there may be an excessive amount

[13] U.S. Library of Congress, Congressional Research Service, Background Paper for use of the Members of the Senate Finance Committee on Payments for Medical Education by the Medicare Program Washington, DC, May 1985.

of physicians, a physician shortage is expected to exist for certain specialty areas such as psychiatry and primary care specialists. Additionally, there is also evidence that there remain a large number of medically underserved areas in the Nation, indicating that excess supply does not directly alleviate maldistribution problems, especially in poor inner-city neighborhoods and remote rural areas.

The legislation authorizing PPS took into account the costs of both direct and indirect medical education. However, within a few years, claims were made that reimbursement for both direct and indirect medical education under Medicare was excessive, and that reductions were warranted.

Direct Medical Education.—Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Congress established a PPS for the direct costs of medical education. The Medicare payment to each hospital is equal to the hospital's cost per full-time equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE amount is calculated using data from a base year, increased by 1 percent for hospital cost-reporting periods beginning July 1, 1985, and updated in subsequent cost-reporting periods by the change in the CPI. The number of FTE residents are calculated at 100 percent for residents in their initial residency period. For residents not in their initial residency period, the weighting factor was 75 percent before July 1, 1987, and 50 percent after that date.

OBRA 1990 included a provision addressing direct medical education overpayments. It prohibits the Secretary from making any recoupments related to overpayments resulting from the COBRA payment changes for the costs of graduate medical education in FY 1991. The recoupments will then be made over a 4-year period, with one-quarter of the amount due from each hospital payable in each of the 4 fiscal years beginning with 1992.

Indirect Medical Education.—Under the 1983 PPS legislation, Congress doubled the indirect medical education adjustment in order to counteract the potential negative impact that PPS was expected to have on teaching hospitals. These additional payments are made to compensate for the indirect costs associated with the presence of approved graduate medical education programs (or residency training). They may be due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents. Congressional reports on the PPS authorizing legislation indicate that the indirect medical education payments are also to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients, increased use of diagnostic testing, and higher staff-to-patient ratios.

COBRA provided for additional payments to teaching hospitals based on a formula that increases the Federal portion of the DRG payment from May 1, 1986, to October 1, 1989. The payment increases for each 0.1 increase in the hospital's intern and resident to bed ratio on a curvilinear or variable basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to bed size). OBRA 1987 reduced the adjust-

ment to 7.7 percent effective for hospital discharges occurring on or after October 1, 1988 and before October 1, 1995.

The President's FY 1991 budget proposed to reduce the adjustment factor from 7.7 percent to 4.05 percent on the same curvilinear basis. The estimated savings from this proposal was $1.03 billion. Both ProPAC and the General Accounting Office had made similar proposals based on the argument that this lower amount more accurately reflects the estimated effect of teaching programs on a hospital's costs. The Senate's FY 1991 reconciliation proposal included a reduction in the indirect medical education adjustment to an average of 6.8 percent for each 0.1 percent increase in the hospital's ratio of interns to residents. This Senate proposal, however, was not included in OBRA 1990, and the issue was not addressed in 1992.

(4) Uncompensated Care

In 1991, 33 million Americans under the age of 65—nearly 15 percent of the non-elderly population—were without health insurance. The uninsured are disproportionately young; nearly one-half are under 25 years of age, and more than a quarter are children under 18. They are also disproportionately poor or near-poor. About 30 percent are in families with incomes below the Federal poverty level; just over 30 percent have incomes between 100 and 200 percent of poverty.[14] Surprisingly, 300,000 persons over the age of 65 are without insurance of any kind even though the common perception is that all the elderly are taken care of by Medicare and Medicaid.[15]

The number and proportion of the uninsured is increasing. Before prospective payment, many hospitals were able to shift the burden of providing high levels of uncompensated care to Medicare and other payers, such as Blue Cross. Under PPS and the continued reduction of Federal payments, as well as tightening reimbursement policies among private payers, hospitals are increasingly reluctant to take patients for whom there is no guarantee of reimbursement. The shrinking number of hospitals that take large numbers of low-income patients argue that such patients are generally sicker and require greater intensity of services. To the extent that these hospitals are bearing a disproportionate burden of such patients, they assert that they should be receiving a reimbursement which reflects this special burden.

Disproportionate Share Hospitals.—The special needs of disproportionate share hospitals (DSHs) have been the subject of much debate and have greatly influenced congressional action on a number of issues related to Medicare hospital reimbursement. Special needs could be interpreted to include a broad array of specific problems found in hospitals serving low-income or Medicare patients, ranging from potentially higher costs of treating patients that are more severely ill to the cost of providing uncompensated care. Generally, they have been interpreted more narrowly. Thus,

[14] The Pepper Commission. A Call to Action. (Washington, DC: U.S. Gov. Print Off) September 1990, p. 21.

[15] U.S. Congress, Senate Special Committee on Aging, Americans at Risk: The Case of the Medically Uninsured. Background paper prepared by the staff. Washington, D.C., June 27, 1985.

the costs of additional services and more costly services that may be required to meet the needs of low-income or Medicare patients would be included only to the extent that such costs result in higher Medicare operating costs per case in hospitals serving disproportionate numbers of such patients. Moreover, additional payments to hospitals under Medicare for such costs as uncompensated care have been excluded, usually on the grounds that Section 1861(v) of the Social Security Act specifically prohibits Medicare from paying for the costs of services provided to persons not entitled to benefits under the program.[16]

COBRA provided that additional payments would be made to DSHs. This adjustment was extended until October 1, 1990, by OBRA 1987 and to October 1, 1995, by the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100-647). A hospital's disproportionate patient percentage is defined as the hospital's total number of inpatient days attributable to Federal Supplemental Security Income (SSI) beneficiaries divided by the total number of Medicare patient days, plus the number of Medicaid patient days divided by the total patient days. OBRA 1989 also increased the Federal portion of the DSH's reimbursement rate for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds, by 2.5 percent plus 60 percent (a multiplier of 0.6) of the difference between 15 percent and the hospital's disproportionate patient percentage. Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds that have a disproportionate patient percentage of over 20.2 percent receive a further increase in the adjustment. Hospitals with more than 20.2 percent low-income patients, the payment adjustment is increased by 5.62 percent plus 65 percent (a multiplier of 0.65) of the difference between 20.2 percent and the hospital's percentage of low-income patients.

OBRA 1990 revised the formulas for computing the disproportionate share adjustment, effective January 1, 1991. It increased the disproportionate share payment adjustment for urban hospitals with 100 or more beds and rural hospitals with 500 or more beds by increasing the multiplier used in the payment formula on a phased-in basis from FY 1991-95. Hospitals qualifying for the adjustment based on revenue for indigent care received from State or local governments will receive an adjustment of 35 percent. It also makes the disproportionate share adjustment permanent.

(5) Area Wage Index

The area wage index is an important element used in the calculation of DRG payments to hospitals. The wage index was developed to ensure that the DRG payments reflect differences in wages from area to area. In 1987, ProPAC recommended that the Secretary of HHS update the hospital wage data on a regular basis in order to ensure the most accurate wage index possible, and that the data include wage and hour employment information for hospital occupational categories.[17] In 1987, HCFA published final rules

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[16] U.S. Library of Congress, Congressional Research Service. Medicare Payment Provisions for Disproportionate Share Hospitals. Background Paper. Prepared for the use of the Members of the Committee on Finance, Washington, D.C., July 1985.

[17] Prospective Payment Assessment Commission, Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, Apr. 1, 1987.

for the Medicare inpatient hospital prospective payment system which changed the method of computing the national average wage level for use in determining the area wage index. OBRA 1987 required the Secretary to update the wage index by October 1, 1990, and at least every 3 years after that. OBRA 1989 required the Secretary to update the area wage index annually, in a budget neutral manner. Because of some problems with the OBRA 1987-mandated October 1, 1990, wage index, OBRA 1990 phased it in over 2 years. In FY 1991, each hospital's wage adjustment was based on 75 percent 1988 data, and 25 percent 1984 data. In FY 1992 and beyond, the index will be based on entirely 1988 wage data.

(I) RURAL HEALTH CARE

Rural hospitals are beset by a special set of problems that make them vulnerable to financial difficulties. These problems include fewer hospital admissions, declining lengths of stay, and the increasing severity of illness of patients. Hospitals in rural areas also tend to have fewer personnel and specialized services, lower overall occupancy rates, and serve a population more likely to be underinsured as well as older than average. Cost containment efforts, particularly Medicare's prospective payment system (PPS) which pays rural hospitals less than urban hospitals, are a source of financial pressure. More broadly, poor economic conditions across rural America adversely affect the hospitals located in these regions.

In remote, rural communities, a hospital may be the sole source of health care. The closure of these so-called "frontier" hospitals means that individuals seeking health care are forced to travel long distances or to forgo needed care. One study finds that largely because of limited resources and poor transportation, about a third of rural residents under age 75 crossed a county line to obtain medical care. Less than one-fifth of those over 75 left their home counties for care.

Over the last several years, the number of hospital closures in rural communities climbed to alarming levels, but more recently appears to be leveling off. In 1985, a total of 20 rural community hospitals shut their doors, followed by 36, 40, and 46 closures in the 3 years that followed. In 1989 and 1990, the number of closures were 44 and 28, respectively in these years. Although this trend is encouraging, Medicare operating margins—namely, the extent to which hospitals realize a profit on Medicare patients—remain problematic. In 1990, two-thirds of all rural hospitals lost money treating Medicare patients.

During this same period, in an effort to strengthen their financial status many rural hospitals diversified their services. Some facilities increased out-patient care and social services, while others joined multi-hospital arrangements to ease financial difficulties. These arrangements ranged from affiliations, shared services, and consortium arrangements, to contract management, leases, corporate ownership with separate management, and complete ownership. The benefits of such arrangements include cost-savings from joint purchasing and shared services, certain operating advantages such as increased productivity and lower staffing requirements, and improved access to capital resulting in lower interest costs.

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In response to the increasing numbers of rural hospital closures Congress significantly modified features of Medicare reimbursement policy. In the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), provisions were included to set a higher PPS update factor for rural hospitals than for urban hospitals (the update factor is discussed in greater detail in the above section); liberalize the criteria for classifying hospitals as sole community hospitals, a status which qualifies institutions to special treatment under PPS; extend the status of current referral centers for 3 additional years, including all hospitals classified as referral centers before October 1, 1989; require the Secretary of the Department of Health and Human Services (HHS) to establish a Geographical Review Board for hospitals to direct appeals for a change in classification from rural to urban, or from one urban area to another urban area; require the Secretary of HHS to develop a proposed phase-out plan of the urban-rural differential; permit small rural hospitals classified as Medicare-dependent, caseloads consisting of 60 percent or more Medicare beneficiaries, to receive payment based on the sole community hospital reimbursement schedule; and to increase rural health care transition grants to $25 million for FY 1990 and allowing these grants to be awarded for telecommunications projects.

Another important provision is the Essential Access Community Hospital (EACH) demonstration program, providing grants in up to seven States to develop a rural health network. The EACH program is based on the premise that it may make more sense for some rural areas to preserve access to needed services through some other means other than operating a full-service acute care hospital. The prototype for the program is Montana's project to develop a class of acute care providers called "medical assistance facilities" (MAFs). An MAF is licensed to provide inpatient care while a patient is awaiting transfer to another hospital, or for stays lasting 4 days or less. Under the EACH project, a new type of facility, Rural Primary Care Hospitals (RPCHs), would serve as provider of only limited emergency inpatient care and temporary inpatient care for patients requiring stabilization before discharge or transfer to another hospital. RPCHs would be linked with full service hospitals (EACHs).

In the following year, legislation included in OBRA 1990 authorized further important changes to Medicare policy. The most significant provision eliminates, over a 5-year phased in period, the reimbursement differential between urban and rural hospital PPS rates. For FY 1991, the update factor was the market basket index (MBI) minus 0.7 percent; FY 1992, MBI minus 0.6 percent; FY 1993, the full MBI increase; FY 1994, MBI plus 1.5 percent; and FY 1995, MBI plus the percentage necessary to close the gap between other urban and rural standardized amounts. In years subsequent to 1995, there will be no difference in the standardized amounts between other urban and rural. Another provision increases the disproportionate share adjustment for large rural hospitals with 500 beds or more.

The shortage of primary care health personnel is also a critical factor threatening the survival and effectiveness of rural health care services. Despite increased numbers of physicians, it continues to be difficult to impossible to attract needed physicians to medical-

ly underserved and remote rural areas. Recent studies have documented a great need for doctors in rural areas.

In 1988, physician availability in rural counties was less than one-half the national average—97 physicians/100,000 people versus 225 physicians/100,000 people. Adding to this problem, a 1988 survey of rural physicians found that as many as 26 percent of rural physicians were considering retirement or relocation within the next 5 years. In that same year, 111 rural counties had no practicing physician. In contrast, no metropolitan county lacked a physician.

Because of the geographic maldistribution of physicians, nurse practitioners and physician assistants have become even more important in rural areas. However, in recent years, the number of nurse practitioners in these areas has fallen. Evidence suggests a similar decrease of physicians assistants in rural areas.

To address this maldistribution and shortage of rural health care personnel, in the 102nd Congress Senators Pryor, Packwood, and Graham introduced the proposed "Rural Primary Care Incentives Act." The bill, which was reintroduced at the start of the 103rd Congress as S. 241, attempts to begin to address rural personnel shortages through the use of modest tax incentives and the elimination of a tax disincentive; preventive health care grants for rural county health departments; and grants for 10 State demonstration projects to promote recruitment and training primary care providers from among the poor and disadvantaged populations.

Specifically, S. 241 would provide qualified primary care physicians, nurse practitioners and physician assistants who are practicing in rural areas in class 1 and 2 Health Professions Shortage Areas (HPSAs) a tax credit for 3 years based on a 5-year service incentive. It would also eliminate the taxable status of funds given to physicians through the National Health Service Corps Loan Repayment Program. Additionally, the legislation would mandate studies to determine the feasibility of extending the tax benefit to practitioners in medically underserved urban areas.

In the past, HPSAs have relied on the recruiting and placement efforts of the National Health Service Corps (NHSC). The NHSC, which has proven to be the breeding ground for HPSA primary care providers, employs scholarship and loan forgiveness programs as recruitment tools. The legislation will complement the NHSC's efforts to place physicians in underserved areas. In the past, scholarship physicians have tended to leave the areas they were practicing after they had fulfilled their obligation. A substantive tax credit has potential to encourage many of them to stay or return to the HPSA.

Moreover, this complementary approach addresses the fact that even with the recent increase in funding of the NHSC scholarship and loan repayment program, it will take years before sufficient numbers of NHSC primary care providers are available for placement in underserved rural communities.

In another step toward addressing rural health care practitioner shortages, the Senate Aging Committee held a workshop in the 102nd Congress to identify disincentives toward training practitioners in rural settings. A panel of rural health policy analysts, educators, and program administrators discussed the role the Federal

Government plays in both promoting and undermining rural-oriented training programs through Title VII of the Public Health Service Act and Medicare graduate medical education (GME) policy. In particular, panelists noted that because Medicare GME payments flow to large, teaching hospitals, they help perpetuate a high-tech, specialized style of medicine at the expense of rural-oriented medicine. In 1993, the Aging Committee can be expected to further scrutinize Medicare GME policy, with an aim toward developing needed reforms.

Rural Referral Centers, Medicare Dependent Hospitals, and Sole Community Providers.—Rural hospitals classified as rural referral centers (RRCs) are defined as rural hospitals having more than 275 beds and meeting certain other criteria, such as having at least 50 percent of their Medicare patients referred from other hospitals, and more than 60 percent of their Medicare patients residing more than 25 miles from the hospital. RRCs are paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index. OBRA 1989 extended the RRC classification through October 1, 1992. In 1992, a provision to extend the RRC status until FY 1995 was included in H.R. 11; this legislation was vetoed by the President in November 1992. As of March 1992, 235 hospitals were qualified as referral centers.

Sole community hospitals are those hospitals that (because of factors such as isolated location, weather conditions, travel conditions, or the absence of other hospitals) are the sole source of inpatient services readily available in a certain geographic area. OBRA 1989 established payment provisions that apply to all cost reporting periods beginning on April 1, 1990. An SCH may receive the higher of the following rates as a basis of reimbursement: a target amount based on 100 percent hospital specific prospective rates based on FY 1982 costs updated to the present; a target amount based on hospital specific prospective rates based on FY 1987 costs updated to the present; or the Federal PPS rate. As of March 1992, there were 635 SCHs.

OBRA 1989 created a new classification of hospitals termed Medicare dependent hospitals (MDHs). MDHs are those hospitals that are located in a rural area, have 100 beds or less, are not classified as a sole community provider, and for which not less than 60 percent of inpatient days or discharges in hospital cost reporting period that began during FY 1987 were attributable to Medicare. These hospitals are reimbursed in the same fashion as sole community providers. As of January 1992, there were 514 such hospitals. This provision expired on October 1, 1992. Although H.R. 11 contained a provision to extend this status in a modified fashion through FY 1995, this legislation was vetoed by the President.

(J) MEDICARE END STAGE RENAL DISEASE

Since 1973, the Medicare program has paid for the medical and related health care services for over 90 percent of the U.S. population with End Stage Renal Disease (ESRD). ESRD, or chronic renal failure, occurs when an individual irreversibly loses a sufficient amount of kidney function so that life cannot be sustained without

treatment. If the kidneys lose their ability to function, the blood cannot be cleansed of metabolic waste products and the patient will die from toxemia. The primary form of treatment for ESRD is some form of continuous kidney dialysis, where the blood is filtered and the waste products in the blood are removed. Kidney transplantation is also performed on a select number of patients, which obviates the need for continuous dialysis.

The majority of ESRD patients in the United States are elderly. Because of the increasing number of elderly patients in this country, the number of ESRD patients in the United States is expected to increase over the next few years. However, ESRD afflicts patients of all age groups.

In 1991, Medicare paid for the care of 142,488 dialysis patients in the United States, an increase of almost 10 percent from 1990. Approximately 117,371 patients (82 percent of all dialysis patients) were receiving some form of dialysis in an organized health care setting, such as a hospital or dialysis facility, while 25,117 patients (18 percent of all dialysis patients) were performing dialysis in their own home. About 10,000 kidney transplants were performed in the United States in 1991, an increase of about only 2 percent from 1990.

Total ESRD program costs in 1990, the last year for which accurate expenditure data are available, were $5.3 billion dollars. Total costs for dialysis patients were $4.4 billion, while the costs of performing transplants totalled $888 million. The cost of maintaining those patients who already had a kidney transplant was $308 million.

Those ESRD patients who are not covered by Medicare are either covered by Medicaid, have private insurance (including those who have employer group health insurance coverage for the first year of ESRD, with Medicare becoming the primary insurer after 12 months after diagnosis), or pay out-of-pocket.

While there were no major legislative changes made in the ESRD program by the U.S. Congress in 1992, several changes were proposed, and came very close to being enacted. Three provisions were included in H.R. 11, an omnibus tax and health care legislation bill that was crafted at the very end of the session, but the legislation was vetoed by President Bush after the November election. It is likely that Congress will consider these changes once again in 1993. The proposed legislative changes were as follows:

(1) Secondary Payer Provisions for ESRD Beneficiaries

Under current law, Medicare is secondary payer to other insurance plans for 18 months for beneficiaries who are eligible for Medicare solely because they have ESRD. Also under current law, after January 1, 1996, Medicare is the secondary payer for a 12-month period. Under H.R. 11, the period for which Medicare is secondary to other payers would be extended to 24 months, from January 1, 1993, to January 1, 1996. After January 1, 1996, until January 1, 1998, the period for which Medicare is secondary payer is 18 months. By extending the time before which Medicare becomes the primary payer for ESRD, total Medicare ESRD program expenditures would be reduced.

(2) Reduction in Payment to Dialysis Facilities for Recombinant Erythropoietin

Under a provision in H.R. 11, payment to dialysis facilities per 1,000 units of recombinant erythropoietin (rEPO) administered to a dialysis patient would be decreased from $11 to $10. Currently, the $10 per 1,000 units administered payment is made as an add-on to the composite rate that a dialysis facility receives for each session in which the patient is dialyzed. On average, a dialysis patient receives 3,300 units of rEPO during each dialysis session.

The Congress has for each year since 1989 focused on its expenditures for rEPO. That is because the ESRD program incurs millions of dollars in expenditures to pay for administrations of this biological. For example, in 1989, government expenditures for rEPO were $45 million, in 1990 they were $250 million, and in 1991 they were $310 million. It is estimated that rEPO expenditures will top $400 million in 1992.

Medicare pays for rEPO because the ESRD program covers the costs of prescription drugs and biologicals for dialysis and kidney transplant patients. This product treats the anemia that is common in patients who are unable to produce the naturally-occuring substance erythropoietin, which is made by healthy kidneys. Erythropoietin (EPO) is responsible for manufacturing red blood cells in the body. Patients in renal failure are unable to produce EPO, causing a constant state of chronic anemia. Because of the anemia, dialysis patients are often weak, lethargic, and unable to perform the normal activities of daily living. Recent studies show that regular administrations of rEPO alleviates the anemia and enables dialysis patients to live more normal lives.

Over two-thirds of all Medicare Part B expenditures on prescription drugs and biologicals are attributable to rEPO costs. The program incurs significant expenditures for the product because it is very expensive and because a high proportion of ESRD patients receive the product on a regular basis.

The intent of this provision was to reduce total Medicare program expenditures for rEPO by encouraging the manufacturer of the biological, Amgen Inc., of Thousand Oaks, CA, to reduce the cost of the drug to dialysis facilities. By reducing the reimbursement to dialysis facilities, it was anticipated that the manufacturer would negotiate or renegotiate contracts with the dialysis facilities that would lower the purchasing costs of the drugs for the facilities.

Because the current list price for the drug is $40 per 4,000 units, or $10 per 1,000 units, dialysis facilities expressed concern that the manufacturer would not reduce the sales price, and that the cost of purchasing the drug and the reimbursement from Medicare would be the same. This reimbursement would then become inadequate to cover the other incidental costs involved in administering the biological, such as nursing time and supplies, such as syringes. As an unintended consequence, this might result in a reduction of the biological being provided to the patient in some cases.

Responding to these concerns, Chairman Pryor and Senators Breaux (D–LA), Rockefeller, (D–WV), Riegle (D–MI), and Baucus (D–MT) wrote to Secretary Sullivan about the situation. They en-

couraged the Secretary to closely monitor the response of the manufacturer to the reduction in reimbursement, should it have been enacted, and the ability of dialysis facilities to safely administer the proper amounts of the biological to dialysis patients. The Secretary was also encouraged by the Senators to develop an alternative method to contain the cost of rEPO, such as the establishment of a manufacturer rebate program for rEPO. Such a program was established for drugs purchased by the Medicaid program, and has helped the $5.4 billion Medicaid program save on prescription medication costs.

Congress amended the Social Security Act in 1990 to permit self-administration of rEPO for home dialysis patients starting in July 1991. Because the Social Security Act prohibits HCFA from paying for drugs or biologicals that can be self administered, patients that would normally dialyze at home could not receive rEPO unless they went to a dialysis facility. This proved inconvenient to these patients who had to make adjustments in their home dialysis schedules and lifestyles to travel to facilities just to receive rEPO. This was a particular problem for elderly and other immobile dialysis patients that did not live near facilities.

OBRA 1990 provided that rEPO could be self-administered at home for those patients who are competent to use the biologic without medical or other supervision, subject to methods, standards, and reimbursement rates established by the Secretary of HHS. Because of the short time period between the implementation of the new self-administration provision and the development of this report, HCFA was unable to determine the number of dialysis patients that were actually self-administering the biological at home.

(3) Extension of Medicare Immunosuppressive Drug Coverage

The Medicare Catastrophic Coverage Act (MCCA) of 1988 permitted extended coverage of immunosuppressive drugs for Medicare patients for years after the first year of the transplant, but MCCA was repealed by the Congress in November, 1989. A provision that was included in H.R. 11 would have extended coverage for immunosuppressive drugs under Medicare to 24 months in 1995, 30 months in 1996, and 36 months in 1997. Given the significant costs of these medications and the need for transplant patients to take these drugs on a chronic basis, providing this additional coverage would help, if enacted, but would not solve the long-term drug affordability problems for transplant patients. Because H.R. 11 was vetoed, this provision was not enacted in 1992.

(K) MEDICARE FRAUD AND ABUSE

Although it is generally believed that only a small minority of health care providers unfairly profit from Medicare, there is no question that the program is vulnerable to fraud and abuse. According to some insurance industry estimates, as much as 10 percent of all health care spending may be a result of fraudulent billings.

In recent years, both the Office of Inspector General (OIG) and the General Accounting Office (GAO) have identified serious weak-

nesses in the administration of Medicare that open the program to financial abuse. The first of these studies, conducted by the OIG in 1988, investigated approximately 20 percent of all Medicare carriers—private insurance companies that have contracted with the Health Care Financing Administration (HCFA) to process Medicare Part B claims.

According to the OIG study, Medicare carriers have moved away from post-payment review of claims, and no value has been placed by HCFA on the deterrent value of such reviews. In addition, staffing levels to carry out this function have not kept pace with rising workloads and HCFA has failed to review many carrier's post-payment review activities. At the same time, HCFA gave other carriers full credit for efforts in this area despite known deficiencies.

In the same study, the OIG found that a significant number of carriers often failed to identify substantial fraud and abuse violations, to properly develop fraud cases, and to refer fraud cases to the OIG for prosecution. Carriers referred only a small number of potential fraudulent cases to the OIG for investigation. Of those that were referred, many cases were poorly documented, while many unreferred cases may have warranted criminal or administrative sanctions. Seven out of nine carriers audited closed fraud cases prematurely, failing to make any effort to determine whether there was a pattern of abuse.

Another focus of the OIG's 1988 study was the extent to which HCFA monitored efforts of the carriers to investigate complaints of fraud and abuse raised by Medicare beneficiaries. Out of hundreds, if not thousands of such complaints, the OIG reported that HCFA reviewed annually a total of 10 cases per carrier. Furthermore, the staff who reviewed these cases were insufficiently trained, according to the study. In response to this criticism, HCFA increased the number of claims annually reviewed to 20 per carrier.

A key reason for Medicare fraud and abuse, according to 1990 GAO testimony, is that Federal funding to Medicare contractors for program safeguards activities has not kept pace with the growth in the number of claims and other related responsibilities. In an investigation into this problem, GAO documented cuts as high as 50 percent in the size of the claims review staff at Medicare contractors. As a result, there has been a decrease in the use of computerized screens designed to help identify suspect claims. Contractor personnel expressed concerns to GAO that health care providers know which screens are used, that cost-saving screens are being turned off, and that Medicare increasingly is vulnerable to abuse as a result. In addition, GAO found evidence that billions of dollars in costs claimed by small hospitals, skilled nursing homes, and home health agencies are not audited because of insufficient funds. The funding shortfall has occurred in the face of evidence that $11 are saved for every $1 spent on program safeguards. An estimated $14 is saved per $1 spent in this area.

In response to these concerns, for FY 1992 and 1993 the Congress increased funding to Medicare contractors for program safeguard activities. Nevertheless, in January 1993 GAO again warned Congress that fraudulent and abusive billing to Medicare remains a costly problem, resulting in billions of dollars in program losses.

(1) Beneficiary Role in Controlling Fraud and Abuse

Elderly persons, who spend almost three times per capita more on health care than do other adults, have a particular stake in curbing health care fraud and abuse. Unchecked, this problem contributes to higher premiums, cutbacks in covered services, and increased out-of-pocket expenses. Beyond financial harm, unnecessary surgery, tests, and services also pose a health threat.

In 1990, the Senate Special Committee on Aging received numerous reports from elderly Medicare beneficiaries that they had encountered great frustration in trying to get Medicare to follow up on their complaints of provider fraud and abuse. According to these reports, telephone lines to many Medicare contractors were busy for days, and when beneficiaries succeeded in getting through, complaints were not investigated. Similarly, written requests for investigations went unanswered.

Aging Committee Chairman, Senator David Pryor, and the Ranking Minority member, the late Senator John Heinz, requested that the GAO investigate Medicare carriers' responsiveness to beneficiary complaints of fraud and abuse in billing practices. At a 1991 Aging Committee hearing, GAO reported on the results of its investigation. After monitoring a thousand telephone calls from beneficiaries at five Medicare carriers at locations throughout the Nation, GAO found that on average one out of every two such complaints was ignored. In addition, three-quarters of the investigated complaints that contain evidence of a pattern of abuse were treated as isolated cases. At some carriers, negligence on the part of the telephone operators receiving the complaints and those charged with investigating them was much higher.

In its testimony, GAO also stated that Medicare beneficiaries are by far and away the largest source of leads on Medicare fraud and abuse, serving potentially as the first line of defense against this problem. To communicate their concerns, beneficiaries use the toll-free telephone lines to their regional Medicare carrier. According to GAO, HCFA fails to emphasize to Medicare carriers the importance of following up on these leads. Instead, beneficiaries who call in to report false billing commonly are instructed to "put it in writing," or to try to resolve the problem themselves. GAO reported that the toll-free lines beneficiaries use to alert Medicare about billing discrepancies could be eliminated as a result of budgetary concerns.

Efforts to maintain the carrier toll-free lines culminated in an amendment in October 1991 to legislation reauthorizing the Older Americans Act. Under the amendment, HCFA would be required to keep the lines open, using existing funds appropriated to the agency. Although the amendment was unanimously accepted, it was later dropped in conference as a result of budgetary issues unrelated to the merits of retaining the toll-free line. As a result of this pressure, the Administration agreed to retain the toll-free line.

Above and beyond the toll-free line, concerns persist over what steps, if any, HCFA will take to remedy the deficiencies in carrier responsiveness to beneficiary complaints of fraud and abuse. GAO recommended that HCFA provide guidance to, and conduct oversight of, the carriers to ensure that such complaints are heeded

and to assess and report to the Congress whether funding for this purpose is adequate. Bowing to congressional concerns, in 1992 HCFA began placing a far greater emphasis on safeguard activities. However, the Aging Committee can be expected to continue monitoring the progress of these activities in 1993.

(L) PRESCRIPTION DRUGS

(1) Legislation to Contain Prescription Drug Costs

Several bills were introduced during the 1992 session to expand coverage of prescription drugs for older Americans or contain their costs. However, the primary pharmaceutical cost containment bill which was debated and acted on during the session was S. 2000, the Prescription Drug Cost Containment Act. Chairman Pryor, Senator Cohen, and eight other cosponsors introduced S. 2000 in November 1991. However, because the Congress adjourned shortly thereafter, action was not taken on the bill until March 1992.

The primary purpose of S. 2000 was to provide tax-based incentives to drug manufacturers to limit their price increases on prescription drugs. Under the bill, drug manufacturers would lose a certain percentage of their section 936 tax credits if drug prices were increased faster than the rate of inflation, as measured by the Consumer Price Index (CPI).

Frequent and persistent price increases on prescription drugs have become a major barrier to older Americans' ability to afford their medications. According to the Bureau of Labor Statistics, price increases on prescription drugs were triple the rate of general price increases in the economy during the 1980's and the early 1990's. Under this legislation, a link would be established between the availability of the section 936 tax credit and a drug manufacturer's price increase policy. That is, drug manufacturers would still have full access to the section 936 tax credit as long as they increased their drug prices no faster than the rate of inflation.

The section 936 tax credit was created in the early 1920's as a mechanism to encourage the development of manufacturing operations in the commonwealths and territorial possessions of the United States, in particular, Puerto Rico. Many industries have established manufacturing facilities in Puerto Rico, such as the machinery, apparel, and shoe industries. The pharmaceutical manufacturing industry has established the most significant manufacturing presence on the island of Puerto Rico, and is the primary beneficiary of this credit. The drug industry claims about 56 percent of the total amount of the section 936 tax credit each year, or about $2 billion.

Senator Pryor was concerned that the section 936 program had become a very lucrative tax credit for the pharmaceutical industry, and was producing few drug manufacturing jobs in Puerto Rico in relation to the size of the credit that the drug industry was receiving. In fact, while the industry receives 56 percent of the credit, it only hires 18 percent of the employees in Puerto Rico. In addition, a report of the Senate Special Committee on Aging in September 1991 found that the average drug manufacturer section 936 tax credit was $57,000 per employee, while the average salary paid per employee by a drug manufacturer was about $21,000. A report re-

leased in May by the General Accounting Office provided a more detailed description of the tax benefits that the drug industry receives from operating in Puerto Rico.[18]

A more detailed description of the provisions of the bill are described below and summarized as follows:

Using Section 936 to Contain Drug Costs.—Section 1 would provide, as noted above, a strong tax-based incentive for drug manufacturers to keep price increases at or below the general inflation rate. The approach in the legislation first compares the drug manufacturer's section 936 tax credit to the amount of wages it paid in Puerto Rico. If the manufacturer's section 936 tax credit exceeds the wages paid in Puerto Rico, the excess will be subject to a reduction of 20 percent of the tax credit for each percentage point its drug prices increase over the general inflation rate (CPI-U). The formula will be applied on a drug-by-drug basis and be weighted according to the percent of sales that each drug accounts for manufacturer's total drug sales. If the manufacturer's section 936 tax credit does not exceed wages paid, the reduction formula does not apply.

Establishment of Medicaid Drug Benefit Demonstration Project.—Section 2 would provide that up to $200 million saved from the recapture of the 936 tax credit (and directly attributable to excessive and inflationary pricing practices of drug manufacturers) would be directed each year for 5 years to a new Federal Prescription Drug Trust Fund. The Fund would finance the establishment of a 15-site Medicare Outpatient Prescription Drug Demonstration program. The purpose of the demonstration is to find the most efficient and cost-effective way to establish an outpatient prescription drug benefit for Medicare recipients. Revenue above the amount necessary to fund the Demonstration program would be directed for reducing the Federal budget deficit.

Establishment of Prescription Payment Review Commission.—The next section of the bill, Section 3, establishes a Prescription Drug Policy Review Commission (RxPRC). The Commission would be responsible for analyzing trends in national and international prescription drug prices and making recommendations on providing or improving coverage, reimbursement, and financing for prescription drugs under Federal health care programs, such as Medicaid and Medicare. In addition, it would monitor the use and effectiveness of the various financial incentives given to the drug industry, including the revised section 936 tax credit. Finally, the Commission would be charged with studying the feasibility of establishing a pharmaceutical products price review board in the United States. The board would be responsible for developing guidelines for manufacturers on the pricing of pharmaceutical products. Membership on the Commission would include health care and pharmaceutical economists, physicians, pharmacists, other health care professionals, and consumer representatives.

[18] Tax Benefits of Operating in Puerto Rico. The U.S. General Accounting Office, May 1992. GGD-92-72BR.

The legislation was endorsed by 40 national organizations representing a wide range of interest groups, including advocates for older Americans, pharmacist groups, unions, consumer groups, and rural organizations. Groups opposed to the legislation included trade associations representing the pharmaceutical and biotechnology industry, certain groups representing minority interests, and some advocacy groups, such as the American Diabetes Association.

On March 11, 1992, the Senate considered S. 2000 as an amendment to a tax bill that was being debated on the Senate floor. The debate over S. 2000 extended for over 8 hours. There was bipartisan support both for and in opposition to the bill's enactment.

In summary, those speaking in favor of the legislation's enactment cited the escalating cost of pharmaceuticals in the United States, and the impact that these price increases have had on the ability of many Americans, including older Americans, to afford medications. Supporters also argued that drug manufacturers were making excessive profits, and spending hundreds of millions of dollars on marketing and advertising campaigns that were unnecessarily increasing drug costs. Finally, many Senators expressed concerns that the citizens of other industrialized nations, such as Canada, England, France, and Germany, paid much lower prices for pharmaceuticals than Americans. One study released by the GAO in October found that Americans paid 32 percent more for prescription drugs than the average Canadian.

Those speaking in opposition to the bill said that it was unfair to single out the pharmaceutical component of the health care industry for cost containment at a time when the other larger segments, such as hospital and physician costs, were going unchecked. It was argued that the issue of pharmaceutical cost containment should be addressed in the context of overall health care reform, an issue that was likely to be taken up in the 103rd Congress.

Opponents of the bill also argued that the legislation was tantamount to imposing price controls on pharmaceuticals, which would reduce drug industry revenues and impair the ability of the drug industry to conduct research and development on new drugs. Finally, it was argued that using the approach of reducing section 936 tax credits would not affect all drug manufacturing industries operating in the United States since not all companies had manufacturing operations in Puerto Rico. Thus, there was a question of whether use of the section 936 tax credit was the fairest way to contain pharmaceutical costs.

At the end of the debate, the Senate voted to table the legislation, 61–38. Senator Pryor indicated that he believed that the debate over S. 2000 was constructive and educational, and gave Members a flavor of the upcoming debate over comprehensive health care reform. He promised to continue to work with Members of the Senate to find a way to make drugs more affordable and accessible to vulnerable populations, especially older Americans.

Since the debate over the legislation, several drug manufacturers have stated that they would voluntarily limit their pharmaceutical price increases to the rate of inflation. These companies include Merck, Pfizer, Bristol Myers-Squibb, ICI/Stuart, Marion Merrell Dow, and Hoffman LaRoche. While these voluntary efforts are welcome and a step in the right direction, not all manufacturers have

taken this pledge, and there is no guarantee that those that do take the pledge will continue to do so.

(2) Legislation To Expand Prescription Drug Coverage

Provisions to contain overall health care expenditures in the United States, including prescription drug costs, and improve the coverage of prescription drugs in public and private programs, were included in various legislative proposals introduced during the year.

Many of these proposals were designed to deal with the issues of overall health care reform. In may cases, coverage or cost containment mechanisms for pharmaceuticals were included in the packages. Some of the bills included provisions that would expand Medicare coverage to outpatient prescription drugs, or develop ways to contain their costs as part of overall health care reform.

Based on the number of bills that were introduced just in 1992, there seems to be significant interest among health-related legislators in establishing a Medicare outpatient prescription drug benefit. Since the repeal of the Medicare Catastrophic Coverage Act (MCCA) of 1988, several attempts have been made to resurrect the outpatient drug benefit, especially since new data show that the inability of older Americans to afford their medications is increasing. The need for an outpatient prescription drug benefit increases as new, more expensive drugs come to market, and as a greater percentage of the population reaches age 65.

A few of the major bills that were introduced that contained provisions to expand coverage of outpatient prescription drugs are described below:

(a) Prescription Drug Cost Containment Act of 1991 (S. 2000)

As noted above, a provision in this legislation, introduced by Chairman Pryor and Senator Cohen, would establish 15 demonstration projects in various geographic regions to determine the most efficient way to structure a Medicare outpatient prescription drug benefit. The demonstrations would be funded for 5 years, with funding in the initial year set at $200 million. Revenues from the section 936 tax reductions would be used to fund the demonstration projects from a special trust fund. The Senate voted to table this legislation as an amendment to the tax bill in March by a vote of 61–36.

(b) Health Care Cost Containment and Reform Act of 1992 (H.R. 5502)

A provision in this legislation, introduced by Congressmen Stark (D–CA), and Gephardt (D–MO) would establish an outpatient prescription drug program under Medicare Part B. The annual deductible would be set at $800 in 1996, $850 in 1997, and $900 in 1998. After meeting this deductible, Medicare beneficiaries would be responsible for paying 20 percent of the cost of each prescription. The plan would cover all FDA approved prescription medications. To monitor the operations of the outpatient prescription drug program, and analyze the impact of drug price increases on the pro-

gram, the legislation established an 11-member Prescription Drug Cost Containment Commission. This drug benefit was included in legislation which was designed to reform the health care delivery system in the United States.

(c) Health Choice Act (H.R. 5514)

This legislation, introduced by Congressmen Dingell (D–MI) and Waxman (D–CA), would substantially alter the way that health care is financed and provided in the United States. The bill would provide that all Americans have access to health insurance and health care services. In addition, to contain costs, it would provide for overall limits on health care expenditure growth, and seek to promote managed competition of health care services among various providers.

Outpatient prescription drugs would be included as a standard benefit in a basic benefits health care package that would have to be offered to all Americans whether they were enrolled in a fee-for-service health care plan or a managed care plan. A deductible of $500 per person per year ($750 per family) would apply to the outpatient prescription drug benefit. Annual out-of-pocket prescription drug costs would be limited to $1,000 per person per year or $1,500 per family per year. Individuals and families with incomes below 100 percent of the poverty level would have their cost sharing fully subsidized. Those between 100 and 200 percent of poverty would be eligible for partial subsidies. No action was taken on this legislation in 1992.

(d) Long-Term Care Family Security Act of 1992 (S. 2571)

This legislation, introduced by Senators Pryor, Rockefeller, Mitchell, and others would provide universal coverage for long-term care for disabled persons of all ages. The provisions in the bill were based on the recommendations of the Pepper Commission. The Commission was established under the Medicare Catastrophic Coverage Act (MCCA) of 1988 to address the issues of universal access to health care and long-term care services.

To address the cost of taking long-term, chronic-use prescription medications, S. 2571 established demonstration projects to determine the most cost-effective way to provide drug benefits for Americans that take medications on this basis. Because many older Americans have chronic medical conditions, such as hypertension, glaucoma, diabetes, and arthritis, it is very common for older Americans to take multiple, expensive medications for many years. In fact, for the average older American, prescription drug costs are their highest out-of-pocket medical expense, and in many cases, their highest out-of-pocket long-term health care medical expense.

The demonstrations would be designed to use various indicators to determine when an individual would become eligible for a long-term care drug benefit. For example, individuals might be eligible for the benefit when they take a certain number of long-term prescriptions on a regular basis, or when they are unable to perform a certain number of activities of daily living (ADLs). No action was taken on any part of this legislation in 1992.

(e) Expansion of Medicare Immunosuppressive Drug Coverage

Under a provision incorporated into S. 3274, the Medicare and Medicaid Amendments Act of 1992, Medicare would expand coverage of immunosuppressive drugs under Medicare Part B. Currently, Medicare pays for immunosuppressive drugs for 1 year after the date of a Medicare-approved organ transplant. Under this provision, Medicare coverage for immunosuppressives would be extended for 2 years in 1995, to 30 months in 1996, and to 36 months in 1997. The expansion in this benefit would be paid for by a $1 reduction in the payment provided to dialysis facilities for administration of 1,000 units of recombinant erythropoietin (rEPO). This biological is administered to dialysis patients to treat the anemia complications of renal failure.

In May, the Pharmaceutical Manufacturers Association (PMA) Board of Directors took a position concerning the inability of older Americans to find affordable private prescription drug insurance coverage. The association endorsed the inclusion of a prescription drug benefit in one or more insurance plans that were established under S. 1872, "The Better Access to Affordable Health Care Act of 1992." The legislation was introduced by Senator Lloyd Bentsen (D–TX) in order to improve the ability of small businesses and self-insured individuals to obtain affordable health insurance packages. The bill also established a Health Care Cost Containment Commission that would help to develop mechanism to contain health care costs in general, including the cost of pharmaceuticals. The PMA did not, and has not to date, taken a position on the nature of pharmaceutical cost containment that should be included under S. 1872, or other health care reform proposals.

In addition, while the PMA endorsed the inclusion of an outpatient drug benefit in private insurance plans under S. 1872, it did not indicate whether it would support a drug benefit under the Medicare program.

At the end of the year, Senator Donald Riegle (D–MI), indicated that he was working on the development of a Medicare outpatient prescription drug benefit, and would likely introduce the benefit plan in the 103rd Congress. In a statement describing his intent, Senator Riegle said that he would seek to contain overall drug program costs by using the aggregate purchasing power of Medicare to obtain the best deal possible from drug manufacturers.

The significant interest in the cost of prescription medications, and the accessibility of prescription drug insurance coverage for older Americans reached a new level of significance in 1992. Policymakers will be challenged to address both the issues of containing the cost of medications and finding a way to make prescription drug insurance more accessible and affordable as the health care reform debate continues into 1993.

3. Prognosis

Medicare was left virtually untouched by legislation in the 102d Congress as Congress kept to the 5-year agreement under OBRA 1990. Although OBRA 1990 kept beneficiary out-of-pocket costs to a minimum, providers cuts were fairly substantial. A convincing argument can be made that cuts to providers eventually filter their

way down to beneficiary in the form of higher costs, reduced access, or lower quality. Continued careful and constant monitoring will be required to make certain that providers do not sacrifice quality care in order to reduce their costs.

In addition to the deficit reduction debate, the lack of protection against long-term care expenses (detailed in the next section), the need for addressing the issue of the 33 million plus Americans under the age of 65 who have no health insurance, and the issue of ever-increasing out-of-pocket costs for physician services can be expected to be a major focus of the aging and health policy debate.

Many Members believe that before we can address these issues, or ask the American public to pay higher taxes to finance expanded access and availability, health care costs must be contained. The success of the health care cost containment reforms rides on the willingness of patients, providers, and regulators to get the most out of what will have to be an increasingly lean system. Similarly, the success of new approaches to deal with health care needs of the Nation depends on the ability of policymakers and advocates to develop initiatives that can either significantly alter budget priorities or offer creative, cost-effective health policy alternatives. All eyes will be on the new Clinton Administration in 1993 to see where he and his staff will lead America in the area of health care.

C. MEDICAID AND LONG-TERM CARE

OVERVIEW

When a chronic illness strikes, most older Americans find that the long-term care services they need are not covered by Medicare, other public programs, or private insurance. In many communities, particularly in rural areas, the availability of services can be a problem, regardless of one's financial resources or the coverage offered by various programs. And because these services are often needed over an extended period of time, they can impoverish all but the most affluent. For these and many other reasons, long-term care is one of the greatest threats to the financial security of older Americans and their families.

There have been some incremental improvements in long-term care financing and delivery within the last few years, although fundamental change has yet to occur. The reluctance to implement new initiatives can be attributed to several major factors. The enormous costs of improving access to long-term care services for the elderly tend to deter interest in comprehensive legislative reform, particularly in light of the need to reduce the Federal budget deficit. In addition, there is no consensus on a variety of issues relating to long-term care, such as the relative roles of public and private financing, what services should be provided and by whom, and how to determine eligibility. Finally, the 7.1 million older Americans who need long-term care are a relatively new phenomenon. More Americans are living longer than ever before, and the incidence of chronic illness—and hence the need for long-term care—increases dramatically with advancing age.

As the need for increased access to and affordability of long-term care continues to grow more pressing, Members of Congress have

begun to take a more serious look at fundamental change to our current system. While there is no consensus at present, many Members envision a public-private partnership in which the Federal Government would provide a basic level of coverage for all Americans, with greater coverage extended to the low-income, and viable private long-term care insurance policies available to others. The long-term care insurance market has grown rapidly over the past few years, and many believe that this area may show promise for those who are able to afford the premiums. Currently, only 5 percent of older Americans have private long-term care insurance policies, and while this number is expected to rise over the next several years, the affordability, adequacy, and quality of this coverage are key issues. Employers, too, have a crucial role in the debate, as some argue that employer-offered group coverage would make long-term care insurance more accessible and, if the employer contributes to the cost, more affordable.

Because of budget constraints, many members of key congressional committees have focused their efforts in the 102nd Congress on improving the quality and desirability of the private long-term care insurance market. These efforts, which are discussed later in this section, include legislation that would require policies to meet minimum consumer protections, and would clarify certain provisions of the tax code with respect to long-term care expenses.

In addition, a variety of comprehensive long-term care bills were introduced in the 102nd Congress that would fundamentally reform the current system. The Congress has made some steps forward over the past few years—such as the spousal impoverishment provisions in the Medicare Catastrophic Care Act (MCCA), the publication of the Pepper Commission report in September 1990, and the passage of legislation in 1990 to provide home and community-based care to low-income, frail elderly. While it is clear that there is no one solution to improving the access of the elderly and disabled to comprehensive long-term care services, any successful improvements in this area will involve the participation of all parties—Federal, State, and local governments, the private sector, Americans of all ages, advocates of the chronically ill, and consumer-oriented organizations.

Medicaid's role in the debate surrounding long-term care—and in discussions of access of low-income Americans to health care—has become an increasingly central and contentious one. States are feeling increasingly overburdened by the costs of their Medicaid programs, which can be attributed to general health care inflation, growing numbers of people without health insurance, as well as new mandates required by Congress in the late 1980's. Many policymakers argue that the Medicaid program needs to be completely restructured as a part of general health care reform. For example, although not originally intended to pay for the costs of nursing home care except for the very poor, a large percentage of Medicaid dollars are now spent on nursing home costs. These expenditures make it exceedingly difficult to fund other vital health care needs. The increasing funding pressures have produced proposals to shift more funding to the Federal Government and away from the States and their Medicaid programs.

One of the most noteworthy efforts to curb skyrocketing Medicaid costs is a provision that was included in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) that will assure State Medicaid programs lower prices in their purchase of prescription drugs. This provision was based on legislation introduced by Chairman Pryor in 1990. Although not traditionally thought of as long-term care, protections against prescription drug costs represent a true long-term care coverage necessity for older Americans, as 7 of the top 10 drug classes used by them are for the treatment of chronic conditions.

Issues, debates, and challenges surrounding the need for long-term care and prescription drug coverage were raised in the 102nd Congress and can be expected to receive even greater attention in 1993, particularly with the new Administration in the White House. However, low-cost interventions are likely to continue to dominate the legislative initiatives that have the best chance of being enacted.

1. Background

The phrase "long-term care" encompasses a wide array of services offered in a variety of settings ranging from institutional settings (such as nursing homes) to noninstitutional settings such as adult day care centers and a person's own home. Community-based long-term care typically involves a variety of noninstitutional health and social services such as home health care, homemaker, chore and personal services, occupational, physical and speech therapy, adult day care, respite care, friendly visiting, and nutritional and health education. The great majority of long-term care services are provided by family members. Nearly three-quarters of disabled older people not in nursing homes received assistance from relatives and friends in 1989.[19]

Long-term care services provide for the needs of those individuals who are not able to completely care for themselves as a result of chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Those groups needing long-term care include the elderly and nonelderly disabled, the developmentally disabled (primarily the mentally retarded), and the mentally ill. Older people, because of their high risk of chronic illness that results in disability and functional impairment, are the primary recipients of long-term care in this country.

The range of chronic illness and conditions resulting in the need for supportive long-term care services is extensive. Unlike acute illnesses, which occur suddenly and are usually resolved in a relatively short period of time, chronic conditions are of an extended duration and may be difficult to treat medically except to maintain the status quo of the patient.

When these chronic conditions manifest themselves in functional or activity limitations called limitations in "activities of daily living" (ADLs), assistance may be required. ADLs include bathing,

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[19] The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care. *A Call for Action.* (Washington, D.C.: U.S. Government Printing Office), Final Report, Sept., 1990, p. 97.

dressing, eating, getting in and out of bed, and toileting. A second set of measures, called limitations in instrumental activities of daily living (IADLs), reflect a lower level of disability such as difficulties with shopping, cooking, cleaning, and taking medicine.

Although limitations in ADLs and IADLs can occur at any age, their incidence and prevalence increase with advancing age. Approximately 19.5 percent of those 65 and older have a limitation in at least one IADL and ADL. Of those age 85 and older, 56.8 percent suffer some limitation.[20] However, the presence of a chronic illness or condition alone does not necessarily result in a need for long-term care, and most older persons are able to live independently in spite of these conditions.

(A) NUMBERS OF PEOPLE RECEIVING LONG-TERM CARE

(1) Nursing Home Care

Of the approximately 29 million people age 65 and older in the United States, about 25 percent (7 million) are disabled. Of this group, about 3 million are severely disabled; that is, needing assistance with three or more ADL's. However, less than 20 percent (1.5 million) of the disabled elderly reside in nursing homes. Those with severe disabilities are more likely to be in nursing homes, although more than half of the severely disabled are residing in the community.[21]

On any given day, approximately 5 percent of the elderly population is in a nursing home. These "snapshot" estimates, however, do not provide a true picture of the use of nursing home care among the elderly. According to a recent article, of those persons who turned 65 in 1990, 43 percent will enter a nursing home sometime before they die.[22] And because the elderly population, particularly those age 85 and older, is growing, nursing homes will be increasingly burdened in the years ahead. With current disability rates, the Pepper Commission estimates that the number of elderly persons residing in nursing homes will increase from 1.5 million in 1990 to 5.3 million in 2030.[23] Not only will utilization increase, but those in nursing homes will be older and therefore more severely disabled. Researchers at the Brookings Institution estimate that in the years 2016–20, 51 percent of nursing home residents will be age 85 and older, compared to 42 percent in 1986–90.[24]

Analysis of nursing home utilization has found a high degree of variance in length-of-stay patterns among nursing home residents. The majority (75 percent) of persons entering a nursing home stay less than 1 year, and one-third to one-half stay for less than 3 months. Although only 5 percent of all older Americans are likely to be in a nursing home at any given time, those residents are more likely to be very old, female, and white. Residents age 85 and

[20] *Aging America: Trends and Projections, 1991 Edition.* Prepared by the U.S. Senate Special Committee on Aging, the American Association of Retired Persons, the Federal Council on the Aging, and the U.S. Administration on Aging. DHHS Publication No. (FCoA) 91-28001.

[21] Rivlin, Alice M. and Joshua M. Wiener, *Caring for the Disabled Elderly: Who Will Pay?* (Washington, D.C.: The Brookings Institution, 1988), p. 5-6. And, Pepper Commission, p. 91-92.

[22] Kemper, Peter, Ph.D., and Christopher M. Murtaugh, Ph.D., "Lifetime use of Nursing Home Care," *New England Journal of Medicine*, February 28, 1991, Vol. 324, No. 9, p. 595.

[23] The Pepper Commission, p. 108.

[24] Rivlin and Wiener, p. 11.

older comprise 45 percent of the nursing home population; 75 percent of elderly residents are female, and 93 percent are white.[25] For women age 85 years and older, their rate of nursing home use per 1,000 population is 248.9, compared to 13.8 per 1,000 for women age 65 to 74, and 66.5 per 1,000 for women age 75 to 84. A similar pattern exists for men, although their utilization rates are much lower. The greater likelihood of elderly white people to live in nursing homes is particularly true in the oldest age group. Of those age 85 and older, 23 percent of white people, compared to 14 percent of black people, reside in nursing homes.[26]

(2) Home and Community-Based Care

For every person age 65 and older residing in a nursing home, there are nearly 2 times as many living in the community requiring some form of long-term care. According to the Brookings Institution, there were approximately 4.9 million noninstitutionalized elderly residing in the community in 1985, or 18 percent of the over age 65 population, that had limitations in ADLs and IADLs. About two-thirds of the 4.9 million disabled elderly were moderately impaired (less than three ADL limitations).[27] About 850,000 elderly individuals were residing in the community with severe limitations (five or six ADLs).

About 70 percent of the noninstitutionalized disabled elderly relied exclusively on unpaid sources of home and community health care in 1989. Twenty-seven percent received at least some paid care and only 3 percent used paid care only.[28] Of the $9.7 billion spent on home care, $2.1 billion was from out-of-pocket payments, $3.3 billion was from Medicaid, $2.6 billion was from Medicare, and only $600 million was from private insurance.[29]

These figures illustrate the extent to which informal, family caregiving provides for the long-term care needs of the disabled elderly population. One study estimates that more than 27 million unpaid days of informal care are provided each week.[30] The majority of unpaid caregivers are women, usually wives, daughters, or daughters-in-law. Caring for a frail friend or family member places severe emotional, and physical strain—and to a lesser degree, financial strain—on the caregiver. For example, according to the 1982 Long-Term Care Survey, 27 percent of caregivers surveyed reported that they were unable to leave their elderly disabled relatives at home alone, and 54 percent reported that their social life or free time had been limited by caregiving. However, only 15 percent said that their parents' care cost more than they could afford. Although most studies have found that worsening health is the primary factor precipitating institutionalization, the stresses associat-

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[25] National Center for Health Statistics, E. Hing: Use of Nursing Homes by the Elderly: Preliminary Data From the 1985 National Nursing Home Survey. *Advance Data From Vital and Health Statistics*. No. 135. DHHS, Public Health Service. Washington, D.C., May 14, 1987

[26] National Center for Health Statistics, E. Hing, p. 3.

[27] Rivlin and Wiener, p. 6.

[28] The Pepper Commission, p. 97.

[29] The Pepper Commission, p. 93.

[30] Liu, Korbin and Kenneth Manton, "Disability and Long-Term Care," paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Workshop, Bethesda, MD, June 1985, p. 14. As cited in *Caring for the Disabled Elderly* by Alice Rivlin and Joshua Wiener (Washington, D.C.: The Brookings Institution), 1988, p. 5.

ed with caregiving are often cited as a factor contributing to that decision.

Health care policymakers have recognized for some time the need to develop a more equitable balance between institutional and noninstitutional care. Most frail elderly in need of assistance with ADL's would prefer to receive that assistance in their homes. While nursing home care is a necessary part of the long-term care system, many feel it should be an option of last resort.

There is some disagreement whether home and community-based care is less costly than institutional care. Clearly in those instances where round-the-clock care is required, nursing home care is the more economical. However, many frail elderly persons need only intermittent care and assistance, which can be provided less expensively then nursing home care. Further, as the patient's needs for care and assistance change over time—as his or her health improves or worsens—home and community-based services are more flexible in providing the level of care needed by the patient.[31] However, it has been extremely difficult to target those populations that would be most economically served in the home. For the most severely disabled who need a great deal of skilled care, a nursing home may be the best and most cost-efficient setting, although they may prefer to remain at home. There is also some concern about possible induced demand for home care services if they were made more widely available.

(B) COVERAGE AND FINANCING

At least 80 Federal programs assist persons with long-term care problems, either directly or indirectly through cash assistance, in-kind transfers, or the provisions of goods and services. Most of the public sector's expenditures for long-term care services, however, are for institutional care—primarily for nursing homes, and primarily through the Medicaid program.

Data on total national public and private spending for institutional and noninstitutional long-term care are difficult to collect and quantify. According to the Pepper Commission report, total national spending on long-term care for all age groups was $52.8 billion in 1988. Of this amount, $43.1 billion was for nursing home care, and $9.7 billion was for home health services (defined as nursing care, home health aides, medical social services, and speech, physical and occupational therapy). In 1988, direct out-of-pocket payments covered 48 percent of the costs of nursing home care ($20.8 billion) and 22 percent of the costs of home health care ($2.1 billion). Private long-term care insurance paid only $1.3 billion of the total costs of nursing home care, and $600 million of the costs of home care.[32]

Nearly one-half of nursing home expenditures were financed by Federal, State, and local governments in 1988. By far the largest portion of public expenditures for nursing home care is financed by the Medicaid program. In 1988, Federal and State Medicaid ex-

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[31] Burwell, Brian, "Home and Community-Based Care Options Under Medicaid," in *Affording Access to Quality Care*, eds. Richard Curtis and Ian Hill (Washington, DC.: National Governors Association, 1986).

[32] Pepper Commission, Table 3-1, p. 93.

penditures for nursing home care amounted to an estimated $19.2 billion—representing approximately 45 percent of total national spending for nursing homes and over 90 percent of public spending for nursing home care.

In contrast, Medicare accounts for only a small portion of the Nation's expenditures for nursing home care. Medicare's 1988 expenditures amounted to $800 million and represented less than 2 percent of national spending and less than 4 percent of public spending for nursing home care.

About one-half of all long-term care costs are financed directly by the elderly and their families. Although more elderly will be better off financially in the coming years, there will also be increased number of elderly requiring some form of long-term care. The real incomes of those age 65 to 74 will more than double over the next 30 years because of higher pensions and increased Social Security benefits. For those age 85 and older (the group most at-risk of needing long-term care), however, the future is not so bright. Their income is expected to increase only 17 percent in the same time period. This group is already age 50 or older and therefore will not benefit from higher pension benefits or from the increased participation of women in the work force.

Further, because long-term care costs are expected to rise more rapidly than the incomes of the old-old (those age 85 and older), those most likely to need long-term care in the future will be worse off financially than the elderly today—even though they will have higher incomes. For example, if nursing home costs rise 5.8 percent per year over the next 30 years, assuming a 4 percent annual general inflation, spending on nursing home care will triple—from $33 billion in 1986–90 to $98 billion in 2016–20.[33]

The following is a discussion of the six primary sources of long-term care financing: Medicaid, Medicare, Social Services Block Grants, the Older Americans Act, Supplemental Security Income, and private sources of financing. No one of these programs can provide a comprehensive range of long-term care services. Some provide primarily medical care, others focus on supportive or social services. The Medicaid program, for example has certain income and asset requirements, while the Medicare program does not. Many advocates for the elderly content that these differences reflect the fragmented and uncoordinated nature of the long-term care system in this country. These advocates are frustrated with the lack of prescription drug covers for the elderly and other chronically ill populations.

(1) Medicaid

(a) Coverage

Medicaid is a Federal-State entitlement program which provides medical assistance for certain low-income persons. Each State designs and administers its own Medicaid program, settling eligibility and coverage standards within broad Federal guidelines. Although originally intended to provide basic medical services to the poor and disabled, Medicaid has also become the primary source of

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[33] Rivlin and Wiener, p. 12.

public funds for nursing home care. Approximately 90 percent of all public expenditures for nursing home care are paid by Medicaid and 50 percent of all nursing home residents use Medicaid as their primary source of payment.[34] Because of the enormous role of the Medicaid program in the financing of nursing home care for the elderly, a section of this chapter provides an in-depth discussion of Medicaid.

Although Medicaid pays primarily for nursing home care, there is some coverage of home and community based care, mostly through the Section 2176 waiver program. Congress established these waivers in 1981, giving HHS the authority to waive certain Medicaid requirements to allow the States to broaden coverage to include a range of community-based services for persons who, without such services, would require the level of care provided in a SNF or a NF. Services covered under the Section 2176 waiver include cash management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) established a new home and community-based services waiver program similar to the Section 2176 program, but the new program is available only to persons over age 65. While the waivers have been enthusiastically received by the States, there has been some concern about the administration's support for the Section 2176 waiver program, as is discussed later in this chapter.

(b) Expenditures

Medicaid expenditures for nursing home care in 1990 were approximately $24.1 billion, an increase of 17.5 percent over 1990. This represents approximately 45 percent of total national spending for nursing homes and 87 percent of public spending for nursing home care.[35]

Medicaid's share of total national expenditures for nursing home care rose steadily since the program's inception in 1965, to a high of 48.6 percent in 1979. In the early 1980's, however, the percentage gradually declined, and appears to have leveled off in the past few years. This decline can be attributed to two factors: cost containment measures, and a shift in the distribution of the Medicaid nursing home population from skilled nursing facilities to less expensive intermediate care facilities (although the distinction between the two types of homes was eliminated as of October 1, 1990, and all Medicaid-certified facilities are now referred to as "nursing facilities"). From 1977 to 1985, the number of SNF residents increased from 260,000 to 263,000 an increase of 0.9 percent. However, the number of ICF residents increased from 362,600 in 1977 to 488,300 in 1985, an increase of 34.7 percent.[36]

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[34] National Center for Health Statistics: The 1985 National Nursing Home Survey, data from the National Health Survey. *Vital and Health Statistics.* Series 13, No. 97. DHHS Pub. No. (PHS) 89-1758. Public Health Service. Hyattsville, MD, Jan. 1989.

[35] Katherine R. Levit, Helen C. Lazenby, Cathy A. Cowan, and Suzanne Letsch. "National Health Expenditures, 1990." *Health Care Financing Review,* Fall, 1991, Vol. 13, No. 1, p. 40.

[36] *Medicaid Source Book: Background Data and Analysis.* Report prepared by the Congressional Research Service for the use of the Senate Subcommittee on Health and the Environment, Committee on Energy and Commerce. (Committee Print 100-AA). Washington, D.C.: GPO, November 1988, p. 470.

There are a variety of cost containment measures taken by States to control their Medicaid expenditures. For example, most States use a form of prospective reimbursement for nursing home care. At least 30 States have instituted formal preadmission screening programs for all Medicaid eligible persons wishing to enter a nursing home. The OBRA 1987 nursing home reforms require all States to screen current and prospective residents for mental illness or mental retardation, based on the premise that nursing homes are inappropriate for such persons. These screening programs are intended to identify those mentally disabled people who could be cared for in their own homes or in the community if appropriate services are available, and to assure that nursing home beds are available for those who have medical needs. The certificate of need process, in which a provider must apply to the State in order to expand or construct new beds or risk becoming ineligible for Medicare or Medicaid reimbursement, is seen as a Medicaid cost-containment measure in some States.

(2) Medicare

(a) Coverage

The Medicare program, which insures almost 98 percent of all older Americans without regard to income or assets, primarily provides acute care coverage for those age 65 and older, particularly hospital and surgical care and accompanying periods of recovery. Medicare does not cover either long-term or custodial care. However, it does cover care in a skilled nursing facility (SNF), home health care, and hospice care in certain circumstances.

The Skilled Nursing Facility Benefit.—In order to receive reimbursement under the Medicare SNF benefit, which is financed under Part A of the Medicare program, a beneficiary must be in need of skilled nursing care on a daily basis for an acute illness. The program pays for neither intermediate care facility services nor custodial care in a nursing home.

The SNF benefit is tied to a "spell of illness" which begins when a beneficiary enters the hospital and ends when he or she has not been an inpatient of a hospital or SNF for 60 consecutive days. A beneficiary is entitled to 100 days of SNF care per spell of illness, following a 3-day prior hospitalization. Days 21–100 are subject to a daily coinsurance charge ($84.50 in 1993), which is equal to one-eighth of the hospital deductible.

In 1988, Medicare covered 10,448,847 days of care for aged beneficiaries, which was an average of 28.2 days for each person served. In comparison, in 1983 there were 9,010,052 days of care, with an average of 35.1 days for each person served.[37] This change is a result of both an increase in shorter SNF stays and a decrease in longer SNF stays. From 1983 to 1985, SNF stays with 7 or fewer covered days increased more than 56 percent, and SNF stays with 31 or more covered days decreased 18 percent.[38] There are two pri-

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[37] Silverman, Herbert A., "Medicare-Covered Skilled Nursing Facility Services, 1967–1988." *Health Care Financing Review*, Spring 1991, Vol. 12, No. 3, p. 106.

[38] Latta, Viola B. and Roger E. Keene. "Use and Cost of Skilled Nursing Facility Services under Medicare, 1987." *Health Care Financing Review*, Vol. 11, No. 1, Fall 1989, p. 105.

mary factors affecting the changing use of the SNF benefit—Medicare's Prospective Payment System (PPS) and the rising SNF copayment. When PPS was implemented in 1983, HCFA anticipated an increase in SNF utilization because of the incentives for earlier discharge, and consequently, possible abuse of the benefit. As a result, fiscal intermediaries intensified their reviews of SNF claims, leading to the lowest utilization rate in the history of the program in 1987—248 per 1,000 enrollees.[39] Rising hospital costs in the 1980's increased the Part A hospital deductible, which in turn increased the SNF copayment. Often, the SNF copayment exceeds the SNF's regular daily charge, in which case the beneficiary usually prefers to end Medicare coverage for that stay.

The Home Health Benefit.—Both Part A and Part B of the Medicare program cover home health services without a deductible or coinsurance charge. There is no statutory limit on the number of home health visits covered and no prior hospitalization requirement. The Medicare home health benefit has no statutory limit on the number of days covered; however, it is most often received for short periods of care and only for treatment of an acute care condition or for post-acute care. Below is a brief description of Medicare's home health benefit; developments with regard to this program are discussed in greater detail in Part B of this chapter.

Home health services covered under Medicare include the following:

Part time or intermittent nursing care provided by, or under the supervision of, a registered professional nurse;

Physical, occupational, or speech therapy;

Medical social services provided under the direction of a physician;

Medical supplies and equipment (other than drugs and medicines);

Medical services provided by an intern or resident enrolled in a teaching program in a hospital affiliated or under contract with a home health agency; and

Part time or intermittent services provided by a home health aide, as permitted by regulations.

To qualify for home health services, the Medicare beneficiary must be confined to the home and under the care of a physician. In addition, the person must need intermittent skilled nursing care or physical or speech therapy. Services must be provided by a home health agency certified to participate under Medicare, according to a plan of treatment prescribed and reviewed by a physician. The patient is not subject to any cost-sharing, such as deductibles or coinsurance, for covered home care. Although there is no limit on the number of covered visits, program guidelines generally limit daily home health care to 5 days per week for 2 to 3 weeks.

The Hospice Benefit.—Medicare also covers a range of home care services for terminally ill beneficiaries. These services, authorized in 1982 and referred to as Medicare's hospice benefit, are available to beneficiaries with a life expectancy of 6 months or less. Hospice care benefits include nursing care, outpatient drugs, therapy serv-

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[39] Silverman, *Health Care financing Review*, p. 107.

ices, medical social services, home health aide services, physician services, counseling, and short term inpatient care. A Medicare beneficiary who elects hospice care waives entitlement to Medicare benefits related to the treatment of the terminal condition or related conditions, except for the services of the patient's attending physician. Payments to providers for covered services are subject to a cap, which was $11,551 for November 1, 1991, to October 31, 1992, and enrollees are liable for copayments for outpatient drugs and respite care. Coverage for hospice services was subject to a lifetime limit of 210 days, although this limitation was extended by the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), if the beneficiary is recertified as terminally ill by a physician.

(b) Expenditures

Medicare expenditures for these services generally have been small. In 1991, Medicare outlays for SNF care were $2.7 billion, which represents 4.5 percent of the total $60 billion spent on nursing home care, and slightly over 2 percent of total Medicare spending.[40] Medicare payments for home health care in 1992 were $6 billion, an increase of about 24 percent over 1991. This represents 2,480 visits per 1,000 enrollees, with an average charge of $74 per visit.[41] Expenditures for hospice care in 1992 were $605 million, which represents 120,477 admissions with an average of 55 days of covered care per admission.

(3) Social Services Block Grant

(a) Coverage

Title XX of the Social Security Act authorizes reimbursement to States for social services, now distributed through the Social Services Block Grant (SSBG). Among other goals, the SSBG is designed to prevent or reduce inappropriate institutional care by providing for community-based care, and to secure referral or admission for institutional care when other forms of care are inappropriate.

Athough the SSBG is the major social services program supported by the Federal Government, its ability to support the long-term care population is limited. Because it provides a variety of social services to a diverse population, the Title XX program has competing demands and can only provide a limited amount of care to the older population.

Prior to 1981, States were required to make public a report on how SSBG funds were to be used, including information on the types of activities to be funded and the characteristics of the individuals to be served. In 1981, these reporting requirements were eliminated, and as a result, data concerning the extent to which Title XX now supports long-term care are very limited. According to a HHS analysis of the States' fiscal year 1989 pre-expenditure reports, home care services, which may include homemaker, chore, and home management services, were provided to adults and chil-

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[40] Levit, et al., *Health Care Financing Review*, p. 40.

[41] Committee on Ways and Means, U.S. House of Representatives. *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means.* Committee Print 102-44, 102nd Congress, 2nd Sess. (Washington, D.C.: U.S. Govt. Print. Off.), May 15, 1992, p. 160. Levit, et al., *Health Care Financing Review*, p. 49.

dren by 46 States; adult day care services were provided by 26 States.

(b) Expenditures

States receive allotments of SSBG funds on the basis of its population, within a Federal expenditure ceiling. There are no requirements for the use of Title XX funds. States have relative freedom to spend Federal Social Service Block Grant funds on State-identified service needs. Appropriations in FY 1992 and FY 1993 are $2.8 billion for each year.

(4) The Older Americans Act

(a) Coverage

The Older Americans Act (OAA) carries a broad mandate to improve the lives of older persons in the areas of income, social services, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities. The OAA was reauthorized in 1991, and Chapter 10 has a detailed explanation of the various changes that were made to the various programs during that process.

While the OAA funds a wide range of supportive services, inhome services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each area agency on aging is required to spend a portion of its supportive services allotment on home care services, with States defining minimum amounts of funding to be spent in each particular area.

The number of home care visits to older persons under the OAA represents only a small fraction of the amount provided under Medicare and Medicaid. The OAA services, however, may be provided without the requirement under Medicare that persons be in need of skilled care and without the strict income and asset tests under the Medicaid program. In some cases, OAA funds may be used to assist persons whose Medicare benefits have been exhausted or who are ineligible for Medicaid.

Congress recognized the growing need for in-home services when it amended the OAA to expand in-home services authorized under Title III. The Older Americans Act Amendments of 1987 (P.L. 100–175) added a new Part D to Title III, authorizing grants to States for nonmedical in-home services for frail older persons. These services include assistance in such areas as bathing, dressing, eating, mobility, or performance of daily activities such as shopping, cooking, cleaning, or managing money. In-home respite services and adult day care for families, visiting and telephone reassurance, and minor home renovation and repair are additional examples of allowable services under Part D.

(b) Expenditures

Unlike the Title XX program in which States receive a block of funds for unspecified social services, Congress makes separate appropriations of Title III funds for supportive services, congregate and home-delivered nutrition services, and in-home services for the frail elderly. States receive allotments of these funds according to

the number of persons age 60 and older in the State as compared to all States. FY 1993 Title IV appropriations equaled $924.8 million, including $313.7 million for supportive services and centers, $89.7 million for home-delivered meals; $363.2 million for congregate meals; $142.9 million for USDA commodities; $7.1 million for in-home services for the frail elderly.

The total number of meals served under the nutrition program have increased by 42 percent in the years FY 1980 through FY 1991. Home-delivered meals accounted for the largest share of that growth, increasing by 179 percent during that period, compared to only 4 percent for congregate meals. Home-delivered meals represent about 43 percent of total meals served in FY 1990. There are a number of reasons for this enormous growth in home-delivered meals. From 1980–93, funding for home-delivered nutrition services has increased more rapidly than funding for congregate meal services. Funding for congregate meals increased 35 percent for the period 1980 to 1993, compared to an increase of 79 percent for home-delivered meals over the same period.

The aging of the population is also a factor, because the old-old (those age 85 and older) are more likely to need more in-home services, such as home-delivered meals. States' efforts to develop comprehensive home and community-based long-term care also have had an impact on this growth, as more and more states are working toward providing services to enable older persons to stay in their homes longer. Finally, earlier discharge of elderly patients from the hospital as a result of the incentives in Medicare's PPS reimbursement system has resulted in an increased demand for home-delivered meals.

(5) Private Insurance

The financing of long-term care through private long-term care insurance has been receiving a great deal of attention recently. This is occurring not only because of growing concerns about public program expenditures, but also because the costs of long-term care represent the largest out-of-pocket health expense for the elderly. To date, very few older Americans have purchased this type of coverage, however the market is growing rapidly. From 1987 to 1990, the number of policies sold has doubled. According to the Health Insurance Association of America, as of June 1990, the 130 companies writing long-term care insurance policies had sold more than 1.65 million policies.

Although growth has been considerable in a short period of time, the private insurance industry has approached this potential market with caution. Tax law does not explicitly recognize or define long-term care insurance. Insurers are also concerned about the potential for adverse selection for this product, where only those people who are likely to need care buy insurance.

Insurers point to the problem of induced demand for services that can be expected to be generated by the availability of new long-term care insurance. With induced demand, individuals decide to use more services than they otherwise would because they have insurance and or will shift from nonpaid to paid providers for their care. In addition, insurers are concerned that, given the nature of

many chronic conditions, people who need long-term care will need it for the remainder of their lives, resulting in an open-ended liability for the insurance company.

As a result of these risks, insurers have designed policies that limit their liability for paying claims. Policies are medically underwritten to exclude from enrolling people with certain conditions or illnesses. They contain benefit restrictions that limit access to covered care. Policies also limit the period of coverage they offer, typically to a maximum of 4 or 5 years. In addition, most plans provide indemnity benefits that pay only a fixed amount for each day of covered service. If these amounts are not updated for inflation, the protection offered by the policy can be significantly eroded by the time a person actually needs care.

These design features of long-term care insurance have lead advocates, policymakers, and others to question the quality of coverage offered. Although the insurance industry has continued to offer new products that provide broadened coverage and the National Association of Insurance Commissioners (NAIC) has established standards for regulating these policies, concerns remain about the need for consistent and uniform consumer protections.

Policymakers continue to examine the numerous problems associated with the development of long-term care insurance. A December 1990 GAO report on the private long-term care insurance market, requested by Congressman Pete Stark, identified significant problems with long-term care insurance policies and with the model standards developed for this insurance by the NAIC.

The GAO report found that although today's NAIC model standards have improved since 1986, consumers are still vulnerable to considerable risks. Consumers are at risk because many States have not adopted important NAIC standards. For example, 23 States do not require insurers to guarantee policy renewal, and 19 States have not adopted the NAIC standard disallowing Alzheimer's disease exclusions. GAO also found that NAIC standards are not sufficient. Lack of uniform policy terms, definitions and eligibility criteria make it difficult to compare policies and know when benefits will be received.

GAO also cited financial risks for consumers. For example, price is not a good indicator of value, with premiums varying as much as 150 percent for policies with similar benefits. In addition, many consumers face price increases that make it difficult to retain their policies. And, when policies lapse, policyholders almost always lose the investment component of their premium.

In their report, GAO recommended that NAIC standards be extended to require greater uniformity of language among policies, improve methods for determining eligibility, and provide greater protection against loss of a policyholder's coverage and financial investment. It States fail to incorporate both existing and improved NAIC standards into their laws and regulations, GAO recommended that the Congress consider legislation that sets Federal minimum standards for long-term care insurance.

A June 1991 Inspector General Report, requested by Senator Pryor and Congressman Wyden, revealed further information on consumer problems and State regulation of private long-term care insurance. The Inspector General found that only 17 States sub-

stantially meet both the NAIC model act and model regulation standards. In examining long-term care insurance complaint data, the Inspector General found that the major categories of complaints are: claims handling delays; premium and refund disputes; and agent misrepresentation. States reported little enforcement action against insurers and agents, and stated that resource constraints prevent them from adequately enforcing their long-term care insurance laws and regulations.

Other reports and studies have identified problems in the long-term care insurance market. In June 1991, *Consumer Reports* advised consumers seeking insurance coverage for nursing home or home care to proceed with caution. In the magazine's second major analysis of this market, they found many problems for consumers, including agent abuses, large rate increases, difficulty of comparison shopping, and inadequate inflation coverage. A recent report from Families USA Foundation, *The Unaffordability of Nursing Home Insurance,* said that most older Americans cannot afford the cost of a basic nursing home insurance policy. A State-by-State analysis showed that in no State can more than 25 percent afford the average cost of basic plans sold by nine leading companies.

Despite the problems inherent in this area, many believe that significant market developments may occur in the next several years, particularly in the absence of any significant public role in the provision of long-term care. Not only is there growing interest in this area among insurance companies, but many States, faced with mounting Medicaid nursing home expenditures, have expressed interest in having such coverage made more widely available.

Federal interest in the potential and problems of long-term care insurance is growing. Using the same framework as the Medigap reform passed last year, Senators Pryor, Daschle, Riegle, and others introduced legislation will provide basic Federal consumer protections for the first time. Specifically, the bill will focus on cleaning up restrictive insurance policy limitations and marketing abuses.

The bill establishes minimum Federal consumer protections to be adopted by each State for regulating the private long-term care insurance market. The minimum protections are designed to make long-term care insurance policies understandable and comparable, and their benefits meaningful, while also giving insurance companies enough flexibility to innovate in response to new information and changing consumer demands.

The bill specifies that the NAIC is to promulgate the required standards within 12 months of the bill's enactment, and that the standards are to be developed in consultation with a working group of insurers, consumer representatives, and other qualified individuals. If the NAIC fails to develop the standards, the Secretary of HHS assumes the responsibility for producing them.

Similar bills have been introduced in the Senate and the House. Also, Senators Bentsen, Pryor, Packwood, and others have introduced legislation that would link consumer protections with the clarification of the tax treatment of long-term care insurance.

Hearings on these and other proposals were held during the second session of the 102nd Congress. A consumer protections bill

proposed by Senators Kennedy and Hatch was passed in Labor and Human Resources Committee, though was not considered by the full Senate. This issue is likely to continue to receive a lot of attention in the 103rd Congress.

(6) Out-of-Pocket Costs

While the cost of long-term care represents an increasing share of Federal and State budgets, relatively few older Americans have access to publicly financed services. The cost of nursing home care and home and community-based care often falls on individuals and their families.

Most older persons and their families pay for nearly one-half of the costs of nursing home care directly out of their own pockets. In 1991, 45 percent of the costs of nursing home care for all age groups ($23.9 billion out of a total of $53.1 billion) were paid out-of-pocket.[42] For those age 65 and older, of the $32.8 billion spent on nursing home care for that age group in 1987, nearly 60 percent was from private sources, most of which were direct out-of-pocket payments.[43] Of the total $6.9 billion spent on home care in the United States in 1990, $800 million, or 12 percent, was paid out-of-pocket.[44] Although home care is generally a less expensive option for the elderly, about 14 percent have out-of-pocket costs from home care that range from $360 to $1,680 per year, depending on the level of disability.[45] These out-of-pocket costs are only for home health care, and do not include other health-related expenses, such as prescription drugs, or the other community-based services needed by many functionally impaired individuals.

The cost of community-based care pales when compared to the cost of nursing home care. The price of a year in a nursing home ranges from $24,000 to $50,000; the cost at even the lower end of this range is beyond the resources of many older Americans. Thus, many elderly people must spend their entire savings and become eligible for Medicaid soon after they enter a nursing home. Although there are no national data on the subject of spend-down as it relates to length of stay, there are various studies and reports that have examined this issue. A 1987 study released by the House Select Committee on Aging shows that this spend-down occurs on average within 13 weeks after admission for 70 percent of single older Americans.[46] A 1992 report from the Department of Health and Human Services stated that somewhere between 20 percent and 25 percent of persons who entered a nursing home as a private pay resident convert to Medicaid before final discharge.[47]

[42] Waldo, Daniel R., Sally T. Sonnefeld, David R. McKusick, and Ross H. Arnett III. "Health Expenditures by Age Group, 1977 and 1987." *Health Care Financing Review,* "Summer 1989, Vol. 10, No. 4, p. 167.

[43] Levit, et al., *Health Care financing Review,*" p. 49.

[44] 1982 National Long-Term Care Survey.

[45] House Select Committee on Aging. "Long-Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are At Risk." Comm. Pub. 100–631. U.S. Govt. Print. Off: Washington, D.C., October 1987.

[46] Adams, E. Kathleen, Mark R. Meiners and Brian O. Burwell, "A Synthesis and Critique of Studies on Medicaid Asset Spenddown," Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, January, 1992.

[47] The Pepper Commission, p. 93.

The vast majority of the chronically ill and disabled elderly population rely on informal support. In 1989, nearly 75 percent of the severely disabled elderly receiving long-term care at home or in their communities relied solely on family members or other unpaid help. Seven out of ten informal caregivers have the primary responsibility for caring for their disabled friend or family member; one out of three is the sole provider of care.[48]

The burden of caregiving falls overwhelmingly on women. Three-fourths of caregivers are women; one-fourth of women caregivers are between the ages of 65 and 74, and another 10 percent are over age 75, which makes these women vulnerable to chronic illness themselves.[49] Many caregivers are also low-income; one-third report incomes in the poor or near-poor category, and both men and women caregivers are more likely to have family incomes below the poverty line than those persons of the same age with no caregiving responsibilities.[50] One in three caregivers also reports fairly poor health, and among spousal caregivers, the proportion is even greater. More than 4 out of 10 caregiving wives and over one-half of caregiving husbands report fair to poor health.[51]

2. Background on Medicaid

(A) MEDICAID COVERAGE FOR THE IMPOVERISHED AGED

(1) Availability and Eligibility

Medicaid was created by Title XIX of the Social Security Act in 1965. It is a means-tested entitlement program; in other words, certain groups of persons (e.g., the aged, blind, disabled, members of families with dependent children, and certain other pregnant women and children) qualify for coverage if their incomes and resources are sufficiently low. Medicaid recipients are entitled to have payment made by the State for covered, medically necessary services. States then receive matching funds from the Federal Government to pay for covered services. There is no Federal limit on payments; allowable claims are matched according to a formula which takes into account a State's per capita income. Therefore, States with a higher per capita income will receive a lower percentage of Federal matching funds and vice versa. The established minimum matching is 50 percent; the highest is 83 percent (although the highest rate in effect in FY 1991 was 80 percent, in the State of Mississippi).

State Medicaid programs are required by Federal law to cover the categorically needy; that is, all persons receiving cash assistance under a welfare program—Aid to Families with Dependent Children (AFDC) and most people receiving assistance under the Supplemental Security Income (SSI) program. Eligible persons must meet the cash assistance program's definition of age, blindness, disability, or membership in a family with dependent chil-

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[48] The Pepper Commission, p. 93.
[49] Pepper Commission, p. 93.
[50] Pepper Commission, p. 94.
[51] Senate Subcommittee on Health and the Environment, Committee on Energy and Commerce. *Medicaid Source Book: Background Data and analysis.* U.S. Govt. Print. Off: Washington, D.C. Committee print 100-AA.

dren. Therefore, if a person does not fall into one of these categories, he or she is ineligible for Medicaid, regardless of income. Furthermore, people who fall into one of these categories must also meet specific income and resource standards, which vary from State to State.

In addition, States may, at their discretion, cover the optional categorically needy and the medically needy. Optional categorically needy programs extend Medicaid eligibility to those persons who are not receiving cash welfare assistance but who meet certain other criteria. Insofar as the elderly are concerned, optional categorically needy coverage enables persons living in institutions (e.g., nursing homes) to be covered by Medicaid if their incomes are low enough. Medically needy persons are defined as those whose income and resources are large enough to cover daily living expenses, according to income levels set by the State, but are not large enough to pay for their medical care. These State-by-State variations in eligibility can mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

A State may also, within Federal guidelines, define its own benefit package. Mandatory services include physicians' and hospital services, and care in a nursing facility (NF). Optional services include prescription drugs, eyeglasses, and services in an intermediate care facility for the mentally retarded (ICF/MR). States may also limit the coverage of all services; e.g., a limit on the number of hospital days. Reimbursement levels vary from State to State as well, so States vary widely in both the breadth and depth of their covered services.

Overall, Medicaid covers less than one-half of the population with incomes below the Federal poverty line. Approximately 45 percent of the noninstitutionalized poor were covered by Medicaid in 1990; the percentage varied by age with coverage extended to 62 percent of poor children under age 18, 35 percent of poor working age adults (age 18–64), and 30 percent of the poor elderly. However, although the elderly constituted only 13 percent of beneficiaries in FY 1990, they accounted for 33 percent of total Medicaid spending. Conversely, while 68 percent of Medicaid recipients in FY 1990 qualified because they were a member of an AFDC family, these recipients accounted for only 24 percent of program benefits.

The approximately 3.1 million elderly covered by Medicaid can be divided into three groups. The first is those elderly who have incomes low enough to qualify for cash assistance; in other words, the categorically needy. Fifty-four percent of elderly Medicaid beneficiaries (1.7 million) are categorically needy.

The second and third groups are composed of persons who do not receive cash welfare assistance. The second group, the optional categorically needy, comprises about 23 percent of elderly beneficiaries, or about 728,000 people. The third group is the medically needy, which accounts for another 23 percent, or approximately 732,000 people. These two groups include many persons using nursing home care. Many of these beneficiaries were not poor when they entered a nursing home; however, the high cost of nursing home care (in excess of $24,000 per year) result in many middle

income elderly "spending down" their resources to Medicaid eligibility levels.

These different groups account for widely varying proportions of Medicaid spending for the elderly, largely as a result of their varying utilization of nursing home care, an especially costly service. The categorically needy account for 25 percent of Medicaid expenditures for the elderly; the optional categorically needy, 33 percent; and the medically needy 42 percent.

In 1986, nursing home costs accounted for two-thirds of payments for elderly Medicaid beneficiaries. Seventy percent of the optional categorically needy and the medically needy elderly used nursing home services, accounting for 58 percent of all Medicaid payments for elderly beneficiaries.[52] Nursing home payments were seven times more for aged beneficiaries than they were for non-aged beneficiaries. Although this results in part because the elderly need and use more nursing home services than the nonelderly, it also reflects the fact that nearly all elderly Medicaid beneficiaries have Medicare as their primary payer of acute health care services. However, because Medicare provides extremely limited coverage of nursing home care, and there is virtually no private insurance available, Medicaid has become the primary source of public funds for nursing home care.

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1990, Federal Medicaid expenditures for home health care were $2.2 billion, accounting for 3 percent of total Medicaid spending.[53] For a variety of reasons, very few States have made extensive use of this benefit. The benefit itself is very limited, in that only medical services are covered. Furthermore, because services must be made available to all Medicaid beneficiaries, States have not been permitted to target services to specific populations, such as the elderly. Many States have taken up the slack and have funded home care out of State funds, or have established programs under the Section 2176 waivers, which are discussed below.

(2) Qualified Medicare Beneficiary Program

The Qualified Medicare Beneficiary Program (QMB), which was originally part of the Medicare Catastrophic Care Act, requires States to "buy-in" the Medicare premiums, copayments, and deductibles for low-income Medicare beneficiaries with incomes below the Federal poverty level and assets below twice the Supplemental Security Income (SSI) level ($4,000 in liquid assets). This provision was to be phased-in over 3 years, beginning in 1989 for those beneficiaries with incomes at or below 85 percent of poverty, and increasing in 5 percent increments up to 100 percent of poverty by 1992.

A provision in the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) accelerated the implementation of the QMB program by 1 year; that is, up to 100 percent of poverty by January 1, 1991. OBRA 1990 also requires States to buy-in the Part B premiums

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[52] Levit, et al. *Health Care Financing Review*, p. 51.

[53] Families USA Foundation. "The Secret Benefits: The Failure to Provide the Medicare Buy-In to Poor Seniors." Washington, D.C., June 1991.

(but not other copayments and deductibles) for Medicare beneficiaries with assets below twice the SSI level and incomes below 110 percent of poverty beginning on January 1, 1993, going up to 120 percent of poverty by January 1, 1995.

Unfortunately, participation rates in the QMB program have been lower than anticipated. Although HHS does not have any national data, participation is estimated to be between 20 percent and 30 percent. According to a recent report by Families USA, an estimated 2.2 to 2.3 million elderly persons are eligible for the QMB benefit but are not receiving it.[54] This is largely because many low-income elderly and disabled are unaware of the program. While some States have been more aggressive than others in informing the public about the QMB program, many aging advocates, including Families USA, believe that a more active role on the part of HHS in promoting the QMB program could serve to increase participation rates across the country. In July 1991, the Senate Aging Committee held a hearing to examine the implementation of the QMB program, and to explore ways the Federal and State governments, as well as the private sector, could strengthen their outreach efforts to inform the public about the program and to increase participation rates. Options that were discussed at the hearing included accepting applications for the QMB program at local Social Security Administration offices and including information about the program in the monthly Social Security checks of recipients whose checks are under a certain amount. In 1992, legislation was introduced by Senator Riegle (S. 2814) that would have improved beneficiary access to the program; unfortunately, no action was taken on this or any other QMB-related legislation in the 102d Congress.

(3) Spousal Impoverishment

A particularly important concern over the past few years has been the issue of Medicaid spend-down for nursing home care. To become eligible for Medicaid coverage, persons must either be poor or spend-down their income to the level set by their State Medicaid program. While there is a great deal of variability among States' Medicaid programs and income eligibility levels, nursing home residents—and often their spouses—frequently face impoverishment before they become eligible for Medicaid coverage.

A recent study on the effects of nursing home use on Medicaid eligibility status found that the likelihood of being Medicaid eligible was 31 percent if a person spent time in a nursing home, as opposed to 7 percent for those who had not.[55] Medicaid eligibility is also closely related to the length of stay in a nursing home. Although temporary or short stays in a nursing home do not increase one's risk of spending down to Medicaid eligibility, 41 percent of those persons studied who had long-term says (i.e., at least 2 years) in nursing homes spent down to Medicaid eligibility.

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[54] Liu, Korbin, and Kenneth G. Manton. "The Effect of Nursing Home Use on Medicaid Eligibility." *The Gerontologist*, Vol. 29, No. 1, 1989, p. 63.

[55] Pharmaceutical Benefits Under State Medical Assistance Programs. National Pharmaceutical Council, Reston, VA., September, 1991.

A provision in the Medicaid Catastrophic Care Act (MCCA) that was retained addresses this issue of Medicaid spend-down. The so-called "spousal impoverishment" provisions are intended to protect some of the income and assets of the spouse who remains at home when the institutionalized spouse is in the process of spending down to become Medicaid eligible.

Generally, when determining Medicaid eligibility, income (such as Social Security checks, pensions and interest from investments) is attributed to the person whose name is on the instrument conveying the funds. In the case of Social Security, the amount attributed to each spouse is the individual's share of the couple's benefit. Therefore, if the couple's pension check is made out to the husband, all of that income would be considered his for the purpose of determining Medicaid eligibility. The attribution of resources such as certificates of deposit and savings accounts is done similarly. Because the current generation of women whose husbands are at risk of needing nursing home care typically did not work outside the home, they likely have very little income or assets other than those in their husband's name.

Prior to the passage of MCCA, once an institutionalized spouse was determined Medicaid-eligible, some of his monthly income was reserved for the use of his spouse. When combined with the community spouse's income (if any existed) it allowed a maintenance needs level, which could not exceed the highest of the SSI, State supplementation, or "medically needy" standards in the State. According to a survey taken by the American Association of Retired Persons in March 1987, maintenance needs levels varied widely from State to State—from a high of $632 in Alaska to zero in Oklahoma. Thus, in a State with a maintenance needs level of $350, if the community spouse's monthly income was equal to $150, the contribution from the institutionalized spouse would have been $200.

Beginning in September 1989, the spousal impoverishment provisions allowed the community-based spouse to keep a monthly income equal to 122 percent of poverty, which was increased to 133 percent on July 1, 1991, and increased again to 150 percent on July 1, 1992. However, the maximum allowance will not exceed $1,718 per month. This provision also provides for a one-time determination of liquid assets, with half attributable to each spouse. The institutionalized person may transfer an amount equal to one-half, or $13,740 (in 1992), whichever is higher, to the spouse, up to $68,700 (the amount of protected assets increases each July 1, based on the increase in the Consumer Price Index). For example, if the couple has assets worth $20,000, the institutionalized person may transfer $13,740 to the spouse. If they have assets worth $150,000, the institutionalized person may transfer $68,700 to the spouse, keeping the remainder for him- or herself. In other words, if the spouse's share of assets exceeds $68,700, the excess is attributed to the institutionalized person. States have the option to increase the minimum level of protected income to any amount above the required minimum of $13,740, up to the maximum of $68,700. In 1991, 30 States set their minimum above $13,700; 16 States permit a minimum of $68,700.

(4) Personal Needs Allowance for Medicaid Nursing Home Residents

Nursing home residents who are Medicaid-eligible depend on their personal needs allowance (PNA) each month to cover a wide range of expenses not paid for by Medicaid. On July 1, 1988, the PNA was increased from $25 to $30 per month. States have the option to supplement this payment, which 26 States do. Prior to this, the PNA had not been increased—or adjusted for inflation—since Congress first authorized payment in 1972. As a result, the $25 PNA was worth less than $10 in 1972 dollars. Unfortunately, there is no provision for a cost-of-living adjustment (COLA) in the PNA, even though noninstitutionalized recipients of Social Security and SSI benefits have received annual COLA's to their benefits since 1974.

For impoverished nursing home residents, the PNA represents the extent of their ability to purchase basic necessities like toothpaste and shampoo, eye glasses, clothing, laundry, newspapers, and phone calls. In addition to personal needs, many nursing home residents have substantial medical needs that are not covered by State Medicaid programs. Although the PNA is not intended to cover medical items, these residents may have to save their PNA's over many months to pay for these costs, such as hearing aids and dentures.

If a nursing home resident enters a hospital, he must pay a daily fee to the nursing facility to reserve his bed there. Even though a resident who cannot pay this fee is likely to lose his place in the nursing home, 40 percent of State Medicaid plans will not cover the cost nor guarantee the nursing home resident a bed to come back to. As a result of the various expenses not covered by many Medicaid programs, advocates of the Nation's nursing home residents believe the $30 PNA is inadequate to meet the needs of most residents.

(5) Medicaid Section 2176 Waivers Program

Prior to 1981, Federal regulations limited Medicaid home care services to the traditional acute care model. To counter the institutional bias of Federal long-term care spending, Congress in 1981 enacted new authority to waive certain Medicaid requirements to allow States to broaden coverage for a range of community-based services and to receive Federal reimbursement for these services. Specifically, Section 2176 of the Omnibus Budget Reconciliation Act of 1981 authorized the Secretary of the Department of Health and Human Services to approve "Section 2176 waivers" for home- and community-based services for a targeted group of individuals who, without such services, would require the level of care provided in a hospital, nursing facility or intermediate care facility, or who are already in such a facility and need assistance returning to the community. The target population may include the aged, the disabled, the mentally retarded, the chronically mentally ill, persons with AIDS, or any other population defined by the State as likely to need extended institutional care. Community-based services under the waiver include case management, homemaker/home health aide services, personal care services, adult day care services, habilitation services, respite care, and other community-based serv-

ices. As of February 1991, 48 States had approved waiver programs; of that amount, 41 States had waivers for the elderly and disabled. In 1989, waivers for the elderly and disabled served 108,000 people.

HCFA has expressed concern that the home and community-based waiver program may actually increase Federal expenditures for long-term care. While home- and community-based care may be less costly on an individual recipient basis, aggregate Medicaid costs may increase if the program results in the provision of a new range of services to persons who would not otherwise use nursing homes or other institutional care funded by Medicaid. Previous research and demonstration efforts in home- and community-based care suggest that achieving program savings depends on how effectively waiver services are targeted. HCFA has argued that targeting the services to the population most at risk of entering an institution is quite difficult, if not impossible.

The Section 2176 waivers have proven to be very popular with States, and Congress has taken action to ensure their continued availability. OBRA 1987 included provisions aimed at expanding the program. It created a new waiver authority (Section 1915(d) waivers) under which States can provided home- and community-based services for the elderly alone. Under the 1915(d) waiver program, the requirements that the program be statewide and comparable for all eligibility groups may be waived. In addition, income and resource rules applicable to persons residing in the community may be waived. Expenditures for skilled nursing facility services, intermediate care facility services, and home- and community-based services for individuals age 65 and older may not exceed a projected amount, which is determined by comparing the amount spent in the base year for such services, increased by factors that take into account increases in the cost of goods and services, the over-age 65 population, and the level of services provided. As of 1991, only Oregon has received authority from HCFA to provide services under the 1915(d) waiver.

(6) Prescription Drug Coverage Under Medicaid

The Medicaid program is a primary source of prescription drug coverage for a significant number of elderly and minority Americans. About 19.6 million Americans relied on Medicaid for prescription drug coverage in 1991, many of them poor elderly. This represents a 13.3-percent increase from 1990 in the number of Americans receiving drug coverage under Medicaid.[56]

Prescription drug program expenditures accounted for 7.0 percent of total Medicaid program expenditures, totaling $5.4 billion in 1991. Total drug program expenditures increased 23 percent over 1990, the largest dollar increase in the drug program in many years. This sharp rise in program expenditures can be attributed to an increase in the number of Americans eligible for the drug program, as well as the rapidly increasing prices for prescription drug products in the United States.

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[56] Senate Special Committee on Aging. *Nursing Home Care: The Unfinished Agenda.* S. Prt. 99-160, U.S. Govt. Print. Off.: Washington, D.C., May 1986.

Prescription drugs remained the fourth highest category of Medicaid program spending in 1991, ahead of hospital inpatient care, intermediate care facility services, and skilled nursing care. Although drug coverage is optional, each state Medicaid program offers a prescription drug benefit. The largest drug program is in the State of California, accounting for 12 percent of all Medicaid drug program expenditures; New York State is second, accounting for about 11 percent. On the average, each State paid on average $256 in 1991 for prescription drugs for each Medicaid recipient, unchanged from the previous year.

Concern about rapidly escalating costs in the Medicaid prescription drug program—due primarily to drug manufacturer's price increases—prompted congressional action in the 2nd session of the 101st Congress (1990) to limit the growth rate of Medicaid drug program expenditures. The overall rate of inflation in the decade of the 1980's was 58 percent, but prescription drug price inflation rose 152 percent, almost three times the amount. These drug price increases caused economic hardship both for many elderly Americans, and for the state-based Medicaid drug programs.

As part of OBRA 1990, Congress enacted a program that was originally estimated to save Federal and State taxpayers $3.4 billion in Medicaid program prescription drug costs. Current estimates are that the program will bring in $6.4 billion in rebates through 1997, almost double the amount originally estimated.

Savings are achieved because drug manufacturers are required to give the Medicaid program a rebate or discount as a condition of providing reimbursement for that manufacturer's products under Medicaid. The program also significantly expands access to needed medications because States are required to cover all drugs for which a manufacturer is giving a rebate.

The rebate law went into effect on January 1, 1991, and at the end of the 1992, all States were receiving millions of dollars in rebate checks from the over 400 pharmaceutical manufacturers that signed an agreement to participate in the program. An update on the changes made in the program and its implementation is provided later in this chapter.

3. Issues and Congressional Response

(A) Nursing Home Care

The demand for nursing home services is expected to escalate over the next several years because of the growing population of older Americans. The age 65 and older group is expected to increase from the present level of 25 million to 36 million by the year 2000. More notably, the age 85 and over population (those most at risk of needing institutional care) is expected to increase from 2.5 million at the present time to 5 million in the year 2000—an increase of 100 percent.

As interest in providing comprehensive long-term care services to our Nation's elderly continues to grow, it is likely that issues surrounding nursing home care will become the focus of increased congressional and public attention. Following is a discussion of nursing home quality of care and the OBRA 1987 nursing home reform pro-

visions, as well as the long-term care ombudsman program under the Older Americans Act.

(1) Nursing Home Quality of Care and OBRA 1987

Quality of care in nursing homes has been an item of great concern to the elderly and their advocates for a number of years. During the 1980's, several investigations and studies, including a 2-year investigation (completed in 1986) by the Senate Special Committee on Aging,[57] a report by GAO,[58] and a report by the Institute of Medicine,[59] found that thousands of frail elderly citizens live in nursing homes that fail to provide care adequate to meet even their most basic health and safety needs. Legislation was passed in 1987 to implement many of the recommendations of the various studies and aging advocacy organizations. The OBRA 1987 (P.L. 100-203) contains extensive nursing home quality care provisions. This legislation will be outlined in greater detail below, following discussion of the findings that led to its passage.

In response to congressional concern about controversial nursing home regulations proposed by HCFA in 1982 to essentially "deregulate" the nursing home industry, HCFA commissioned a study in 1983 from the Institute of Medicine (IoM) of the National Academy of Sciences. The study, which was released in 1986, concluded that the quality of care and quality of life in many nursing homes are unsatisfactory, and that a stronger Federal role is essential to improve the quality of care. The study made a number of recommendations to strengthen and improve the current Federal regulations that were incorporated into OBRA 1987. These reforms were the result of a virtually unprecedented consensus of Congress, consumers, and nursing home provider groups, professional associations, and aging advocacy organizations. The provisions were written in great detail, similar to agency regulations, leaving little to interpretation. Many contend that this reflected congressional distrust of HCFA and the Reagan Administration on this issue as a result of their previous attempts to weaken the nursing home regulatory system.

Below are highlights of the OBRA 1987 nursing home reform provisions:

Definition of a Nursing Facility.—Eliminates the distinction between SNF's and ICF's as of October 1, 1990, and repeals a requirement that States pay less for ICF services than for SNF services; as of October 1, 1990, all nursing homes participating in either Medicare or Medicaid must meet the same requirements for provision of services, the rights of residents, staffing and training, and other administrative matters.

Requirements for Care.—As a condition of participation in Medicare or Medicaid, facilities must, at least once a year, conduct a comprehensive assessment of each patient's ability to perform such everyday activities as bathing, dressing, eating, and walking. Re-

[57] U.S. General Accounting Office. *Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed.* GAO-HRD-87-113, Washington, D.C., May 1987.

[58] Institute of Medicine, National Academy of Sciences. *Improving the Quality of Care in Nursing Homes.* National Academy Press: Washington, D.C., 1986.

[59] *Improving the Quality of Care in Nursing Homes,* p. 89, 90.

sults of such assessments will be used in a written plan of care, describing how a person's medical, psychological, and social needs will be met.

After January 1, 1989, nursing homes are prohibited from admitting residents who are mentally ill or mentally retarded unless they also require the level of care provided in the facility. Preadmission screening must be completed on all prospective residents, whether the costs of care are covered by private or public sources.

Residents' Rights.—Requires that nursing home residents be informed both orally and in writing of their legal rights, including the rights to: choose a personal physician, and be informed in advance about treatment; be free from physical or chemical restraints; have privacy in accommodations, medical treatment, written and telephone communications; confidentiality of personal and clinical records; and have immediate access to a State or long-term care ombudsman.

Staffing Requirements.—As of October 1, 1990, all nursing facilities participating in Medicare or Medicaid must have at least one registered nurse on duty 8 hours per day, 7 days per week, and at least one licensed nurse on duty, 24 hours per day, 7 days per week. These requirements can be waived under certain defined circumstances, with different waivers in place for Medicare SNFs and Medicaid NFs. All nursing facilities with more than 120 beds must employ at least one full-time social worker.

Training for Nurse Aides.—All nurse aids in facilities participating in Medicare or Medicaid must complete an approved training course (75 hours) that includes instruction in basic nursing skills, personal care skills; cognitive, behavioral, and social care; and residents' rights. States must maintain a registry of individuals who have successfully completed such a course, and must also report instances in which the aide has committed acts of resident neglect or abuse (although the aide has the right to an appeal).

Survey and Certification Process.—States are responsible for ensuring compliance with new requirements (except State-owned facilities, which would be monitored by the Federal Government). Each facility is subject of an unannounced "standard survey" on a statewide average of at least one per year, but no less than every 15 months. Facilities found to be delivering substandard care will be subject to an "extended" survey. However, States may impose sanctions based solely on the results of a standard survey.

States also must maintain procedures and staff adequate to investigate complaints of violations of requirements, and to monitor on site, on a regular basis, the compliance of facilities found in violation or suspected of violations.

Enforcement Process, Intermediate Sanctions.—If a State or the Federal Government finds a facility out of compliance and the deficiencies immediately jeopardize the health or safety of the residents, the State or HHS must take immediate action to correct the deficiencies through the appointment of temporary management or terminate the facility's participation in the Medicare or Medicaid program.

If the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the State or HHS may impose one or more intermediate sanctions, terminate the facility's participa-

tion or both. Intermediate sanctions include denial of payment for new Medicare or Medicaid admissions, civil penalties for each day of non-compliance, appointment of temporary management for the facility, and emergency authority to close the facility and transfer its residents.

Facilities found out of compliance for 3 consecutive months are automatically subject to denial of payment for new admissions. Facilities remaining out of compliance for 3 consecutive standard surveys and found to be delivering substandard care are subject to automatic denial of payments and to on-site monitoring by State officials.

(a) Issues in the Implementation of OBRA 1987

The implementation of OBRA 1987 has been fraught with many problems—a lack of guidance from HCFA, concerns among the States and providers about the costs of implementation, and congressional inaction on technical corrections. Many aging advocates and providers contend that one of the biggest stumbling blocks has been HCFA's inability to meet deadlines established by the legislation, and to provide needed guidance on implementation. Because OBRA 1987 requires States to implement the law whether or not they have received guidance from HCFA, HCFA's lack of leadership and guidance on OBRA is particularly troubling. It is only in the past year or two that HCFA has begun to issue the rules and regulations to implement OBRA 1987. This occurred despite the explicit deadlines that were included in OBRA as well as intense pressure from the Congress, States, providers, and the public.

In 1991 and 1992, there was no legislative action on nursing home reform. After the long-awaited inclusion in OBRA 1990 of a variety of OBRA 1987 technical provisions, there was a general consensus among Members of Congress who had been active on this issue that the implementation of OBRA 1987 would progress more successfully without further legislative intervention. Members continue to be involved in overseeing the process of implementation in the form of letters to HCFA and HHS, oversight hearings, and seminars, such as the July 1991 Aging Committee seminar on the use of chemical restraints in nursing homes. On the whole, however, congressional attention vis-a-vis nursing home issues in the 102nd Congress turned to the more global concern of overall long-term care reform.

(b) OBRA 1990 Technical Corrections

Following is a discussion of various provisions of OBRA 1990, which was the primary vehicle for technical corrections to OBRA 1987. Until the passage of OBRA 1990, there was little congressional action taken to make technical corrections to OBRA 1987, creating problems for States, providers, and advocates alike. They looked to Congress to make corrections to the existing law, which would help with the implementation, particularly in the absence of guidance from HCFA. In the 1989 budget reconciliation process, the invocation of an obscure rule on the Senate floor resulted in elimination of most of the OBRA 1987 technical provisions from the

budget bill. A number of these provisions were later included in OBRA 1990:

Preadmission Screening and Annual Resident Review.—OBRA 1987 requires preadmission screening of mentally ill and mentally retarded nursing home applicants to determine if they need the care that a nursing home provides and, if so, whether they need active treatment. It also requires an annual review of mentally retarded or mentally ill residents to ensure that their continued placement in a nursing home is appropriate. Those suffering from Alzheimer's disease are excepted from this process, otherwise known as PASARR. OBRA 1987 requires that prospective applicants be screened beginning January 1, 1989, regardless of whether the Secretary had promulgated regulations; by April 1, 1990, all such residents who have lived in a nursing home for less than 30 months must be placed elsewhere. Nursing homes that do not comply are subject to a cutoff of all Medicare and Medicaid funds.

OBRA 1990 provisions relating to PASARR include:

HCFA cannot take enforcement actions against States that make a good faith effort to comply with PASARR before the effective date of the May 1989 HCFA guidelines;

the definition of mental illness is changed from a "primary or secondary diagnosis of mental disorder described in DSM–III" to "serious mental illness to be defined by HHS in consultation with the National Institute of Mental Health;"

replaces references to "active treatment" with "specialized services;" and

States must report to HHS the number and disposition of residents who were discharged from nursing homes because of PASARR.

The final rule on PASARR was published in November 1992.

Nurse Aide Training.—The IoM report found that over 70 percent of the nursing personnel in long-term care facilities are nurse aides, and that as much as 90 percent of resident care is delivered by them.[60] For this reason, the IoM recommended that the Federal Government mandate the training of nurse aides prior to their employment. As a result, OBRA 1987 established new requirements for nurse aide training. The law states that for those nurse aides hired prior to July 1, 1989, nursing homes participating in Medicaid and/or Medicare must provide a competency evaluation program and the preparation necessary for the aide to complete this program by January 1, 1990. For newly hired nurse aides, the law requires that they complete both a training program and a competency evaluation. The training program must include a minimum of 75 hours of initial training. Training and evaluation programs may include those offered by or in nursing homes. OBRA 1987 also requires that Medicare and Medicaid recognize the costs of nurse aide training incurred by facilities. The Secretary was required to establish requirements for approval of these programs by September 1, 1988; final regulations were issued in September 1991.

[60] "A Study of the Involvement of State Long-Term Care Ombudsman Programs in Board and Care Issues." Prepared for the Administration on Aging by the National Center for State Long-Term Care Ombudsman Resources of the National Association of State Units on Aging, Washington, D.C., Dec. 1989.

Among the nurse aide training provisions included in OBRA 1989 was a delay from January 1, 1990 to October 1, 1990, the date by which aides must complete training and/or competency evaluation programs and be determined qualified to provide care. It also included provisions to provide for the "grandmothering" of already-employed nurse aides. Those nurse aides who have received 60 hours of initial training and at least 15 hours of unsupervised practical nurse aide training or inservice education as of July 1, 1989, shall be considered to have completed a training and competency evaluation program. Those nurse aides who have completed a training course of at least 100 hours and have been found competent before July 1, 1989, shall be considered to have completed a training and competency evaluation program as well. Finally, States are authorized to waive the competency evaluation program as well. Finally, States are authorized to waive the competency evaluation (but not the training) requirements with respect to persons who can demonstrate that he or she has served as a nurse aide at one or more facilities of the same employer in the State for at least 24 consecutive months before the date of enactment.

There were a number of nurse aide training provisions in OBRA 1990 as well. These include:

HCFA cannot take enforcement action against States that failed to meet program requirements before the effective date of May 1989 HCFA guidelines if the State made a good faith effort to comply;

Temporary or per diem aides employed after January 1, 1991, must meet the same training and competency requirements as other nurse aides;

States must reimburse aides' training costs (on a pro-rata basis) if they enter into an employment agreement with a nursing facility within 12 months of completing a training and competency evaluation program.

A Facility is not permitted to conduct nurse aide training if, within the previous 2 years it: (a) has operated under a waiver of nurse staffing requirements in excess of 48 hours per week; (b) has been subject to an extended (or partially extended) survey; or (c) has been subject to certain sanctions, including a civil monetary penalty of not less than $5,000, denial of payment, appointment of temporary management, closure, or transfer of residents.

(c) Nurse Staffing Waivers

The IoM report noted that one of the main factors affecting quality of care and quality of life in nursing homes is the number and quality of nursing staff. Greater numbers of nursing staff have been associated with improved resident outcomes. One of the primary differences between ICFs and SNFs is their nurse staffing requirements. Medicare (and Medicaid) SNFs must have licensed nurses on duty 24 hours per day, including the services of a registered nurse at least during the day shift, 7 days per week. Medicaid ICFs require only that a licensed nurse be on duty on the day shift 7 days per week. A licensed nurse is defined in both cases as registered nurse, a licensed practical or vocational nurse.

IoM also looked at the differences between SNFs and ICFs with regard to the needs of residents that they served, and found that the distinctions between the two do not necessarily reflect differences in the residents that they care for. Accordingly, IoM recommended that the distinction between the two types of facilities be eliminated and that participating facilities be subject to the same quality assurance criteria and procedures, including the SNF minimum staffing requirements. OBRA 1987 eliminates the distinction, and creates a new category referred to as a nursing facility (NF). As of October 1, 1990, all nursing facilities must meet a single set of requirements for participation in Medicaid. These are almost identical to Medicare's requirements.

For nurse staffing, OBRA 1987 requires that NFs meet Medicare's requirements. However, it provides for a broader waiver authority for NFs than for SNFs. NFs are permitted to waive either the registered nurse and the licensed nurse requirements; SNFs can waive only registered nurse requirements. Waivers will be granted by the States in strictly defined circumstances, and HCFA is in the process of drafting regulations implementing these requirements. Because registered nurses are in short supply nationwide, health care providers often must pay higher salaries to recruit and retain nursing personnel. These higher salary costs, as well as OBRA's mandate for increased nurse staffing, will likely lead to an increase in States' Medicaid costs. For this reason, there is some concern that States will have an incentive to grant waivers. The implementation of this provision of OBRA 1987 will likely be carefully monitored by nursing home consumer groups and State regulatory agencies.

OBRA 1990 contains a provision that will affect nurse staffing waivers. In the February 2, 1989 Final Rule, HCFA had interpreted the nurse staffing waiver requirements to mean that NFs could waiver either the LPN or RN requirement in its entirety, but not both. The OBRA 1990 provision would allow States to grant waivers of either or both requirements to the extent the NF cannot meet them. For example, if a facility can find an RN for 40 hours during the week but not for the 16 hours over the weekend, the facility would only get a waiver for the 16 hours. However, if a facility can demonstrate that it cannot find any nursing staff for any of its shifts, it can get a waiver for both requirements. Residents, ombudsmen, and protection and advocacy systems must be notified when waivers are granted. The Secretary of HHS is also required to conduct a study and report to Congress on the appropriateness of establishing minimum caregiver to resident ratios and minimum supervisor to caregiver ratios for SNFs and NFs, and to include recommendations for appropriate minimum ratios.

(d) Other OBRA 1987-Related Issues

There were several other provisions in OBRA 1990 making technical corrections to OBRA 1987. Among them were:

Enforcement. HCFA cannot take compliance action against States that demonstrate a good faith effort to establish alternative sanctions required by OBRA 1987 prior to the date on which the

Secretary of HHS issues guidelines regarding the establishment of remedies for facility noncompliance.

Administrator Licensure. When HHS issues standards for nursing home administrators, the pre-OBRA 1987 law requiring States to license nursing home administrators and set criteria for State licensing boards will be repealed.

Maintenance of Standards for Personnel. The Secretary must establish requirements for social workers, activities professionals, and dietitians employed in a nursing facility that are at least as stringent as those requirements in place prior to the enactment of OBRA 1987.

Resident Assessment. The period for completing the initial assessment is expanded from 4 to 14 days.

PPS for SNFs. The Secretary is required to develop a proposal to modify the Prospective Payment System for SNFs.

(2) Long-Term Care Ombudsman Program

The long-term care ombudsman program began as a demonstration project in the early 1970's as a part of the Federal response to serious quality-of-care concerns in the Nation's nursing homes. These demonstration ombudsman programs were charged with the responsibility to resolve the complaints made by or on behalf of nursing home residents, document problems in nursing homes, and test the effectiveness of the use of volunteers in responding to complaints. As a result of the success of the early programs, Congress incorporated the ombudsman program into the 1978 amendments to the Older Americans Act (OAA).

Under the OAA, each State is required to establish and operate a long-term care ombudsman program. These programs, under the direction of a full-time State ombudsman, have responsibilities built upon those outlined above. The programs are to: (1) Investigate and resolve complaints made by or on behalf of residents of long-term care facilities, (2) monitor the development and implementation of Federal, State, and local laws, regulations, and policies with respect to long-term care facilities, (3) provide information as appropriate to public agencies regarding the problems of residents of long-term care facilities, and (4) provide for training staff and volunteers and promote the development of citizen organizations to participate in the ombudsman program. The 1981 amendments to the OAA added the requirement that ombudsmen serve residents of board and care homes.

The primary role of long-term care ombudsmen is that of consumer advocate. However, they are not limited to responding to complaints about the quality of care. Problems with public entitlements, guardianships, or any number of issues that a nursing home resident may encounter are within the jurisdiction of the ombudsman. A major objective of the program is to establish a regular presence in long-term care facilities, so that ombudsmen can become well-acquainted with the residents, the employees, and the workings of the facility. This presence is important because it helps the ombudsmen establish credibility and trust. Further, because about one-half of nursing home residents have no family, many may have only ombudsmen to speak on their behalf.

In FY 1990, there were 578 local ombudsman programs throughout the Nation. According to the Administration on Aging (AoA), which is the Federal agency responsible for the OAA and the ombudsman program, the number of complaints handled by programs across the country nearly quadrupled from 1982 to 1990, rising from 41,000 in 1982 to 154,000 in 1990. Of the complaints received in 1989, AoA reports that about 69 percent were fully or partially resolved.

Funding devoted to the ombudsman program has grown in recent years. In fiscal year 1982, States reported that a total of $10.4 million was spent on ombudsman activities, an amount which grew to almost $28 million in fiscal year 1990. Staffing, both paid and volunteer, more than doubled from fiscal year 1982 to fiscal year 1988, from 4,171 to 10,381.

Despite the program's growth and effectiveness, Federal support, in terms of funding and statutory requirements has been inadequate. The Institute of Medicine's report on the quality of care in nursing homes noted that the ombudsman programs varied widely in their effectiveness, and stated the need to make improvements to the program in the future.

To address these concerns, the Older Americans Act Amendments of 1987 (P.L. 100-175) and 1991 (P.L. 102-375) contained several provisions to strengthen and improve the long-term care ombudsman program. Among the provisions in the 1987 legislation was a requirement that States provide access to facilities and to records, and immunity to ombudsmen for good faith performance of duties. The 1987 legislation also required improved AoA reporting on the ombudsman program, including an annual report to Congress on complaints and conditions in long-term care facilities and recommendations on ways to improve conditions, among other things. In addition, the Commissioner of AoA was required to submit a report to Congress on the findings and recommendations of a study on the impact of the long-term care ombudsman program on the care of residents of board and care facilities, and other adult care homes, as well as the effectiveness of recruiting, supervising, and retaining volunteers. The study found that State long-term care ombudsman programs appear to have a significant role in monitoring board and care legislation and regulation, as well as in coordinating with other agencies. The 48 States participating in the study were evenly divided as to whether their impact on board and care homes was significant, moderate or slight.[61] The study on the use of volunteers in ombudsman programs found that of the 46 States responding, 26 categorized themselves as using mostly volunteer staff, and 20 used primarily paid staff. However, 80 percent of the paid programs expressed interest in developing or expanding their volunteer capacity.[62]

Congress for the first time established a separate authorization of funds for the ombudsman program in the 1987 OAA Amend-

[61] "A study of the Use of Volunteers by State Long-Term Care Ombudsman Programs: The Effectiveness of Recruitment, Supervision, and Retention." Prepared for the Administration on Aging by the National Center for State Long-Term Care Ombudsman Resources of the National Association of State Units on Aging, Washington, D.C., Dec. 1989.

[62] U.S. General Accounting Office. *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met.* GAO/HRD-89-50, Feb. 1989.

ments, with an authorization of $20 million in fiscal year 1988, and such funds as may be necessary in fiscal years 1989-91. In 1993, Congress appropriated $8.3 million for ombudsman and elder abuse activities ($3.9 million for ombudsman activities, and $4.4 million for elder abuse).

The Older Americans Act was due to be reauthorized in 1991; and the conference on the Senate and House-passed versions of the reauthorization bills was finally signed into law in September 1992. (Please see Chapter 10 for an overview of the 1991 reauthorization legislation.) The 1991 legislation created a new title, Title VII, that expands, consolidates, and amends OAA programs that focus on the protection of the rights of older persons. The authorization of appropriations for the long-term care ombudsman is therefore shifted from Title III to the new title. It also establishes a new office of Long-Term Care Ombudsman Programs in the Administration on Aging (AoA), which will be headed by an Associate Commissioner. Functions of the Associate Commissioner include serving as an advocate for residents in long-term care facilities, supervising activities related to the ombudsman program, and reviewing and making recommendations on Federal legislation, regulations, and other policies affecting the program. The law also establishes a National Ombudsman Resource Center administered by the Associate Commissioner for Ombudsman Programs. The functions of the Center include performance of research and training on long-term care ombudsman activities. An amendment to Title III sets forth requirements on protection of the rights of older persons who receive Title III in-home services, including the rights to be fully informed about services, to voice grievances, and to have confidentiality protected.

(B) ISSUES AFFECTING THE MEDICAID PRUDENT PHARMACEUTICAL PURCHASING PROGRAM

On November 5, 1992, President Bush signed H.R. 5193 (P.L. 102-585), the Veterans Health Care Act of 1992. In addition to making several changes to the Medicaid rebate program, the legislation requires drug manufacturers to give statutory discounts to other Federal health care programs, such as the Department of Veterans Affairs (VA) and Public Health Service (PHS) clinics.

The enactment of this legislation was the culmination of almost 2 years of legislative initiative to assure that all Federal health care programs had access to fair and affordable pharmaceutical prices. The legislation was also enacted to minimize the potential for any intragovernmental cost shifting by drug manufacturers among Federal health care programs. For example, several Federal agencies had raised concerns that drug manufacturers would simply increase prices to other Federal health care programs to offset the discounts that they were required to provide to Medicaid under OBRA 1990. The legislation was designed to protect against this happening.

The final legislation was based on several different proposals that had been developed and introduced in the House and Senate during the 102nd Congress. On the Senate side, legislation providing prescription drug discounts to VA, DOD, and Public Health

Service clinics was included in S. 2575, and reported out by the Committee on Veterans Affairs in August. The legislation was developed by Senators Jay Rockefeller (D–WV), Edward Kennedy (D–MA), Barbara Mikulski (D–MD), Alan Cranston (D–CA), and Chairman Pryor. On the House side, legislation was reported out by the House Committee on Veterans Affairs at the end of 1991 that would have restored VA prescription drug prices to levels in effect prior to October 1990. When all the compromises were made, H.R. 5193 was enacted by the Congress, making the following changes in the way that the Federal Government buys pharmaceuticals:

Manufacturers are required to enter into a "master agreement" with the Secretary of VA. The master agreement requires that, in order for the manufacturer to receive any payment (either directly or through reimbursement) for its pharmaceutical products from the Medicaid program, VA, DOD, PHS clinics, or any entity that receives funds under the PHS Act, the manufacturer must meet certain conditions.

The manufacturer must list all of its products on the VA pharmaceutical Federal Supply Schedule (FSS) as of January 1, 1993, and provide a discount of at least 24 percent off the non-Federal average manufacturers price (non-FAMP) for a drug that is listed on the FSS or procured by any federally operated depot, including depots of the VA, DOD, and the PHS.

This legislation expands the number and type of entities whose prices are exempt from the calculation of the Medicaid "best price" rebate. That is, manufacturers are no longer required to base their "best price" rebates to Medicaid on certain prices if they are the lowest or "best" prices in the market. These include FSS prices, State Veterans home prices, other VA, DOD, and Indian Health Service prices, PHS clinic prices (including certain Disproportionate Share Public hospital prices), and State pharmaceutical assistance program (PAP) prices.

In order to maintain budget neutrality as a result of exempting these additional prices from the calculation of the Medicaid "best price" rebate, the Medicaid "minimum rebate" for single source and innovator multiple source drugs is increased to 15.7 percent between October 1, 1992 and December 31, 1993, to 15.4 percent for 1994, to 15.2 percent for 1995, and 15.1 percent thereafter. No change was made to the "best price" provision of the Medicaid rebate legislation. That is, for each calendar quarter, manufacturers still have to base their rebate to Medicaid on the new minimum discount or the lowest (best) price for the drug in the market, whichever is greater, excluding those prices that are exempt from the determination of the "best price."

Under the legislation, the following Public Health Service clinics are entitled to receive the same price for drugs that Medicaid pays: Federally qualified health care centers (FQHCs, including section 329, 330, and 340 clinics, as defined in section 1905 of SSA); Section 340A public housing primary care clinics; family planning clinics (1001); Title XXVI (Ryan White AIDS clinics); black lung clinics; hemophilia clinics; native Hawaiian health centers; Indian Health Service nonprofit grantees; STD

clinics; TB clinics; disproportionate share public hospitals with a DSH percentage of greater than 11.75 percent.

(1) The Issue of "Best Price" for the Medicaid Program

In addition to legislation that was introduced to provide fair drug prices to Federal health care programs, other legislation was introduced which would have significantly altered the method by which the Medicaid pharmaceutical rebate is calculated. Under legislation introduced by Senator John Chafee (R-RI) and Congressman Jim Slattery (D-KS), Medicaid's "best price" rebate would be replaced with a flat rebate percentage that would have been set to maintain budget neutrality for the program.

Under current law, manufacturers have to give Medicaid their "best" or lowest price in the market, or a minimum discount, whichever is greater. This provision was enacted in the rebate law under the premise that Medicaid—as the largest purchaser of drugs in the Nation—is entitled to the same price that drug manufacturers make available to other large volume pharmaceutical purchasers.

Reports circulated throughout the year that manufacturers were eliminating these low prices that they had traditionally extended to large-volume purchasers so that they would not have to give them to Medicaid as well. Hospitals and HMOs, purchasers who have traditionally been able to negotiate these discounts, expressed serious concerns about the impact of the "best price" provision of the law on their drug costs. By eliminating the "best price" component, and replacing it with a "flat rebate," it was argued, manufacturers would stop raising prices to these institutional purchasers.

A hearing was held on July 31 by Congressman Henry Waxman (D-CA), Chairman of the House Subcommittee on Health and the Environment on all the proposals to modify the Medicaid rebate law. Support for switching the "best price" rebate to a flat rebate came from HMOs, hospitals, and the majority of drug manufacturers. Supporters of retaining the "best price" in the Medicaid rebate law included the National Governors Association, the State Medicaid Directors, the community pharmacy groups, and several major pharmaceutical manufacturers.

These latter groups argued that the "best price" provision of the rebate law was working well, and was bringing in far more in rebates for the States than originally estimated. In fact, according to a HCFA report issued in September, the "best price" component of the rebate law was estimated to have accounted for one-third of all the rebates collected during the first three quarters of 1991. In addition, the full revenue impact of "best price" had not yet been realized by the States since the "best rebate" rebate was capped at 50 percent of the average manufacturers price (AMP) through 1992. The cap expired at the end of 1993.

Finally, a comprehensive analysis of the impact of the Medicaid rebate law on private purchasers, that is, the hospitals and HMOs, had yet to be completed by the GAO. The GAO report was requested by Congress to determine if manufacturers were cost shifting to other providers in order to recoup the rebates that they were required to give to Medicaid. Originally due to Congress in May, the

report was not delivered in 1992 because the GAO had difficulty in collecting in the data that they needed to complete the study.

Because of the States' opposition to the change, and the lack of conclusive data about the impact of the law on private purchasers, the "best price" component of the Medicaid rebate law was retained by Congress in 1992. It is possible that this issue will be revisited in the 103rd Congress once more data are available, and the full impact of the "best price" provision of the rebate law can be assessed.

(2) Impact of the Rebate Program on Medicaid Drug Expenditures

Several reports issued in 1992 provided evidence that the Medicaid pharmaceutical rebate program enacted in OBRA 1990 was meeting its intended result—helping to contain Medicaid prescription drug program expenditures.

A report released by the Policy Research Group in May analyzed Medicaid drug program expenditure and rebate data from 1991, the first year that the rebate program was in effect. The report found that, while Medicaid prescription drug payments increased by 20 percent form 1990, increases in the average cost per prescription accounted for only a small increase in the total program costs: 24 percent.

The primary increase in Medicaid drug program expenditures—75 percent—was due to increases in the number of recipients receiving prescription drugs under Medicaid. On the other hand, the primary reason for the increase in program costs in the overall Medicaid program was not due to population growth, it was due to an increase in payment for services.

In addition, according to the report, from 1990 to 1991, the average Medicaid prescription price increased only 5.6 percent, from $17.90 to $18.90. The modest increase in Medicaid's average prescription drug price could be directly attributable to the cost containment mechanism incorporated into the Medicaid rebate program. The program not only requires the drug manufacturer to provide a discount to the Medicaid program, but also requires that the manufacturer provide an additional rebate to the Medicaid program for any price increase that exceed the increase in the CPI–U. That is, drug manufacturers also have to provide to the Medicaid program another rebate equal to the difference between the actual price of the drug in the market, and the price of the drug had it only increased by the general rate of inflation.

This inflation-adjustment rebate is a vital component of the program because it protects Medicaid from drug price increases that are excessive. In fact, CBO estimates that this component of the program will account for about 50 percent of all rebates that will be collected by the program in 1996 and beyond.

(3) Implementation of Drug Use Review Provisions

Update on General DUR Program.—State Medicaid programs worked diligently throughout the year to prepare for implementation of the Drug Use Review (DUR) provisions of OBRA 1990. The program was scheduled to go into effect on January 1, 1993. The program is designed to improve the quality of prescribing and dis-

pensing of prescription drugs to Medicaid recipients. There are three components of the program: prospective DUR, retrospective DUR, and an educational outreach program for physicians and pharmacists.

Under the prospective component, pharmacists are required to check the prescription at the time of dispensing to determine if there is the potential for any adverse reactions for the patient from the medication. The pharmacist must also offer to counsel the patient on how to take the medications.

Under the retrospective component, patterns of inappropriate drug prescribing and dispensing to Medicaid recipients are supposed to be determined, based on pre-selected criteria and standards for drug use review. Once deviations from the standards and criteria are identified, educational interventions are supposed to ensue to alert health care professionals about the prescribing patterns detected during the retrospective review.

The Health Care Financing Administration was charged with implementation of the program; however, each State must establish a Drug Use Review Board consisting of physicians and pharmacists with knowledge about the clinical use of drugs in various population groups. It is the responsibility of the DUR Board to recommend policies and procedures to the State Medicaid agency on how to operate an effective DUR program.

The major issue that developed during the year regarding the implementation of the program concerned the definition of the pharmacist's "offer to counsel" the Medicaid recipient on how to use their medications. Under the current OBRA DUR law, State guidelines regarding patient counseling require at a minimum, that the pharmacist is supposed to offer to counsel the patient, in person, on how to use their medication.

In a draft instruction manual issued by HCFA to the States in the summer, the requirement that the pharmacist make the offer to counsel the patient in patient was excluded from the minimum requirements that States had to include in their own guidelines in order to be deemed in compliance with HCFA regulations. By omitting this provision from the minimum requirements, the pharmacist did not have to personally make the offer to counsel the Medicaid recipient. Instead, the States Medicaid agency could define the "offer to counsel" as it so chose.

While not precluding the offer being made face to face, this interpretation of the law would have permitted the offer to be made by the pharmacist in nonpersonalized means, such as posting a sign in the pharmacy, or by placing a sticker on a bag or a prescription bottle, indicating that counseling was available from the pharmacist.

Because of HCFA's interpretation of the statue in a manner that was inconsistent with congressional intent, Senator Pryor wrote to Secretary Sullivan in April to express his concerns. In the letter, the Senator indicated that, taken together, the language in the statute and the legislative history of the DUR provisions clearly indicate that, at a minimum, the pharmacist must orally offer to counsel the patient in person on how to use the medication. Such an offer, the Senator contended, would be the best mechanism for promoting interaction between the patient and the pharmacist.

In his response to the Senator, the Secretary indicated that he believed that the statute should be interpreted as allowing States to determine the definition of "offer to counsel." The Department would not include a minimum requirement in its regulations that the offer was to be made orally by the pharmacist.

Many States, however, were developing regulations and guidelines that required the pharmacist to orally offer to counsel the patient face to face. In addition, these regulations were developed to apply to all individuals that visit pharmacies to pick up prescriptions, not just Medicaid recipients.

To clarify the intent of Congress regarding the patient counseling provision of OBRA 1990, a technical amendment was introduced as part of S. 3274 that would clarify the language of OBRA 1990 that the pharmacist had to make the offer to counsel the Medicaid recipient "face to face." No Medicaid technical amendments were enacted in the 102nd Congress, so this provision will have to be reintroduced in the 103rd Congress.

In early November, HCFA issued regulations to implement the program. The regulations were relatively consistent with the instruction manual for the States that had been issued earlier in the summer.

Update on Demonstration Projects.—In September, the HCFA Office of Research and Demonstrations (ORD) awarded DUR demonstration projects to three States: Iowa, Mississippi, and Washington State. The purpose of the demonstrations, which were included in OBRA 1990, is to determine the cost-effectiveness of providing information to pharmacists about a Medicaid recipient's drug history through an online electronic system.

The information provided through the electronic system would be used by pharmacists to perform the prospective drug use requirements mandated under OBRA 1990. That is, the information provided would help the pharmacist assure, to the best of his or her abilities, that the prescription is medically appropriate and not likely to result in harmful results to the patient.

The demonstrations are also designed to determine whether and how pharmacists should be compensated for performing cognitive services. These services include providing patient counseling, or not filling a prescription when the pharmacist detects that there could be a potential problem for the patient with the prescription as written. The results of the demonstrations are due to Congress in the mid-1990's.

(4) State-based Pharmaceutical Assistance Programs for the Elderly

To provide financial relief for those low-income elderly that are ineligible for Medicaid's outpatient prescription drug benefit, 10 States have developed their own pharmaceutical assistance programs (PAPs) for the elderly. These States are New York, New Jersey, Pennsylvania, Delaware, Maine, Illinois, Rhode Island, Connecticut, Maryland, and Vermont. These are State-financed programs which help certain populations of elderly subsidize the costs of prescription drugs. Traditionally, these programs serve elderly patients who are poor, but have income levels which make them ineligible to receive Medicaid.

In 1991, these PAP programs provided additional whole or partial prescription drug coverage for almost 4.8 million elderly that were ineligible for Medicaid, accounting for almost $1.5 million in prescription drug expenditures for low-income elderly. However, there were also millions of other older Americans in these 10 States that had no form of prescription drug coverage and many millions more in States that have no PAP.

These programs have experienced funding problems similar to the Medicaid program, primarily because of drug manufacturer price inflation in the 1980's. Although these programs also buy large quantities of prescription drugs each year, they did not receive any discounts or rebates that pharmaceutical manufacturers traditionally give to large-volume purchasers. However, since the enactment of OBRA 1990, several of the State PAPs have enacted their own rebate program.

For example, New York and Pennsylvania enacted rebate programs in 1991. New Jersey and Rhode Island followed the lead of the other States, enacting a rebate program in 1992 that required manufacturers to give these State programs the "best price" that they give to any buyer in the market. Reflecting the incentive incorporated into the Federal rebate program, manufacturers' products are not reimbursed by these State PAP plans if they do not agree to provide the rebates specified under the law.

By lowering the cost of prescription drugs in these PAP programs, States may be able to expand the programs to more elderly that have no insurance but do have substantial costs for prescription drugs. However, many of these State PAP programs, experiencing funding crises due to the exploding costs of prescription drugs, needed to enact these rebate programs just to maintain the level of services that they are providing.

(C) FEDERAL LONG-TERM CARE INITIATIVES

(1) Comprehensive Long-Term Care Legislation

A number of bills were introduced in the 102nd Congress to address the issue of comprehensive long-term care. These bills address the issue from a variety of angles and perspectives, with different financing mechanisms and benefits packages, and varying administrative approaches. They are considered essentially "discussion pieces" in that each piece of legislation is the sponsor's ideal approach to providing comprehensive long-term care. Although no formal action was taken on these bills, when Congress and the Executive branch of the Federal Government finally agree on an approach to long-term care, it will likely combine elements of each.

The following are brief synopses of the key initiatives that were introduced:

Mediplan Long-Term Care Act of 1991 (H.R. 651, Stark).—Establishes a new Title XXI of the Social Security Act to provide coverage for nursing home and home and community-based services for certain chronically ill persons. Benefits would be phased-in over 7 years. Beneficiaries would pay for the first 12 months of nursing home care beginning in 1994 and the first 2 months of care in 1996. Beneficiaries would also pay 20 percent of the costs of nursing home and home and community-based

care. Financed through a 2-percent tax on the modified gross income of individuals (over $16,000 in the case of individual taxpayers, and $32,000 for joint returns) and corporations.

Partnership for Long-Term Care Act of 1991 (H.R. 2174, Kennelly).—Requires States to establish under their Medicaid plans medically needy programs for individuals below 100 percent of the Federal poverty level. Private long-term care insurance premium subsidies would be provided for persons with incomes between 100 percent and 200 percent of the Federal poverty level. In addition, it requires States to provide enhanced asset protection under Medicaid for those who purchase long-term care insurance, in an amount equal to the long-term care expenses paid for by the insurance policy.

Health USA Act (S. 1446, Kerrey).—Replaces existing private and public health insurance (including Medicare and Medicaid) with State-administered plans that would cover both long-term care and medical care. Enrollees would choose between a public plan and approved private plans with State reimbursement. Federal assistance to the State plans would be funded through a new payroll tax, a surtax on unearned income, and other tax increases.

Secure Choice (S. 1668, Packwood and Dole).—Replaces Medicaid long-term care provisions with a new Title XXI of the Social Security Act that would cover nursing home care and a broad range of home and community-based care. States would be required to cover impaired persons with income below the Federal poverty level and would have the option of covering persons with incomes up to 240 percent of poverty. For persons with higher incomes (between 240 percent and 400 percent of poverty), States would have the option of offering subsidized private long-term care insurance benefits to those purchasing qualified policies. All persons purchasing qualified policies, including those with incomes too high to receive subsidized benefits, would become entitled to enhanced assets protection under the new Title XXI.

Long-Term Care Family Security Act of 1992. (H.R. 4848/S. 2571, Waxman/Mitchell).—Based on the recommendations of the Pepper Commission, this legislation establishes a new Title XXI of the Social Security Act to provide coverage for nursing home and home and community-based care services for functionally impaired persons. Home and community-based care benefits would vary with the degree of impairment, with persons entitled to a certain number of hours of service per month according to their level of impairment. Nursing home care would be covered for two episodes of up to 6 months each, and assets protected in amounts up to $30,000 for individuals and $60,000 for couples, if additional care were needed. Benefits would be financed (under H.R. 4848; S. 2571 contains no financing mechanisms) through a new payroll tax, a tax on unearned income, and a decrease in the amount of estates which are tax-exempt.

(2) Frail Elderly Legislation

In 1989, Senator Rockefeller and Congressmen Wyden and Waxman introduced long-term care legislation which utilizes the Section 2176 waiver approach. This legislation, S. 1942 and H.R. 3933, would permit States to amend their Medicaid programs to extend coverage for noninstitutional care services to low-income, functionally disabled persons over the age of 65. These services would include home health aides, nursing and personal care services, assistance with household chores, respite care, and adult day health services.

Although this legislation provided similar types of services as under Medicaid's Section 2176 waivers, this approach has several advantages over the waivers. As discussed earlier, waivers have been very difficult for States for a variety of reasons. Under H.R. 3933 and S. 1942, States are given the authority to choose to provide these services as an option under Medicaid, thus eliminating the need for waivers.

A provision in the OBRA 1990 authorizes a capped entitlement of $580 million over 5 years for this program. States are permitted to provide a range of home and community-based services to persons age 65 and older who are eligible for Medicaid, and who are unable to perform two of three specified ADLs (toileting, transferring, and eating) or who have Alzheimer's disease and meet Alzheimer's disease-specific ADL criteria. Services are furnished in accordance with a community care plan developed by a case manager. The Secretary of HHS is required to establish minimum quality standards for providers of home and community-based care as well as the settings in which the care will be provided. States are responsible for surveying and certifying the compliance of providers and the settings. States also have the option to limit eligibility based on reasonable criteria such as age, degree of functional disability, and need for services, and will not be required to provide services on a statewide basis.

Although many States are eager to offer long-term care services to their elderly citizens, only two States have taken advantage of this option. There are a number of reasons for the States' reluctance, including what they consider to be overly restrictive income and disability requirements, and concerns about the way the available funds are allocated. In 1992, Senator Pryor introduced legislation (S. 3340) that would address some of the States' concerns by allowing States to limit the number of persons who could receive these services, and limiting the number of participating States to 25. This legislation also liberalizes the existing income and disability eligibility requirements, giving the States the flexibility they need to tailor the program to their citizens' need.

(3) Board and Care Homes

"Board and care" is a catch-all term used to describe a wide variety of nonmedical residential facilities, including group homes, foster homes, personal care homes, and rest homes. They may provide room, meals, assistance with activities such as bathing, dressing, and the taking of medication. A 1989 GAO report on board and

care in six States [63] found that they are typically located in cities, have an average of 23 beds or less, and are privately operated. Residents of board and care homes frequently have physical limitations requiring some oversight, limited incomes (and are typically Supplemental Security Income, or SSI, recipients), and have often lived in mental institutions because of mental disabilities. They are also unlikely to have friends or relatives visit them on a regular basis.

Board and care homes present unique quality problems. They provide care for poor, often mentally ill, disabled individuals who frequently have no place else to go. One of the major problems with operating board and care facilities is that the providers, who are often poor themselves, do not receive enough money from their SSI residents to cover the cost of their care. In 1993, individual SSI recipients will receive $434 per month and couples received $652 per month. In 1990, 33 States provided optional supplemental payments to persons who resided in board and care homes. The supplemental payments are intended to cover room, board, personal care, and supervision of residents. The task of providing adequate care is complicated further by the fact that many of the residents have illnesses or disabilities that demand more care than the board and care operator can afford or is trained to provide.

In 1976, in response to concern about problems in board and care homes, Congress enacted the Keys Amendment to the Social Security Act. It requires States to certify to the HHS that all facilities with a large number of residents receiving SSI meet appropriate standards. A 1987 survey of licensed facilities identified about 41,000 licensed homes, with about 563,000 beds serving the elderly, mentally ill, and mentally retarded. Of this amount, about 264,000 beds were identified as serving the elderly only. Data are not available on the number of unlicensed homes, although it is generally acknowledged that a greater number of homes are unlicensed then licensed.

The Keys Amendment does not mandate Federal regulation or licensure of board and care homes. There is only one enforcement sanction available to punish provisions violators—the power to reduce the SSI checks of residents of homes not in compliance with State regulations, which acts as a disincentive for States to report deficiencies. Although all States now have health and safety provisions in law, Federal efforts to enforce board and care home standards have been hampered by lack of direct Federal funding of these facilities (SSI benefits are paid directly to board and care home residents or their representative payee, not the facility). This contrasts with nursing homes, where Federal Medicaid and Medicare programs pay the provider of care directly. Consequently, the Federal Government has been able to achieve stronger regulatory requirements for nursing facilities.

Problems exist in licensed and unlicensed homes alike; in other words, licensing does not ensure quality care. Licensing requirements vary widely from State to State, and most inspections focus on the physical plant, with little or no emphasis on the residents

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[63] GAO. *Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met.* GAO/HRD-89.50, Feb. 1989.

and their quality of life. Because States do not aggregate the data gleaned from the inspection reports, the GAO report was limited in its ability to determine the magnitude and type of the violations or the kinds of homes in which the violations frequently occur. However, GAO did find that homes with predominately low-income residents (i.e., SSI recipients) had about twice as many violations on the average as homes with predominately private-pay residents.

HHS has played a circumscribed role in overseeing board and care facilities. While the Keys Amendment requires States to establish and enforce board and care standards, it only requires HHS to receive the States' annual certifications concerning compliance. According to GAO, HHS allocates only one-eighth of one person's time to checking that the States have sent in their certifications. Under this policy of very limited follow-up and oversight, a State can report its compliance with Keys even though it may have done little or nothing with respect to monitoring or licensing board and care homes.

In March 1989, the Senate Special Committee on Aging, the House Select Committee on Aging Subcommittee on Health and Long-Term Care, and the Subcommittee on Housing and Consumer Interests held a hearing to examine the problems as well as the attributes of the board and care system, and to explore ways to solve the problems while preserving these facilities' desirable qualities. The hearing found that many board and care homes provide grossly substandard care.

Because they offer independence and autonomy as well as some supervision, board and care homes can provide many elderly persons with an alternative to more costly institutional care. With the implementation of the OBRA 1987 regulations regarding screening and appropriate placement of mentally ill and mentally retarded nursing home patients, the role of board and care homes will likely become even more important. Legislation has been introduced in the past few years to address some of the problems facing board and care residents and providers. One of these bills is H.R. 2551, the National Board and Care Reform Act of 1991, introduced by Representative Ed Roybal. The aforementioned frail elderly home and community-based services program that was included in OBRA 1990 may also have an impact on board and care, as it requires the setting where covered services are provided to be surveyed and certified according to Federal guidelines. Unfortunately, the Pepper Commission report, discussed below, made only passing mention to the issue of board and care homes.

(4) The Pepper Commission

The U.S. Bipartisan Commission on Comprehensive Health Care was established—and retained—under MCCA. Also known as the Pepper Commission, after the late Congressman Claude Pepper, who was instrumental in its formation, it was established to study and recommend to Congress ways to finance comprehensive long-term care, comprehensive health care services for the elderly and disabled, and comprehensive health care services for persons of all ages.

The 15 members of this commission were: Senator Baucus (D-MT), Durenberger (R-MN), Heinz (R-PA), Kennedy (D-MA), Pryor (D-AR), and Rockefeller (D-WV); Representatives Gradison (R-OH), Oakar (D-OH), Stark (D-CA), Stokes (D-OH) who replaced Congressman Pepper, Tauke (R-IA), and Waxman (D-CA); and Presidential appointees John Cogan, formerly of the Office of Management and Budget, James Davis, former president of the American Medical Association, and James Balag from the health insurance industry. Senator Rockefeller is the chairman of the Commission, a position held by Congressman Pepper until his death in June 1989.

The Pepper Commission, after more than 18 months of hearings, released its final report and recommendations in September 1990. Its recommendations for long-term care reform use a public-private insurance model for financing expanded long-term care benefits. The proposal has three components: (1) a federally financed social insurance program covering home and community-based care for severely disabled persons of all ages; (2) a federally financed social insurance program covering the first three months of a nursing home stay; and (3) a means-tested Federal and State financed nursing home program covering stays beyond 3 months that would protect certain levels of income and assets of persons needing care. For both the home and community-based care program and the first 3 months of a nursing home stay, individuals would be responsible for 20 percent of the costs of care, with the Federal government subsidizing this cost sharing requirement for those with incomes below 200 percent of poverty. For nursing home stays of longer than 3 months, persons would be required to apply to the costs of their care, nonhousing assets in excess of $30,000 for a single person, and $60,000 for married persons before the program would begin to cover the costs of their care. Individuals would also be required to contribute to the cost of their care, income that remains after certain allowances for housing and personal needs. Private long-term care insurance would fill in the gaps that are not covered by this plan. The estimated cost of this proposal over 1 year is estimated to be $42.8 billion.

The Commission also developed recommendations on universal health insurance. Their proposal has five parts:

(1) Employers and the Federal Government should provide a minimum level of health care coverage for workers and nonworkers; small employers should be encouraged through tax credits and subsidies to provide health insurance for their employees'

(2) Employers, employees, and the Federal Government should share in the responsibility to provide coverage;

(3) Private insurers and the Federal Government should each play a role in administering health care coverage; private insurance practices that are making it increasingly difficult for small employers to provide care should be ended, and the responsibility for providing public coverage (largely through the Medicaid program) should be shifted from the States to the Federal Government;

(4) Universal health care coverage should meet minimum standards, including primary and preventive care; and

(5) Immediate attention needs to be focused on these issues, although implementation must be done thoughtfully and one step at a time.

(D) MEDICAID FINANCING INITIATIVES

In the past few years, many States have grown increasingly frustrated with the rising costs of their Medicaid programs. Health care inflation, new Medicaid mandates, and the recession with its attendant unemployment have all contributed to the rapid growth in the costs of funding Medicaid, for both the States' and Federal Governments. As a result, many States have begun to explore new sources of Medicaid funding; the most notable example of this is provider-specific taxes and voluntary contributions. These were the focus of debate in 1991, because although they were enthusiastically supported by many States, the Administration was strongly opposed to their use.

The controversy surrounding this issue began in February 1990, when HCFA published proposed rules that would prohibit States from using voluntary donations of funds from hospitals and provider-specific taxes to supplement the State's financial share of the Medicaid program. Congress had placed a moratorium on HCFA's issuance of these regulations, which expired on December 31, 1989. HCFA's rationale for the proposed rule is that the use of these aforementioned funding sources unfairly increases the Federal share of Medicaid payments relative to the State's share. In response to these regulations, a provision was included in OBRA 1990 that placed a moratorium on the regulation as it pertained to voluntary contributions to December 31, 1991, and permitted the use of provider-specific taxes.

In September 1991, HCFA published proposed regulations that would prohibit the use of voluntary contributions and severely limit the use of provider-specific taxes. HCFA's actions angered many Members of Congress, as well as those States who had developed new programs, as they believed the regulation (primarily with respect to provider-specific taxes) contradicted the law. After much discussion and debate (and the publication of a revised regulation in October), Congress approved in November 1991 a compromise proposal developed by the National Governors Association and the Administration. This agreement, included in Public Law 102-234, allows States to levy broad-based taxes on providers to raise revenues for their Medicaid programs for the next 3 years, so long as the funds raised do not exceed 25 percent of the State's share of their Medicaid program. The legislation also permits those States which do not have a regular legislative session scheduled until 1993 to keep their existing programs in place until July 1993. Voluntary donations programs are eliminated as of October 1, 1992. Regulations implementing this legislation were published in November, 1992.

4. PROGNOSIS

Although there was no legislative activity in the 102nd Congress with regard to long-term care, many believe that in 1993, with the

advent of a new Administration, the tide on health care reform will begin to turn, and that some meaningful action will take place.

The recommendations of the Pepper Commission with regard to comprehensive long-term care for the elderly and disabled were introduced into legislation early in 1992 (S. 2571), which will no doubt act as a springboard to other, smaller-scale efforts in the 103rd Congress. One of the biggest issues that the Congress must address is the relative roles that the public and private sectors will play in the financing of long-term care. This is an issue that shapes nearly every debate on long-term care, and regardless of the recommendations of the Pepper Commission, it will continue to be a contentious and volatile one.

Although there is little consensus on many aspects of long-term care, there is one area in which nearly everyone agrees: The enormous cost of providing comprehensive long-term care to the frail and disabled. In this time of huge Federal deficits, an economic recession, as well as many pressing social needs, such as homelessness, the drug crisis, and the burgeoning numbers of people in this country with no or very limited access to health care, finding the necessary funding will continue to be difficult. The Congress' interest and commitment to providing long-term care continue to grow, however, as is evidenced by the interest in the Pepper Commission and the number of long-term care bills that were introduced in 1991 and 1992. The interest of the new Clinton Administration in the issue of long-term care will have an enormous impact on the likelihood of change taking place in that aspect of health care reform.

Overseeing the implementation of the OBRA 1990 Medicaid drug purchasing law will continue to be a top priority for the Aging Committee. The Committee will likely focus much of its health care reform efforts on ensuring that prescription drug coverage be made a part of any comprehensive reform that is passed—or discussed—by the Congress. The Clinton Administration has expressed interest in closely examining the issue of prescription drug costs. Given the high and growing cost of drugs, true reform would have to include coverage for them.

Health care reform will undoubtedly be at the top of most Members' lists in the 103rd Congress. Although fundamental reform may be some time away, the need for change is so urgent that Congress will be forced to seriously address these issues. It is likely that health care reform in 1993 will focus on the uninsured, and that long-term care will see incremental, if any, improvements. For example, consumer protections to private long-term care insurance may be enacted, as it is a low-cost approach to long-term care reform. Increased emphasis will be placed on exploring alternatives to traditional long-term care. Congressional hearings and legislation designed to foster the development of creative alternatives to institutional care are anticipated, as are ways to reform the current Medicaid system.

D. HEALTH RESEARCH AND TRAINING

1. Background

Effective vaccines, preventive health measures, and healthier lifestyle choices have significantly increased the lifespan for older Americans. With the rapid expansion of the Nation's elderly population, the incidence of diseases, disorders, and conditions afflicting the aged also is expected to increase dramatically. The frequency of Alzheimer's disease and related dementias, for example, is projected to double before the end of the century and quadruple by 2040 if biomedical researchers do not identify the cause and develop effective treatments. A commitment to expand aging research could substantially reduce the escalating costs of long-term care for the older population.

Although scientific and medical research is helping to decrease or, in some cases, eradicate diseases specifically affecting the elderly population, research has not kept up with the growth rate of this population. The Federal Government's investment in health research, estimated at $10.71 billion in fiscal year 1991, is only about 1.6 percent of the total spending on health care in the United States (estimated at $731.2 billion in 1991). Fiscal year 1993 appropriations for the National Institutes of Health (NIH) totaled $10.33 billion, an increase of $255 million, or 2.5 percent, over the 1992 amount.

The National Institute on Aging (NIA) is the largest single recipient of funds for aging research. NIA appropriations have increased 67 percent over the last 3 years, from $239 million in fiscal year 1990 to $400 million in fiscal year 1993. This increase in aging research funding is significant to not only older Americans, but to the American population as a whole. Research in Alzheimer's disease, for example, focuses on cause/causes, treatments, and the impact on care providers for this debilitating disease. Any positive conclusions that come from this research will help to reduce the cost of long-term care that burdens society as a whole. In addition, research into the effects that caring for an Alzheimer's victim have on family and friends could lead to an improved system of respite care, extended leave from the workplace, and overall stress management. Therefore, the benefits derived from an investment in aging research applies to all age groups.

Several other institutes at NIH are also involved in considerable research of importance to the elderly. The basic priority at NIA is to understand the aging process and to recognize the differences between aging and the diseases and environmental or lifestyle factors that affect older persons. What is being discovered is that many changes previously attributed to "normal aging" are actually the result of various diseases. This is critical because, if a disease can be specified, there is hope for treatment and, eventually, for prevention and cure. One are receiving special emphasis is women's health research, including a multiyear, tran-NIH study addressing the prevention of cancer, heart disease, and osteoporosis in postmenopausal women.

Currently, it is estimated that 36 percent of all health costs in the United States are spent on the 12 percent of the population

that is over age 65. With the projected rapid expansion of the aging population, it is expected that by the year 2000, one-half of each health cost dollar will be spent on older Americans.

2. The National Institutes of Health

(A) History of NIH

The National Institutes of Health (NIH) seeks to improve the health of Americans by increasing the understanding of the processes underlying disease, disability and health, and by helping to prevent, detect, diagnose, and treat disease. It supports biomedical and behavioral research through grants to research institutions, conducts research in its own laboratories and clinics, and trains young scientific researchers.

With the rapid aging of the U.S. population, one of the most important research goals is to distinguish between aging and disease in older people. Findings from NIH's extensive research increasingly challenge health providers to seek causes, cures, and preventive measures for many ailments affecting the elderly, rather than to dismiss them as being the effects of the natural course of aging. A more complete understanding of normal aging, as well as of disorders and diseases, also facilitates medical research and education, and health policy and planning.

(B) ADAMHA Reorganization Act

Three new institutes were added to NIH as of October 1, 1992, following the restructuring of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The ADAMHA Reorganization Act (P.L. 102-321) transferred the three research institutes, the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), to NIH. It also created a new agency, the Substance Abuse and Mental Health Services Administration (SAMHSA), to carry on the nonresearch (services) programs of ADAMHA.

(C) The Institutes

Much of the NIH research into particular diseases, disorders, and conditions is collaborative, with different institutes investigating pathological aspects related to their specialty. At least 15 of the NIH research institutes and centers investigate areas of particular importance to the elderly. They are:

National Institute on Aging
National Cancer Institute
National Heart, Lung, and Blood Institute
National Institute of Dental Research
National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Neurological Disorders and Stroke
National Institute of Allergy and Infectious Diseases
National Eye Institute
National Institute of Environmental Health Sciences

National Institute of Arthritis and Musculoskeletal and Skin Diseases
National Institute on Deafness and Other Communication Disorders
National Institute of Mental Health
National Institute on Alcohol Abuse and Alcoholism
National Center for Research Resources
National Center for Nursing Research

(1) National Institute on Aging

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

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

The longest running scientific examination of human aging, the Baltimore Longitudinal Study of Aging (BLSA), is conducted by NIA at the Nathan W. Shock Laboratories, Gerontology Research Center (GRC) in Baltimore, MD. More than 1,000 men and women, ranging in age from their twenties to nineties, participate every 2 years in more than 100 physiological and psychological assessments, which are used to provide a scientific description of aging. According to the BLSA publication, Older and Wiser, "the objectives of the BLSA are to measure changes in biological and behavioral processes as people age, to relate these measures to one another, and to distinguish universal aging processes from those associated with disease and particular environmental effects." One of the most significant results of the study thus far is that aging does not necessarily result in a general decline of all physical and psychological functions. Rather, many of the so-called age changes appear to be the results of disease, which can often be prevented. The BLSA has entered into its fourth decade, and there are no plans to conclude the research now being conducted.

(2) National Cancer Institute

The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection, and treatment of cancer. Of all new cancer cases reported, more than half are elderly patients, and more than 60 percent of all persons who die of cancer each year are older Americans.

The incidence of cancer increases with age. Although aging is not the cause of cancer, the processes are related. More than 80 percent of all cancers occur in persons age 50 and older, and 58 per-

cent occur in people age 65 and over. The rate of cancer survival has increased from the 30 percent in 1950 to 50 percent today due to advancements in surgery, radiation and chemotherapy treatment. However, the rate of overall cancer incidence and mortality has been increasing, particularly in those age 55 and older.

In addition to basic and clinical, diagnostic and treatment research, NCI supports prevention and control programs, such as programs to stop smoking.

(3) National Heart, Lung, and Blood Institute

The National Heart, Lung and Blood Institute (NHLBI) focuses on diseases of the heart, blood vessels, blood and lungs, and on the management of blood resources. Three of the most prevalent chronic conditions affecting the elderly—hypertension, heart conditions and arteriosclerosis—are studied by NHLBI. In 1989, more than 1.1 million deaths were reported from all of the diseases under the purview of the institute. In 1988, associated economic costs were nearly $202 billion, including $102 billion in direct health care expenditures. Nearly 40 percent of all elderly suffer from hypertension, 25 percent from a chronic heart condition, and 8 percent from arteriosclerosis.

Research efforts focus on cholesterol-lowering drugs, DNA technology, and genetic engineering techniques for the treatment of emphysema, basic molecular biology research in cardiovascular, pulmonary, and related hematologic research, and regression of arteriosclerosis.

NHLBI also conducts an extensive professional and public education program on health promotion and disease prevention, particularly as related to blood pressure, blood cholesterol and coronary heart disease. This has played a significant role in the 58 percent decline in stroke deaths and the 40 percent decline in heart disease over the past 20 years.

(4) National Institute of Dental Research

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

In a national study in conducted 1986–87, NIDR found that 42 percent of men and women age 65 and older examined in the survey had lost all of their teeth, compared to only 4 percent of adults between age 18 and 65. Older Americans also face extensive periodontal disease, a major cause of tooth loss. Faced with these findings, the institute has expanded oral health research with the elderly and is collaborating with the National Institute on Aging and the Veterans Administration in an oral health research, promotion, and disease prevention project.

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(5) National Institute of Diabetes and Digestive and Kidney Diseases

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) conducts and supports research and research training in diabetes, endocrinology and metabolic diseases; digestive diseases and nutrition; and kidney, urologic and blood diseases.

Diabetes, one of the Nation's most serious health problems and the largest single cause of renal disease, affects between 13 and 14 million Americans at an annual cost to society of $20.4 billion. Nearly 10 percent of the elderly are believed to be diabetic.

Benign prostatic hyperplasia (BPH), or prostate enlargement, is a common disorder affecting older men. NIDDK is currently studying growth factors that can inhibit or enhance the growth of cells derived from the human prostate.

(6) National Institute of Neurological Disorders and Stroke

The National Institute of Neurological Disorders and Stroke (NINDS) supports and conducts research and research training on the cause, prevention, diagnosis and treatment of hundreds of neurological disorders. This involves basic research to understand the mechanisms of the brain and nervous system and clinical research.

Most of the disorders studied by NINDS result in long-term disabilities and involve the nervous system (including the brain, spinal cord, and peripheral nerves) and muscles. NINDS is committed to the study of the brain in Alzheimer's disease. In addition, NINDS research focuses on stroke, Huntington's disease, Parkinson's disease, and amyotrophic lateral sclerosis. NINDS is also conducting research on neuroimaging technology and molecular genetics to determine the etiology of Alzheimer's disease.

Recently, a NINDS-supported study revealed that treatment with the drug deprenyl delays the progression of symptoms in patients with early Parkinson's disease and postpones the need for L–dopa therapy. Although scientists are unsure how deprenyl works, they believe that this is the first treatment to actually slow the progress of the neurodegenerative disorder.

Stroke, the Nation's third-leading cause of death and the most widespread neurological problem, primarily affects the elderly. New drugs to improve the outlook of stroke victims and surgical techniques to decrease the risk of stroke currently are being studied.

(7) National Institute of Allergy and Infectious Disease

The National Institute of Allergy and Infectious Diseases (NIAID) focuses on two main areas: infectious diseases and diseases related to immune system disorders.

Influenza can be a serious threat to older adults. NIAID is supporting and conducting basic research and clinical trials to develop treatments and to improve vaccines for high-risk individuals. Since older persons also are particularly vulnerable to hospital-associated infections, NIAID research is leading to a vaccine offering protection against one of the most common, difficult to control and often fatal infections, P. aeruginosa.

(8) National Eye Institute

The National Eye Institute (NEI) conducts and supports research and research training on the prevention, diagnosis, treatment, and pathology of diseases and disorders of the eye and visual system. The age 65 and older population account for one-third of all visits for medical eye care. Glaucoma, cataracts and aging-related maculopathy, which are of particular concern to the elderly, are being studied by NEI. Some of this research is intended to serve as a foundation for future outreach and educational programs aimed at those at highest risk of developing glaucoma.

(9) National Institute of Environmental Health Sciences

The National Institute on Environmental Health Sciences (NIEHS) conducts and supports basic biomedical research studies to identify chemical, physical, and biological environmental agents that threaten human health.

NIEHS-scientists are conducting studies to determine whether the continuing depletion of the protective ozone layer of the atmosphere will lead to increased human exposure to ultraviolent radiation.

(10) National Institute of Arthritis and Musculoskeletal and Skin Diseases

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) investigates the cause and treatment of a broad range of diseases, including osteoporosis and the many forms of arthritis. The institute supports 28 specialized and comprehensive research centers.

Affecting over 40 million Americans, these diseases are among the more debilitating of the more than 100 types of arthritis and related disorders. Older adults are particularly affected. Almost 50 percent of all persons over the age of 65 suffer from some form of chronic arthritis. An estimated 24 million Americans, most of them elderly, have osteoporosis.

Topics of research on the cause and treatment of rheumatoid arthritis, a chronic inflammatory disease of unknown cause, include the study of the immune cells present in the synovial fluid around arthritic joints, and the genetic basis for production of rheumatoid factor (an abnormal antibody found in the blood of patients with rheumatoid arthritis).

Research on osteoarthritis, a degenerative joint disease, focuses on changes in the network of surrounding cartilage cells in the joint.

(11) National Institute on Deafness and Other Communication Disorders

The National Institute on Deafness and Other Communication Disorders (NIDCD) conducts research into the effects of advancing age on hearing, vestibular function (balance), speech, voice, language, and chemical and tactile senses.

Presbycusis (the loss of ability to perceive or discriminate sounds as part of the aging process) is a prevalent but understudied dis-

abling condition. One-third of people age 65 years and older have presbycusis sufficient to interfere with speech perception. Studies of the influence of factors, such as genetics, noise exposure, cardiovascular status, systemic diseases, smoking, diet, personality and stress types, are contributing to a better understanding of the condition.

(12) National Institute of Mental Health

The National Institute of Mental Health (NIMH) is involved in extensive research relating to Alzheimer's and related dementia, and the mental disorders of the elderly. NIMH is focusing on identifying the nature and extent of structural change in the brains of Alzheimer's patients to better understand the neurochemical aspects of the disease. NIMH research has discovered a protein specific to Alzheimer's that shows promise of being a positive diagnostic marker for the disease. Research into amnesis is also increasing knowledge about Alzheimer's and other dementia.

Depression is a relatively frequent and often unrecognized problem among the elderly, contributing to the high suicide rate within this population. Currently, white males over the age of 85 have the highest recorded suicide rate of any group in the population (55.8/100,000). Research has shown that nearly 40 percent of geriatric patients with major depression also meet the criteria for anxiety, which is related to many medical conditions, including gastrointestinal, cardiovascular, and pulmonary disease.

NIMH has identified disorders of the aging as among the most serious mental health problems facing this Nation and is currently involved in a number of activities relevant to aging and mental health.

(13) National Institute on Alcohol Abuse and Alcoholism

Alcoholism among the elderly is often minimized due to low reported alcohol dependence among elderly age groups in community and population studies. Also, alcohol-related deaths of the elderly are underreported by hospitals. Since the elderly population is growing at such a tremendous rate, more research needs to be done in this area.

Although the prevalence of alcoholism among the elderly is less than in the general population, per capita health care utilization by elderly alcoholics is twice as high.

(14) National Center for Research Resources

The National Center for Research Resources (NCRR) is the Nation's preeminent developer and provider of the resources essential to the performance of biomedical research funded by the other entities of NIH and the Public Health Service.

Recently, grantees of the General Clinical Research Centers (GCRC) program found that a drug used to treat breast cancer also may increase bone mass in women who are susceptible to osteoporosis.

A current NCRR grantee discovered that many older people have a lower level of acidity in the stomach than young people. This

lower acidity level can affect the absorption of certain drugs. More research is being done in the area.

(15) National Center for Nursing Research

The National Center for Nursing Research (NCNR) conducts, supports, and disseminates information about basic and clinical nursing research through a program of research, training and other programs. Research topics related to be elderly include: depression among patients in nursing homes to identify better approaches to nursing care; physiological and behavioral approaches to combat incontinence; initiatives in areas related to Alzheimer's disease, including burden-of-care; osteoporosis; pain research; and the ethics of therapeutic decisionmaking.

3. Issues and Congressional Response

(A) NIH APPROPRIATIONS

Congress, in a continuing effort to support as many scientific opportunities as possible in tight budgetary times, gave NIH an 8-percent increase in the fiscal year 1992 appropriation. The fiscal year 1993 NIH's increase was $255 million, or 2.5 percent, bringing the total NIH budget to $10.33 billion.

Although several of NIH's authorities expired at the end of fiscal year 1990, no reauthorization legislation has been enacted since the 1988 Act. The 102nd Congress passed a reauthorization bill (H.R. 2507) that would have extended various programs and made numerous other changes and additions to NIH activities, but the President vetoed it. The legislation is expected to be reintroduced early in the 103rd Congress.

Although several of NIH's authorities expired at the end of fiscal year 1990, no reauthorization legislation has been passed since the 1988 Act. In the 102nd Congress, legislation is pending that would extend various programs and make numerous other changes and additions to NIH activities.

Appropriation levels for the previously mentioned institutes at NIH involved with aging research are as follows:

Fiscal Year 1993 Appropriation for NIH

Institute	FY 1993	FY 1992
NIA	$399,937	$383,611
NCI	1,981,362	1,951,541
NHLBI	1,214,799	1,191,500
NIDR	161,302	159,057
NIDDKD	681,344	662,678
NINDS	600,079	581,847
NIAID	979,474	960,914
NEI	276,191	270,300
NIEHS	251,189	252,031
NIAMS	212,456	203,913
NIDCD	154,815	149,102

Fiscal Year 1993 Appropriation for NIH—Continued

Institute	FY 1993	FY 1992
NIMH	583,643	561,255
NIAA	176,605	172,050
NCRR	312,470	314,551
NCNR	48,120	44,970

(B) ALZHEIMER'S DISEASE

Alzheimer's disease and other related dementias (ADRD) is rapidly becoming one of the most serious threats to the Nation's health and well-being. This progressive and irreversible degenerative brain disease is the fourth-leading killer in the United States. Despite research activity on Alzheimer's disease, no cure has yet been developed. Only through a continued commitment to research will this dreaded disease be cured and possibly prevented. For the first time, Federal appropriations for ADRD will surpass the $200 million mark in fiscal year 1991. This is a substantial increase above the fiscal year 1989 and fiscal year 1990 levels of $130 million and $148 million, respectively.

A recent epidemiological study by Denis Evans, et al., for the first time gives a clear picture of the number of Alzheimer's patients in the elderly population. Previous figures often estimated that 2.5 to 3 million Americans are afflicted with Alzheimer's disease. The Evans study, supported by the National Institute on Aging, reports the number is now approximately 4 million Americans over the age of 65. This is 14 percent of the elderly population. This study also found that the prevalence of Alzheimer's rose more rapidly with age than previously suspected. Overall about 10.3 percent of persons over age 65 living at home had Alzheimer's disease. Of those age 65 to 75, 3 percent had Alzheimer's disease compared to 18.7 percent of those age 75 to 84 and a striking 47.2 percent of those over age 85. Since those age 85 and older is the most rapidly growing sector of the population, the number of Alzheimer's patients is expected to dramatically increase to about 14 million persons in the year 2040 if nothing is done to prevent or cure the disease. As the prevalence of dementia escalates in the coming decades, so too will the costs—financial, physiological, psychological, emotional, and personal.

A recent report by the Office of Technology Assessment (OTA), "Confused Minds, Burdened Families," has turned attention to the effects of ADRD on informal caregivers, such as family members. Specifically, the report analyzes the problem of locating and arranging services for people with dementia and presents a framework for an effective system to connect them to services. As the awareness of Alzheimer's disease increases, appropriate services have been developed in many communities. However, the availability of these services is often fragmented. This report looks to a comprehensive system in which caregivers, families, friends, and

even the patient's themselves can secure access to home care, adult day care, respite care and other available services.

Congressional consideration of Alzheimer's disease has focused on increased funding for research on the causes, diagnosis, and treatment of the disease. At present, there are no known means of prevention or treatment, so concern is centering on the cost and ways of providing care for its victims and caregivers. The burdens and costs of care are roughly $90 million annually. This is only an estimate, however, because the social costs involved are extremely difficult to calculate. For example, the lost productivity and income of a spouse or other family members, and the increased incapacity of caregivers are difficult to measure in dollar amounts. With growing numbers of older persons susceptible to the disease, associated costs could reach almost catastrophic proportions early in the next century.

Most of the federally funded research into Alzheimer's disease is being carried out by the National Institute on Aging, National Institute of Neurological Disorders and Stroke, the National Institute of Allergy and Infectious Disease, the National Eye Institute, the National Center for Nursing Research, the National Institute of Mental Health, the Health Care Financing Administration, and the Administration on Aging. The Administration on Aging has supported research and demonstration programs to develop and strengthen family and community-based care for Alzheimer's disease victims.

A great deal of progress has been made recently in the understanding of the cellular and chemical basis of the disease. Studies on the molecular genetics of Alzheimer's disease indicate a linkage between chromosome 21 and the familial or early onset of Alzheimer's disease. Other important findings point to the potential for biomedical diagnostic tests based on the detection of specific biological markers. Other avenues being explored include enzyme deficiencies, abnormal neurons, a slow virus, an abnormal protein, a genetic defect, a defect in calcium regulation inside the nerve cell, and an accumulation of aluminum in the brain.

Research into treatment of the disease has focused on testing drugs for treating Alzheimer's major symptoms—loss of memory and intellect. No drugs have yet been tested that might stop the underlying progressive process of the disease. Many of the drugs under investigation increase the amount of acetylcholine in the brain. Currently, NIA is sponsoring clinical trials on the safety and efficacy of tetrahydroaminoacridine (THA), an experimental drug that may help control memory loss. The study, begun in 1987, was temporarily suspended when 20 of the first 50 patients enrolled in the drug trial developed toxic liver problems. The doses of THA were subsequently reduced and the experiment continued with plans to enroll up to 300 patients. In April 1991, an FDA advisory panel declined to recommend THA for approval. Currently, THA is still in a clinical trial mode that involves both expanded access and the rapid collection of useful scientific data.

The Alzheimer's Disease Research Centers are an important component of the national effort to find a cause and cure for this disease. Since funding began in 1984 through grants from the National Institute on Aging (NIA), the centers have established spe-

cial units for clinical and basic research, as well as for behavioral studies of Alzheimer's and related disorders. NIA currently funds 15 Alzheimer's Disease Research Centers (ADRC), 13 Alzheimer's Disease Center Core Grants (ADCC), and 19 Alzheimer's Disease Satellites (ADS). Based primarily at universities and hospitals, the centers also train scientists and health care providers, and fund new research projects. Guidelines for the centers were developed by NIA along with the National Institute on Mental Health, the National Institute on Neurological Disorders and Stroke, and the National Institute of Allergy and Infectious Diseases. The ADRCs provide research resources; the ADCCs provide assistance to the university research community and are designed to increase the research resources available to the investigators; and the ADSs are designed to diversify the patient populations of the ADRCs and provide more minorities the opportunity to participate in clinical trials and research.

Congress passed the Alzheimer's Disease and Related Dementias Services Research Act of 1986 as part of the Omnibus Health bill (P.L. 99-487). This legislation established within the Department of Health and Human Services (HHS) the Council on Alzheimer's Disease to coordinate research on Alzheimer's disease and related dementias and the care of individuals with dementia.

In addition, the Budget Reconciliation Act for 1986 (P.L. 99-509), authorized up to 10 Medicare demonstration projects, with an appropriation of $40 million over 3 years, through which a limited number of Alzheimer's patients would receive benefits not previously covered by Medicare. This demonstration began on May 15, 1989. Eight cities are participating: Rochester, NY; Miami, FL; Cincinnati, OH; Memphis, TN; Portland, OR; St. Paul, MN; Urbana, IL; and Parkersburg, WV. Services being provided and paid for under Part B of Medicare include case management, adult day care, homemaker and personal care, mental health, and education and counseling for caregivers. Two different models of case management are being tested in the demonstration; one in which the demonstration sites receive up to $300 a month for services for each patient, and each case manager works with 100 patients, and another model in which the demonstration sites receive up to $500 a month for services for each patient, and each case manager works with 30 patients. Beneficiaries are responsible for 20 percent of this amount.

To date, no conclusions have been reached concerning the effectiveness or impact of the expanded services and case management. This is primarily due to the difficulty that the demonstration sites experienced in enrolling patients. According to a recent Office of Technology Assessment report on Alzheimer's disease, this difficulty may reflect the reluctance of patients and their family and friends to acknowledge the existence of Alzheimer's disease. The demonstration will run for 3 years, and after completion, an evaluation of the project will be published by the Health Care Financing Administration.

A provision in the Omnibus Budget Reconciliation Act of 1990 extended the demonstration from 3 to 4 years and allocated another $15 million for administrative and services costs and an addi-

tional $1 million for the evaluation. The project is scheduled to end in May 1993.

The Advisory Panel on Alzheimer's Disease, established under Public Law 99-660, released its 1990 annual report in January 1991. The third in an ongoing series of annual reports, which contain public policy and science policy recommendations for administrative and legislative actions in the areas of health services, biomedical research, and the financing of health care benefits for Alzheimer's disease victims.

The first report contained a series of recommendations regarding biomedical research, health services research, organization and delivery of services, and financing of care. The second report provides an expanded, detailed examination of options available to finance the care of Alzheimer's disease patients. In addition, this report addresses the chronic shortage of staff trained to respond to the special needs of Alzheimer's disease patients.

(C) ARTHRITIS AND MUSCULOSKELETAL DISEASES

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIMAMS) conducts the primary Federal biomedical research for arthritis and osteoporosis. Support research for these disorders is also carried out by the National Heart, Lung, and Blood Institute, the National Institute of General Medical Sciences, the National Center for Nursing Research, and the Office of the Director, NIH.

Osteoporosis is a major debilitating health problem for an estimated 24 million Americans—half of all women over age 45 and 90 percent of women over age 75. Although the majority of osteoporosis victims are women, men constitute approximately 20 percent of all people with the disease. Osteoporosis, characterized by chronic loss of bone mass, leads to an increased risk of hip, neck, and wrist fractures, immobility, disability and, sometimes, death. Medical costs, now estimated at more than $10 billion annually, will increase significantly as the population ages and incidence increases.

Every year, osteoporosis is responsible for 1.3 to 1.5 million bone fractures in those over age 45, or about 70 percent of all bone fractures in that age group. Forty percent of the people who suffer a hip fracture will never recover full independence. The costs to the health care system of hip fractures alone to people over 64 is about $8 billion a year. By the year 2020, if no preventive measure or cure is discovered, the annual cost will rise to $14 billion (in 1987 dollars). Most of the approximately 250,000 hip fractures suffered by individuals over 45, in 1988, were attributable to osteoporosis. This specific type of fracture often has catastrophic outcomes. According to a recent OTA report, some 12 to 20 percent of people who have hip fractures die as a result of the fracture and related complications. High risk factors for developing osteoporosis are: women of Caucasian or Asian ethnicity, old age, early menopause, chronic calcium deficiency, petite frame, prolonged periods of inactivity, family history of osteoporosis, smoking, and excessive consumption of alcohol and caffeine.

The second international osteoporosis conference, "Research Advances in Osteoporosis," was held in Washington, D.C., in February

1990. Leading researchers reviewed new research into the cause of osteoporosis, including the role of growth factors in bone formation. According to the National Osteoporosis Foundation (NOF), a co-sponsor of the program, new bone mass measurement techniques that determine bone density can help decrease the debilitating and sometimes fatal consequences of osteoporosis.

A task force, commissioned by NOF, found that bone mass measurement is a cost-effective means of identifying certain individuals at risk for osteoporosis. They concluded that single photon absorptiometry, dual photon absorptiometry, dual energy X-ray absorptiometry, and quantitative computed tomography are accurate means of measuring bone mass and that these can influence recommendations for treatment.

Treatment of a fracture, as a result of osteoporosis, is most often addressed with rehabilitation. This can improve mobility, but to date there is no proven method for restoring bone mass in a person once osteoporosis is detected. Therefore, prevention is the primary focus of biomedical research. Medical experts agree that osteoporosis is highly preventable through early screening, balanced diet, regular exercise, limited intake of alcohol, and no smoking of tobacco.

The latest scientific consensus on osteoporosis recognizes estrogen and calcium deficiencies as the major causes of postmenopausal osteoporosis. It has recently been discovered that bone cells contain receptors for estrogen and that estrogen treatment in postmenopausal women can protect against hip fractures in later years, although there is concern about the possible risks involved with this treatment.

A number of experimental therapies for the prevention and perhaps treatment of osteoporosis are being studied. Diphosphonates, such as etidronate, coat bone crystal, which prevents the process of bone resorption. This treatment could be helpful to patients with established osteoporosis. Clinical trials are currently underway for this promising treatment, which is comparatively inexpensive and safe.

In addition to research in osteoporosis, NIAMS is the primary research institute for arthritis and related disorders. The term arthritis, meaning an inflammation of the joints, is used to describe the more than 100 rheumatic diseases. Many of these disorders affect not only the joints, but other connective tissues of the body as well. Approximately 1 in 7 persons has some form of rheumatic disease, making it the Nation's leading crippler. Although no cure exists for the many forms of arthritis, progress has been made through clinical and basic investigations. The two most common forms of arthritis are osteoarthritis and rheumatoid arthritis.

Osteoarthritis (OA), a degenerative joint disease, affects more than 16 million Americans. OA causes cartilage to fray, and in extreme cases, to disappear entirely, leaving a bone-to-bone joint. Disability results most often from disease in the weight-bearing joints, such as the knees, hips, and spine. Although age is the primary risk factor for OA, age has not been proven to be the cause of this crippling disease. NIA is focusing on studies that seek to distinguish between benign age changes and those changes that result di-

rectly from the disease. This distinction will better allow researchers to determine the cause and possible cures for OA.

Rheumatoid arthritis (RA) is a chronic inflammatory disease affecting more than 2.1 million Americans, two-thirds of whom are women. RA causes joints to become swollen and painful, and eventually deformed. There are no known cures for RA, but research has discovered a number of therapies to help alleviate the painful symptoms. Guanethidine, a regional nerve blocker, has been found to decrease pain and increase finger-pinch-strength in patients with active RA. Another drug, cyclosporin A, lessens the pain and swelling of the joints. Its toxicity to the kidney and elsewhere, however, limits its therapeutic value.

(D) PHYSICAL FRAILTY: THE LOSS OF INDEPENDENCE

Physical frailty, severely impaired strength, mobility, balance, and endurance occurs in millions of older people and often leads to serious falls, nursing home admissions, and a loss of independence. In April 1990, NIA and NCNR awarded $2.9 million for clinical trials aimed at reducing and possibly preventing physical frailty in older persons. the trials, known as "FICSIT" (Frailty and Injuries: Cooperative Studies of Intervention Techniques), will extend over 3 years and involve a combination of exercise, nursing, prevention, and rehabilitation techniques. According to Dr. T. Franklin Williams, former director of NIA, "the new trials highlight the fact that frailty and injuries are not the inevitable outcome of aging. Instead they are problems for which we have now found some very viable solutions."

According to Dr. Gene Cohen, Acting Director of NIA, "NIA intramural research on frailty is being actively developed through a research plan that melds three approaches. The first is basic research. The second approach involves studies of the population of the Baltimore Longitudinal Study on Aging. These studies are being enhanced through the recent addition of a state-of-the-art strength component. The third approach is selected behavioral principles and nursing practices to address questions of self-care and independence. This effort has produced a number of exciting new findings—the development of a novel method of bone formation in aged animals which provides a system to assess the potential of gene therapy; growth factors and cell therapy to restore bone; and results suggesting that the heart pumping capacity of older women can be improved by physical conditioning and that the pattern of decreased secretion of growth hormone and related hormones in older men can be restored to that of young men by short-term treatment with growth hormone-releasing hormones."

Other intramural results demonstrate that older postmenopausal women remain responsive to the bone-conserving action of estrogen plus progestin treatment and suggest that optimal benefits to reduce osteoporosis risk may be attained by co-treatment with estrogen/progestin plus growth hormone. Longer term studies are planned to further validate these results and to clarify underlying mechanisms. Other intramural studies have been designed which could yield important new information. These include a series of studies to evaluate the separate and interactive effects of growth

factors, sex steroid hormones, and exercise on functional capacity and physiology of musculoskeletal and other age-affected systems in older women and men.

Researchers are optimistic that one of the benefits of FICSIT will be a reduction in health care needs and costs. Frailty not only increases care needs because of the loss of independence, it also increases the risk of falls, the most common cause of injury in older persons.

(E) GERIATRIC TRAINING AND EDUCATION

Essential to effective, high quality, long-term and other health care for the elderly is an adequate supply of well-trained health care providers, including physicians, physicians' assistants, nurses, dentists, social workers, and gerontological aides. For decades, the Federal Government has supported the education and training of health care professionals by providing financial assistance through a variety of Federal and State agencies. This support has been relatively unrestricted and unfocused, and aimed at increasing the numbers of all types of health care professionals.

Congress now is beginning to focus more attention on training and education for geriatric care, although funding still is limited. The Health Professions Special Education Initiatives Program has been established by Congress to carry out high-priority initiatives in the national interest. Funding has been awarded to schools and other institutions that train health professionals for special educational training programs in geriatrics, health economics, health promotion, and disease prevention, and computer-simulated medical procedures.

Under this initiative, geriatric education centers (GEC's) provide short-term multidisciplinary faculty training, curriculum, educational resource development, and other assistance in affiliation with other educational institutions, hospitals, nursing homes, Veterans' Administration hospitals and community-based centers for the elderly. Many GEC's also serve as geriatric evaluation units which provide clinical training. Congress also has initiated a new trainee and fellowship program under the Public Health Service Act to initiate in-depth training of faculty in geriatrics for the later training of future health care providers in geriatrics.

Although the Federal Government is beginning to recognize the current and future need for health care professionals trained in geriatric care, it has yet to appropriate significant funding for geriatric education and training. This lack of funding poses a dilemma for an aging society in which demands for geriatric and related services by those age 65 and older are increasing at an unprecedented rate. In a 1987 report, "Personnel for Health Needs of the Elderly Through Year 2020," the NIA projected that use of services by the elderly population by 2020 will be more than twice the 1980 volume.

NIA also predicted that older adults will compose up to two-thirds of the practices of most physicians and other health care-givers. Primary care practitioners in family and internal medicine are expected to continue to provide most of the medical care for the aged. NIA also predicted that the demand for personnel specifi-

cally prepared to serve older people will greatly exceed the current supply.

If current medical school enrollments remain stable, the number of practicing physicians in the year 2020 will be approximately 850,000. NIA estimates that the annual rate of increase of physician supply between 1985 and 2020 will be slightly less than the comparable growth rate of the elderly population during that period. An estimated 14,000 to 29,000 geriatricians may be needed by 2020, according to the study.

The most serious shortage is in the number of faculty members and other leaders who have specialized backgrounds in aging and geriatrics and who can develop and teach undergraduate, graduate, in-service and continuing geriatric education programs. The report stated that only 5 to 25 percent of the teaching faculty and researchers estimated to be needed to develop sufficient education training programs are currently available.

Among the most critical health care issues for the elderly in the future are the personnel and training needs for caregivers who work with residents in nursing homes. Projections through the year 2000 of the need for full time registered nurses in nursing homes range from 260,000 (about three times the staffing levels in 1983–84) to 838,000. The estimates of demand for other licensed nursing personnel range from 300,000 to 339,000 and for nursing aides, the prediction is that 1 million will be needed by the year 2000.

Inadequate training is one of the many problems facing workers in nursing homes and private homes, according to the Older Women's League. These 1.5 million workers, mostly women, and mostly middle-aged, receive little or no training, according to its 1988 report, "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly."

The Education Extension Amendment of 1992 (P.L. 102–408) reauthorized the program that provides grants and contracts to GEC's and for geriatric training projects to train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. There was $17 million authorized for these programs for each of the fiscal years 1993 through 1995. Under the GEC provisions, grants and contracts can be provided to health professions schools for training related to the treatment of health problems of the elderly.

The appropriations bill for fiscal year 1993 provided $10 million for geriatric training programs, $3.6 million less than in 1992.

(F) SOCIAL SCIENCE RESEARCH AND THE BURDENS OF CAREGIVING

Most long-term care is provided by families at tremendous emotional, physical, and financial cost. The NIA conducts extended research in the area of family caregiving and strategies for reducing the burdens of care. Research is beginning to describe the unique caregiving experiences by family members in different circumstances; many single older spouses, for example, are providing round-the-clock care at the risk of their own health and adult children are often trying to balance the care of their aged parents, as well as the care for their own children.

Familes must often deal with a confusing and changing array of formal health and supportive services. For example, older people are currently being discharged from acute care settings with severe conditions that demand specialized home care. Respirators, feeding tubes, and catheters, which were once the purview of skilled professionals, are not commonplace in the home.

The employed caregiver is becoming an increasingly common long-term care issue. This issue came to the forefront during legislative action on the "Family and Medical Leave Act." While many thought of this only as a child care issue, elderly parents are also in need of care. Adult sons and daughters report having to leave their jobs or take extended leave due to a need to care for a frail parent.

While the majority of families do not fall into this situation, it will be a growing problem. Additional research is needed to balance work obligations and family responsibilities. A number of employers such as AT&T, Stride-Rite, and Travelers have begun to design innovative programs to decrease employee caregiver problems. Some of these include the use of flex-time, referral to available services, adult day care centers, support groups, and family leave programs.

While clinical research is being conducted to reduce the need for long-term care, a great need exists to understand the social implications that the increasing population of older Americans is having on society as a whole.

4. Prognosis

Within the past 50 years, there has been an outstanding improvement in the health and well being of the American people. Some once-deadly diseases have been controlled or eradicated, and the survival rates for victims of heart disease, stroke and cancer have improved dramatically. Many directly attribute this success to the Federal Government's longstanding commitment to the support of biomedical research.

The demand for long-term care will continue to grow as the population ages. Alzheimer's disease, for example, is projected to double before the end of the century and quadruple by the year 2040 if biomedical researchers do not identify the cause and develop effective treatments. For the first time, however, Federal appropriations for Alzheimer's disease research will surpass the $200 million mark. The increased support for this debilitating disease indicates a recognition by Congress of the extreme costs associated with Alzheimer's disease. It is essential that the appropriation level for aging research remains consistent in order to follow promising research that could lead to treatments and possible prevention of ADRD and many other costly diseases, such as cancer and diabetes.

Various studies have highlighted the fact that although research may appear to focus on older Americans, benefits of the research are reaped by the population as a whole. Much research, for example, is being conducted on the burdens of caregiving on informal caregivers. Research into the social sciences needs to be expanded

as more and more families are faced with caring for a dependent parent or relative.

Finally, research must continue to recognize the needs of special populations. Too often, conclusions are based on research that does not appropriately represent minorities and/or women. Expanding the number of grants to examine special populations is essential in order to gain a more complete understanding of such chronic conditions as Alzheimer's disease, osteoporosis, and Parkinson's disease.

E. HEALTH BENEFITS FOR RETIREES OF PRIVATE-SECTOR EMPLOYERS

1. BACKGROUND

Following the enactment of Medicare in the mid-1960's, the prevalence of employer-sponsored retiree health benefit packages increased dramatically. Once Medicare was established, employers could offer health benefits to their retirees with the assurance that the Federal Government would pay for many of the medical costs incurred by company retirees age 65 and older. Since that time, retiree health benefits have become a common provision of large private employer plans and major source of Medicare supplemental insurance for retirees.

In 1992, over 20 large companies terminated health benefits they were providing to thousands of retired employees. Dozens more announced that they will not provide the coverage for future retirees, and most employers who still offer the benefits are reducing the share of the costs, which have been climbing steeply. A number of class action lawsuits were filed against some of those companies dropping coverage, including McDonnell Douglas, Primerica and Unisys. The corporate actions raised concerns in Congress that companies were using rising health costs and changes in Federal accounting rules as excuses to save money at retirees expense.

Because these benefits commonly lack an adequate funding mechanism, retiree health plans represent large unfunded liabilities to employers. The absence of benefit security has led to a growing concern over whether employers can meet these obligations. Furthermore, rising medical costs, changes in Medicare policy, and new accounting rules have converged to create uneasiness among employers about the wisdom of offering retiree health benefits.

The cost of purchasing an individual health care policy following retirement is often prohibitive for many retirees. For older people or for those with a pre-existing medical condition, an individual plan may be difficult, if not impossible, to obtain. Thus, the opportunity to continue participating in the employer's group plan after retirement can represent a significant savings—and necessity—for many retired workers. Because of this necessity, the growing trend of reducing or eliminating coverage by employers alarmed policymakers as an issue that must be addressed by any approach at comprehensive health care reform undertaken under the leadership of the Clinton Administration.

(A) WHO RECEIVES RETIREE HEALTH BENEFITS?

Although privately sponsored retiree health benefits are far from universal, they are nevertheless a major source of health coverage for a large number of retirees. According to a 1991 Urban Institute study, more than 7.8 million retired workers had health insurance in their own name in 1988, including 2.4 million who were under age 65. According to the General Accounting Office (GAO) nearly 80 percent of companies that offer retiree health benefits cover early retirees, or those workers who retire before age 65, while over 60 percent extend coverage regardless of age. Because early retirees are not covered by Medicare, coverage through their former employer is especially important.

GAO found that only about 105,000 companies, or 4 percent of the total, extended health benefits to their retired workers beyond the period required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA (P.L. 99-272), employers are required to allow retiring and other former workers to continue to participate in the company's group health plan for a limited period of time, usually 18 months, at the former worker's expense.

GAO also reported that the availability of retiree health benefits decreased dramatically with smaller sized companies. As little as 2 percent of companies with a work force of 25 or less provide health coverage following retirement. Companies in this size range make up 85 percent of all companies.

GAO added that because more workers are employed by larger companies, far more workers may be eligible for retiree health coverage than the number of companies with retiree health coverage might suggest. About 73 percent of workers are employed by companies with 100 workers or more. Approximately 38 million workers—or 40 percent of an estimated total of 96 million workers—are employed by companies with retiree health benefits.

(B) DESIGN OF BENEFIT PLANS

Employers who provide coverage for retired employees and their families in a group health plan generally provide full coverage in the company's plan until age 65. At that point, most companies provide comprehensive health coverage related directly or indirectly to the benefits provided by Medicare. There are a variety of plan designs.

The most common are Medicare "carve-out" plans, in which retirees receive the same medical coverage as active employees, but deduct from the coverage those costs which Medicare pays. These plans may require the same co-payments and deductibles from retirees as from active employees. Because retirees share their costs through co-payments and deductibles, carve-out plans tend to be the least costly for employers.

Under "coordination of benefit" plans, the plan pays the difference between what Medicare pays and the actual cost of the services, up to what the plan would pay without Medicare. In effect, the plan will only reimburse the beneficiary for up to 100 percent of the cost, but no more.

Under "Medicare supplement" plans, the employer's benefit plan and Medicare benefits are coordinated to give retirees up to 100

percent coverage of Medicare covered services (as well as additional services not covered by Medicare). These plans may impose co-insurance and deductibles.

Finally, there are "fixed allowance" plans, which pay only for specific benefits not covered by Medicare. Most plans, regardless of design, cover the spouses of retired employees, although employers may require the retiree to pay a premium for the spouse.

(C) ESTIMATING CORPORATE LIABILITY

There is substantial debate about the size of the retiree health benefit liability of American firms. Recent GAO estimates place total corporate liability for current and future retirees at $335 billion.

This estimate is uncertain because of the difficulty of measuring and predicting variables that will affect the liability of firms. For example, to determine the size and duration of the retiree population expected to make claims on benefits, it is necessary to estimate demographic changes—to determine the effects of a graying baby boom generation, increasing life expectancy, the growing number of persons over age 85, and the future age of retirement. While we know that the number of elderly is expected to double between 1980 and 2020, it is difficult to predict the magnitude of their use of health care services and whether past trends in early retirement will continue. The difficulty in predicting health care cost inflation levels, as well as changes in the Medicare program, exacerbates the problem of estimating the extent of American firms' unfunded liability.

(D) RECOGNITION OF CORPORATE LIABILITY

Until 1985, companies were not required to disclose the existence of retiree health plans or liabilities on financial statements or other reporting forms subject to public scrutiny. In November 1984, the Financial Accounting Standards Board (FASB)—the independent, nongovernmental authority that establishes accounting principles and standards of reporting in the United States—adopted an interim rule that required plan disclosure, starting in 1985. Specifically, FASB required firms that provide retiree health benefits to footnote certain information on their financial statements, including descriptions of the benefits provided and the employee groups covered, the methods of accounting and the funding policies for the benefits, and the costs of the benefits for the period of the financial statement.

In December 1990, FASB released final rules requiring corporations to report accrued as well as current expenses for retiree health benefits. This requirement goes into effect in 1993, with a 2-year delay for small nonpublic plans (companies with fewer than 500 employees) and non-U.S. plans.

The new reporting standards may have major financial implications for companies that currently fund their benefits on a pay-as-you-go basis, as is the current practice for most companies. Once a company is required to report its accrued liabilities, the financial markets may reassess its value. Investors may look to see whether a company will be able to fund its retiree health plans and still

remain profitable. Some financial experts believe that the FASB rules could have a significant adverse effect on some companies, especially those that are already in an unstable condition.

In response to the FASB rules, some employers are starting to pre-fund retiree health benefits so they can meet their future obligations without jeopardizing the solvency of their companies. Others are trying to reduce their liabilities by restructuring benefits, by placing more of the financing burden on the retirees, or by discontinuing their retiree health plans altogether.

(E) BENEFIT PROTECTION UNDER EXISTING FEDERAL LAWS

The legal status of retiree health benefits is analogous to the status of pension plans before the passage of ERISA in 1974. Whether retirees receive health benefits depends upon the goodwill of the employer, limited Federal regulation, and some legal precedents which hold that, to the extent there is a contractual obligation to provide health benefits, they should be provided for life unless there is a disclaimer to the contrary in the policy. There are no explicit Federal standards for vesting (the earning of a nonforfeitable right to a benefit) or funding of retiree health plans, and there are few safeguards to protect retirees from losing their benefits in the event of a plan termination. There is also no insurance mechanism to ensure that benefits will continue if the employer's plan runs out of money.

Companies that have tried to change or terminate retiree health benefits often have been sued by their retirees. To decide such disputes prior to the passage of ERISA, the courts tended to fashion contract law theories which looked at benefits either as deferred compensation or as the result of unilateral contracts with employees. The courts generally ruled that employees who worked the requisite number of years to earn benefits were entitled to them, unless there were clear understandings between the employer and the employees to the contrary. They reasoned that employees had accepted lower salaries to ensure that they would receive benefits in retirement. While nonunion employees generally brought suit under State law, arguing that employers had violated their contractual agreements, union employees sued for contract violations under the Labor Management Relations Act, a Federal law.

The enactment of ERISA provided new legal grounds to challenge unilateral attempts by employers to change or terminate health benefits. However, because ERISA resulted from congressional interest in making pensions secure, far fewer protections were provided for health and other welfare benefit plans. The law draws a clear distinction between pensions and welfare benefits (defined to include medical, surgical, or hospital care benefits, as well as other types of welfare benefits). While ERISA sets up explicit vesting and funding standards for pensions, it leaves retiree health and other benefits in a less-protected position. This is especially so because it provides that welfare benefit plans are governed exclusively under ERISA. State laws and regulations are preempted.

ERISA does, however, provide additional safeguards in its requirement that employer-sponsored plans comply with specific

standards relating to disclosure, reporting, and notification in cases of plan termination, merger, consolidation, or transfer of plan assets. (Plans that cover fewer than 100 participants are partially exempt from these requirements.) In addition, plan fiduciaries (those responsible for managing and overseeing plan assets) and those who handle the plan's assets or property must be bonded. Fiduciaries must discharge their duties solely in the interest of participants and beneficiaries, and they can be held liable for any breach of their responsibilities. Plan participants and beneficiaries also have the right under ERISA to file suit in State and Federal court to recover benefits, to enforce their rights under the terms of the plan, and to clarify their rights to future benefits.

If the employer clearly states that it reserves the right to alter, amend, or terminate the retiree benefit plan at any time, and communicates that disclaimer to employees and retirees in clear language, then the courts will sustain the right of the employer to cut back or cancel all benefits. Most employers have amended their plans in recent years to include such disclaimers. By distinguishing pension from welfare benefits, Congress never intended ERISA to require vesting of retiree health benefits. Employees have countered that such benefits are a form of deferred compensation—that employees forego higher wages to receive these benefits in the future. Employers are, therefore, legally obligated to provide the benefits. Moreover, they argue, ERISA does not prohibit vesting of retiree health benefits and clearly does provide strict standards in cases of plan termination.

2. Issues and Congressional Response

(A) Continuation of Coverage

For reasons independent of retiree health concerns, Congress included in the Consolidated Budget Reconciliation Act (COBRA, P.L. 99-272) a provision (Title X) requiring employers with 20 or more employees to offer employees and their families the option to continue their health insurance when faced with loss of coverage because of certain events.

A variety of events trigger COBRA continuation of coverage, including termination or reduction in hours of employment (for reasons other than gross misconduct). When a covered employee leaves his or her job, cuts back in house, or retires, the continued coverage of the employee and any qualified beneficiaries must be provided for 18 months. The employer's health plan may require the employee or beneficiary to pay the premium for the continued coverage, but the premium may not exceed 100 percent of the otherwise applicable premium for that period.

The significance of Title X is that it provides retirees with continued access to group health insurance for either 18 months or until the individual becomes eligible for Medicare, whichever comes first. For retirees of companies that previously did not provide retiree health benefits, Title X provides a new source of coverage. However, if the employer discontinues the health plan for all employees, Title X offers no help, because such an action is explicitly specified as a reason for terminating continuation coverage to

retirees. Thus, Title X adds to the limited protections in Federal law, but only to a small degree.

In the Omnibus Budget Reconciliation Act of 1986 (OBRA, P.L. 99-509), Congress amended Title X to require continuation coverage for retirees in cases where the employer files for bankruptcy under Chapter 11 of the U.S. Code. Under the amended COBRA provisions, retired employees who lose coverage as a result of the employer's bankruptcy can purchase continuation coverage until the death of the retiree. For the surviving spouse or the dependent children of the covered employee, the coverage is limited to 36 months.

(B) RETIREE HEALTH BENEFITS IN BANKRUPTCY PROCEEDINGS

Following LTV Corporation's filing for reorganization under Chapter 11 of the U.S. Bankruptcy Code in 1986, there was a sharp increase in congressional concern over retiree health benefits. As part of the company's reorganization, LTV moved to terminate the health and life insurance benefits of more than 78,000 of its retirees. This crisis forced the Congress to confront the larger and more difficult question of how the Nation's other companies would react in the event of similar financial difficulties.

The LTV bankruptcy highlighted the problems surrounding the enormous unsecured promise of health benefits made to retirees across the Nation. In the case of LTV, a retaliatory strike by the Steelworkers and Federal legislation forced the corporation to reinstate health benefits for 6 months. Congress also included provisions in the Tax Reform Act Of 1986 (P.L. 99-514) that permitted LTV to use certain tax benefits to fund the purchase of health and life insurance benefits.

The LTV incident spurred the Congress to enact legislation aimed at protecting other retirees who found themselves in similar straits. Included were: (1) provisions in COBRA 1985, requiring the 18-month continuation of health benefits for retirees who otherwise would lose their health coverage upon retirement; (2) provisions in OBRA 1986, requiring companies entering Chapter 11 bankruptcy after July 1, 1986, to continue health coverage for their retiring or retired employees for life so long as they continue to offer health insurance to current employees; and (3) provisions in the continuing appropriations resolution for fiscal year 1986 (P.L. 99-591), requiring companies in Chapter 11 bankruptcy as of October 2, 1986, to continue to pay for health and life benefits until May 15, 1987. The last provision was extended by the Retiree Benefits Bankruptcy Protection Act of 1988 (P.L. 100-334).

(C) PRE-FUNDING

There is growing recognition in financial markets that retiree health plans represent current liabilities which must be counted against company earnings. Until 1985, companies were not required to include the financial liabilities associated with a retiree health plan in a financial statement. In fact, at that time few companies had any idea what their total liability was for providing these benefits.

However, in November 1984, the Financial Accounting Standards Board (FASB)—an independent, nongovernmental group which develops standards for financial reporting—adopted an interim rule that required plan disclosure, starting in 1985. Specifically, FASB required employers to footnote certain information on their financial statements, including descriptions of the benefits provided and the employee groups covered, the methods of accounting and the funding policies for the benefits, and the costs of the benefits for the period of the financial statement. Under final rules issued by FASB in December 1990, corporations will be required to report accrued as well as current expenses for retiree health benefits beginning in 1993. There is a 2-year delayed effective date for small nonpublic firms (companies with fewer than 500 employees) and non-U.S. plans.

These new FASB rules have led some employers to consider pre-funding their retiree health benefit plans. Still, relatively few employers actually do pre-fund their plans. Currently, there is no requirement that companies pre-fund and there is little financial incentive to do so. At present, the Federal Government appears unwilling to provide tax breaks to help offset the costs of funding these benefits without some minimum standards guaranteeing that retirees would be eligible for specified minimum benefits.

Currently, there are two major tax vehicles for pre-funding retiree health benefits—401(h) trusts and voluntary employees benefit associations (VEBAs). Both, however, have been of limited use to employers.

Employers do not often use 401(h) trusts because contributions are extremely limited by the law and because these trusts must comply with complex nondiscrimination rules.

Although intended for somewhat different purposes, VEBAs used to be the principal mechanism for pre-funding retiree benefits. Strict limits were originally placed on employer contributions, but these limits were eventually changed to allow employers to deduct contributions to VEBAs from their taxes, and all limits were removed by the Tax Reform Act of 1969. The 1969 law also excluded interest income accumulated in such accounts from taxation. In 1980, the Department of the Treasury issued rules that expanded the definition of VEBAs and clarified the regulations for tax-favored status, thereby making it simpler for companies to establish them.

With the increasing popularity of VEBAs, concerns began to emerge in Congress about their liberal tax treatment. While the tax code treated VEBAs similarly to qualified pension plans, it imposed fewer restrictions on their use, thus providing opportunities for abuse. These concerns led Congress to incorporate strict limits on the use of VEBAs in the Deficit Reduction Act of 1984 (DEFRA). As a result, VEBAs have lost much of their value as a pre-funding mechanism. DEFRA: (1) prohibits employers from taking a deduction for welfare benefits that may be provided in the future; (2) provides that benefits cannot discriminate in favor of highly paid employees; (3) prohibits the plan from being established exclusively for the benefit of retirees (in which case, it could be considered deferred compensation and not a welfare benefit plan); (4) requires separate accounts to be maintained for key employees; (5) prohibits

assumptions about future medical price inflation and utilization to be used in actuarial calculations for determining employer costs for pre-funding benefits; and (6) requires that taxes be paid on investment income earned on reserves.

Pre-funding will remain an unattractive option for employers until tax incentives are provided that offer favorable treatment for setting aside funds to pay for future health benefits—similar to the favorable tax treatment that pension contributions currently receive. At present, faced with growing budgetary constraints, Congress appears unwilling to provide significant tax breaks to help offset the cost of funding these benefits. The enactment of minimum standards that will guarantee specified benefits for retirees is generally seen as a corresponding trade-off for tax-favored treatment.

In the 101st Congress, several bills were introduced that were aimed at encouraging employers to pre-fund their retiree health obligations. These proposals, however, failed to generate significant support, due largely to their high projected revenue loss to the Federal Government. The 101st Congress, however, did pass a law to enable employers to transfer, without adverse tax consequences, excess assets in a defined benefit pension plan (other than a multiemployer plan) to a retiree health plan (H.R. 5835, P.L. 101-508). Transfers cannot exceed certain limits and may only be made once in any taxable year beginning after December 31, 1990, and before January 1, 1996.

In the 102nd Congress, no action was taken on pre-funding proposals due largely to budgetary constraints, as well as a broader focus on national health care issues, in general, including the problems of rising health care costs and the large number of Americans without any form of health care coverage.

3. Prognosis

Congress is likely to hold hearings and conduct investigations in 1993 into the conduct of a number of firms who terminated retiree health benefits in 1992 before the new accounting rules went into effect on January 1, 1993. While most corporations did not undertake such abrupt changes, the minority who did will still affect thousands of retired former employees. A number of outstanding lawsuits on behalf of retirees will be resolved or at least adjudicated in 1993, and will be looked at by other companies as indicators of how accountable they will be held for promises made to workers about future retiree health benefits.

In 1993, health insurance coverage of retirees, especially those under 65, is likely to be incorporated under the larger health care reform measures considered by the 103rd Congress, including the Clinton Administration's plan. Short of comprehensive reform, however, a number of approaches are possible, including: (1) required continuation coverage beyond that mandated by Title X of COBRA; (2) required continuation of benefits in the event of an employer's bankruptcy; (3) mandatory vesting (a proposal usually coupled with mandatory pre-funding); (4) tax law revisions to provide more favorable treatment of pre-funded retiree health benefits; (5) other minimum standards following the ERISA model; (6) plan ter-

mination insurance; and (7) lowering the age of eligibility for Medicare, which would substantially reduce employer's liabilities but drive up the costs of the Medicare program.

As Congress considers issues concerning retiree health in 1993, it will be in the context of the national debate which will take place over reform of the entire health care system in the wake of Bill Clinton's election as President. Notwithstanding the variety of approaches, achieving political consensus for a plan acceptable to employers, employees, retirees, and the Federal Government may be difficult. The retirees at greatest risk of losing benefits are those who work for companies closest to the brink and least able to sustain measures adding to their costs. Legislation providing help for current retirees may discourage employers from providing health benefits to future retirees. Proposals that require Federal expenditures, such as tax incentives for pre-funding or ERISA-like mechanisms for insuring benefits in the case of bankruptcy, run up against concerns about the budget deficit. Adding to the complexity of developing any legislative response is the need for flexibility in the benefit structure so that benefits can respond to changes in medical care prices, medical practices, and Medicare reimbursement policy.

Chapter 8

HOUSING PROGRAMS

OVERVIEW

The growing need for affordable and adequate housing for the elderly continues to be a major social policy concern, especially for those with low and moderate incomes. The recent recession, which for workers in the home building industry has been more like a depression, has only exacerbated the problem. The recent Presidential election did help to create a public awareness of this issue. The candidates expressed a strong desire to respond to the challenges of increasing the rate of homeownership and affordability of housing by committing expanded resources for housing and community development programs.

A lingering problem is the increasing need for supportive services and special living arrangements for older persons whose abilities to live independently have diminished. Approximately 20.9 million households in the United States are headed by persons 65 years of age or older, and 8.9 million are headed by persons over 75. Increasing numbers of elderly persons are "aging in place" in federally assisted housing and other publicly supported housing units. Without key supportive services such as meals and various therapies, these people face the possibility of leaving their homes for more restrictive living environments, including nursing homes.

Elderly renters comprise approximately one-fourth of all elderly households, an two-thirds of renters are single. Some 4 million elderly households spend more than 35 percent of their incomes on housing. For many of the Nation's elderly, their home is their only asset. Three out of every four elderly headed households own their homes; more than 80 percent of them mortgage free. These factors have contributed to the interest in innovative housing arrangements, such as home equity conversion plans.

During the 102nd Congress, a $66.5 billion 2-year reauthorization of housing programs was signed into law by President Bush. This housing bill, created in early 1992, was mainly initiated to fine-tune programs implemented by the Cranston-Gonzalez National Affordable Housing Act of 1990. The focus was on programs that enabled people to own their own homes. However, as the year passed, events happened that resulted in the legislation growing to include proposals targeting community revitalization. Another issue that caused this legislation to gain momentum is the controversial "mixed housing" debate. Many public and subsidized housing complexes, once solely consisting of elderly residents, experienced outbreaks of violence as younger disabled residents, many recovering drug abusers and mentally disabled, moved in.

The HOME Investment Partnership Act, which was the cornerstone of the Cranston-Gonzalez National Affordable Housing Act of 1990, continues to be a program of great importance for establishing affordable housing. This provision establishes a block grant to localities and States under HUD's general supervision. The HOME program is a reaction to a widely held belief that HUD administration of housing assistance has been rigid and unresponsive to varying local markets and needs. Included in this provision is a set-aside for construction of affordable housing, but the majority of funds will be used to renovate existing housing projects.

The Homeownership and Opportunity for People Everywhere (HOPE) programs provide the opportunity for tenants to purchase subsidized housing of various types, including public housing. The HOPE programs, developed by the Bush Administration, are criticized, however, by many housing advocates as providing a means to "sell off the limited public housing stock."

Some longstanding housing problems were settled with the passage of the 1990 Act, in particular, the issue of prepayment. A major housing concern during the past several years has been the imminent threat of the loss of hundreds of thousands of units subsidized under the Section 221(d)(3) and 236 programs. Although these loans or mortgages have a term of 30 to 40 years, they contain a provision permitting owners to pay off the mortgage after 20 years, thereby ending Federal restrictions over the use of the property to benefit low- or moderate-income households. The new law requires HUD to offer incentives to owners to continue renting to low-income households, or to people to purchase the property and continue to provide such use. In very limited circumstances, owners will be able to prepay, but this will undoubtedly be the exception.

A. RENTAL ASSISTANCE PROGRAMS

Beginning in the 1930's with the low-rent public housing program, the Federal role in housing for low- and moderate-income households has expanded significantly. In 1949, Congress adopted a national housing policy calling for a decent home and suitable living environment for every American family. The Federal Government has developed a variety of tools and programs in an effort to achieve this goal. One approach has been to provide housing directly through rental assistance payments aimed at providing adequate and affordable housing for those who could not otherwise afford it.

Heightened concern with elderly related housing issues had its origins in 1950 when the first National Conference on Aging recommended greater Federal emphasis on the housing needs of older persons. It took almost 10 years, however, for legislation to be enacted that would eventually target the elderly as beneficiaries for such housing assistance.

Although low-income public housing created under the Housing Act of 1937 was not intended initially to provide special assistance for the elderly, it began to evolve into one of the principal forms of Federal assistance for low-income older persons in the late 1950's. Prior to 1956, persons 65 years and older occupied only 10 percent of all low-income public housing units. Between 1956 and 1959,

however, several legislative changes were made to encourage construction of units for the elderly. As a result, the percentage of public housing units occupied by the elderly increased to 19 percent in 1964 and to 45 percent in 1988. In addition, the first housing program specifically designed for the elderly, the Section 202 program, was enacted in 1959.

In the mid-1970's, Congress significantly expanded Federal housing assistance to the elderly. The Section 202 elderly housing program was reinstated after being phased out in the late 1960's, and the Section 8 housing assistance program was enacted. Although not specifically targeted to the elderly, Section 8 has become one of the two major sources of assisted housing units occupied by those 65 years of age and older.

1. Supportive Housing for the Elderly

A major element of the Housing and Community Development Act of 1992 addresses a problem that was not envisioned when housing policy was developed during the 1930's, the phenomenon referred to as "aging in place." As tenants of assisted housing grow older, they often become more frail and less independent. In time, many of these individuals, in the absence of various services, such as home-delivered meals and help with personal needs, are forced to leave their residences, typically to go into a nursing home. This problem has grown in significance over the past years, and the so-called "graying of America" ensures that it will become increasingly more important in the years to come. Title VI of the new housing legislation, "Housing for Elderly Persons and Persons With Disabilities" stresses the need for supportive services to ensure independent living for the frail elderly. This Act will help to provide a means for residents who with modest forms of supportive services or with appropriate modifications to their apartment, such as handrails or grab bars, can continue to live in their homes.

Since 1971, public housing authorities have had the authority to use Federal funds for the provision of dining facilities and equipment in public housing projects. No subsidy was to be provided to cover the cost of meals and other services. To date, there has been little development of these congregate facilities. This is due to a variety of reasons, including local housing agencies having had little experience in managing the necessary services, little Federal encouragement and support, and no assurance of funds to pay for the services on an ongoing basis. Most services have been provided by local service agencies funded by the Older Americans Act, Medicaid, and the Title XX Social Services Act.

Section 202 projects were not intended to be either intermediary care facilities or standard apartment rental units. Instead they were meant to provide shelter plus services appropriate to the needs of the elderly and handicapped. Although Section 202 projects for the elderly originally were designed to serve healthy older persons, survey results show that the majority of Section 202 tenants are "aging in place" and are now in need of more supportive-type services than when they entered the projects. This is true, also, for many tenants of public housing.

Although an average of six on-site services are offered per project, the types of services (such as personal care and housekeeping) that will enable the "aging in place" population to remain independent are offered on a very limited and fragmented basis. There is no Section 202 services model that applies to all projects in this program. As a result, project sponsors are free to interpret service needs however they choose.

In 1985, 28.5 million people (11.9 percent of the population) were 65 years of age or older. Of these, 1.3 million were living in nursing homes. Since the disabilities of nursing home residents vary from old age to severe handicaps, many of these people may be candidates for congregate housing. While there is no way of precisely estimating the number of elderly persons who need or prefer to live in congregate facilities, groups such as the Gerontological Society of America and the AARP have estimated that a large number of people over 65 and not living in institutions or nursing homes would choose to relocate to congregate housing if possible.

According to a 1989 report by the Urban Institute, "Providing Supportive Services To The Frail Elderly In Federally Assisted Housing," an estimated 105,000 residents of assisted housing who are age 65 and over require help in at least one activity of daily living; this is some 7 percent of the total over-65 population that reside in assisted housing. According to this same report, this number "is less than the one-third of elderly assisted housing residents who have some degree of frailty."

Many advocates for the elderly object to mandatory meals. They believe that forcing a resident to participate in a meal program when he or she could and would prefer to prepare his or her own food appears to be an infringement of individual rights and contradicts the support for elderly independence to which congregate housing sponsors are dedicated. Those in support of the program cite the fact that the adequate nutrition of elderly residents is a primary concern of congregate housing sponsors, arguing that many residents do not take the time, have the interest, or even remember to eat properly. Furthermore, as they age in place, residents increasingly are unable to prepare meals for themselves. Twice as many residents over 80 experience this difficulty, compared to those between 62 and 79.

Since funding for housing programs has been reduced dramatically in recent years, some States have established their own housing initiatives, including congregate housing programs in an effort to provide their elderly citizens with needed care without relying on Federal funds. In the last few years, private developers have shown a growing interest in development of congregate housing. Congregate housing appears to be a viable alternative for housing the semi-independent elderly.

The Congregate Housing Services Program (CHSP) was originally authorized in 1978 as a demonstration program. The program was designed to help the elderly remain in rented dwellings as they age, rather than be institutionalized. During the demonstration, HUD extended multiyear grants (3–5 years) to eligible public housing agencies and nonprofit Section 202 sponsors for meals and other support services for frail elderly and nonelderly handicapped residents.

Throughout the Reagan years Congress kept the program alive, appropriating funds for the maintenance of existing CHSP sites. The HCDA made CHSP a permanent program, authorizing $10 million for each of fiscal years 1988 and 1989. The fiscal year 1989 appropriation for CHSP was $5.4 million; for fiscal year 1990 it was $5.8 million; for fiscal year 1991 it was $9.5 million; and for fiscal year 1992 it is $17.7 million. As of the end of fiscal year 1990, 60 grantees were in operation, serving approximately 1,920 residents. Although the fiscal year 1991 appropriation level represents a significant increase over previous years, it is less than half of the authorization level approved by Congress in the recently passed National Affordable Housing Act. Under the Act, the fiscal year 1991 authorization is $25 million and for fiscal year 1992, the authorization is $25.1 million. This reflects congressional effort to fund the necessary services to assist the elderly as they "age in place," as opposed to addressing the consequences of the elderly being forced to reside in nursing homes without needing the full and costly level of support provided there.

The National Affordable Housing Act includes a separate title devoted to "housing for persons with special needs." This provision will exclusively serve the elderly, persons with disabilities, homeless persons, or other persons "with special needs requiring supportive services related to their housing." According to the conference report (P.L. 101-943), the purpose of the Section 202 program is to enable elderly persons to live with dignity and independence by expanding the supply of affordable housing designed to accommodate their special needs.

Under the National Affordable Housing Act, the revised congregate housing services program must be coordinated on site and must provide meal services which meet at least one-third of the nutritional needs of the eligible residents. In addition to the meal program, other appropriate services include personal care, transportation, chore services, housekeeping, grooming, case management, nonmedical counseling, and medication assistance. The services provided must reflect the wants and needs of the elderly residents.

In an attempt to promote independence among the housing residents, the recently passed legislation also requires each housing project that receives assistance under the congregate housing services program, to the maximum extent possible, to employ older and disabled adults who are residents to provide the services. These individuals would be paid wages that would not be lower than the higher of the minimum wage under the Fair Labor Standards Act of 1938, the State or local minimum wage, or the prevailing wage rates for persons employed in similar public occupations.

As part of the Bush administration's major housing program (HOPE—Homeownership and Opportunity for People Everywhere), a demonstration project to provide vouchers and certificates to enable low-income frail elderly persons to help pay for needed supportive services is included in the new legislation. As part of this demonstration project, HOPE for Elderly Independence, the Secretary could also provide for services in connection with existing contracts for vouchers and certificates. During the 5-year demonstration, only 1,500 certificates and vouchers can be provided for housing assistance. Funding for the supportive services will be as fol-

lows: The Secretary would provide 40 percent, the public housing agency would ensure the provision of at least 50 percent, and each frail elderly person would pay 10 percent of the costs of the supportive services that he or she receives, except that no frail elderly person could be required to pay an amount that exceeds 20 percent of his or her income. If this 20 percent limitation results in the elderly person paying less than 10 percent of the cost of providing the services, the remaining costs would be divided equally between the Secretary and the public housing agency.

Although the National Affordable Housing Act contains numerous measures pertaining to the provision of supportive services in federally assisted housing, none of the new programs, such as HOPE, received appropriations for fiscal year 1991. The increased funding level for existing programs, such as CHSP, however, is an encouraging sign that Federal housing assistance may be improving.

2. Section 202

The Section 202 program provides rental housing designed specifically for the elderly. In addition, it is the primary Federal financing vehicle for constructing subsidized rental housing for elderly and handicapped persons. The National Affordable Housing Act included a major restructuring of the Section 202 program for elderly and disabled persons. As previously stated, the purpose of the program is to enable elderly persons to live independently by expanding the supply of affordable housing designed to accom-modate their special needs through the provision of supportive services.

The original Section 202 program operated from 1959 to 1969, when it was phased out in favor of other programs. During this 10-year period, the program provided construction financing and 50-year loans at 3-percent interest to nonprofit and limited-dividend sponsors of housing for low- and moderate-income elderly and handicapped persons. Approximately 45,000 units were constructed.

Under the revised Section 202 program authorized in 1974, loans to sponsors were made at a rate based on the average interest rate of all interest-bearing obligations of the United States forming a part of the public debt, plus an amount to cover administrative costs.

The Section 202 program is the most visible elderly housing program. Overall, it is considered one of the most successful of all assisted housing programs. Moreover, it now accounts for virtually all that remains of federally assisted new construction for low-income Americans.

Because Section 202 is one of the few Federal housing programs where new construction is taking place, it is likely that the program will continue to be the focus of attention from the various groups in need of housing. While most housing advocates agree that the elderly are but one of several segments of the population in need of safe and affordable housing, many feel it is tragic that those concerned about the housing needs of a particular segment of our population find themselves competing for scarce housing dollars.

The Cranston-Gonzalez National Affordable Housing Act responded to many of the concerns over past housing policy strategies in the Section 202 program. Most notably, the Section 202 program was revised to ensure that housing developed under the program would be designed to accommodate the special physical and other needs of elderly persons. To achieve this, the Section 202(h) program for persons with disabilities was fully separated from the elderly program. HUD appropriations for fiscal year 1992 funded housing for elderly persons with special physical needs, now called Section 811, with $203 million in capital grants and rental assistance for 1,850 units.

The Housing and Community Development Act of 1992 addressed the problem of housing mixed populations (elderly and disabled) in Section 202 projects. The Act permits owners of assisted housing which was designed primarily for occupancy by elderly families (such as Section 202 units) to provide a preference in renting to elderly families. If there are insufficient elderly family applicants, the owner may give a secondary preference to near elderly families (head of household over 50) who are disabled. If the owner of a Section 202 project elects to do this, he must reserve the percent of units occupied by the nonelderly disabled in that project as of January 1, 1992, or at least 10 percent of the units in that project, whichever would be less.

The Housing and Community Development Act of 1992 also provided authorization for service coordinators in housing with mixed populations or persons with disabilities. The National Affordable Housing Act had already authorized service coordinators for projects occupied by the elderly in 1990. Service coordinators can be part of the management staff, or can be provided under contract to a service agency. In developing a service coordination program, the management should consult with tenants or tenant groups.

As of fiscal year 1992, the means of financing Section 202 housing for the elderly changed to a direct grant and provision of operating assistance in place of the current loan and Section 8 methods of subsidy. The provision of supportive services, including those needed by the frail elderly, is required. Services to nonresidents are permissible if it would not adversely affect the cost effectiveness or the operation of the project.

Other changes to Section 202 include the establishment of tenant rents as the highest of the following amounts: 30 percent of a person's adjusted income, 10 percent of a person's monthly income, or the shelter rent payment as determined by welfare assistance if the person receives such assistance. The revised congregate housing services program contains a number of substantive and technical changes, as discussed in the previous section.

The Section 202 program has undergone numerous changes since its inception in 1959, including the most recent separation of the elderly and disabled programs. The changes to the financing of the program are realized in the fiscal year 1992 appropriation levels. Capital advances for Section 202 received $659 million for fiscal year 1992, and rental assistance received $363 million. Despite the criticism of the program, it continues to receive funding and support from Congress, which enables Section 202 to provide decent, safe, and sanitary housing for the elderly. HUD appropriations for

fiscal year 1993 are $1.13 billion in capital advances and rental assistance for 8,900 units of housing for the elderly.

3. Public Housing

Conceived during the Great Depression as a means of aiding the ailing construction industry and providing decent, low-rent housing for the families of unemployed blue-collar workers, the Nation's Public Housing Program has burgeoned into a system that includes 1.4 million units, housing more than 3.7 million people. In fiscal year 1993, $5.7 billion was appropriated for public housing for operating subsidies, construction debts, and major repairs.

The Low-Rent Public Housing Program is the oldest of those Federal programs providing housing for the elderly. Approximately 45 percent of the Nation's public housing units are occupied by older Americans. It is a federally financed program operated by State-chartered local Public Housing Authorities (PHAs). Each PHA usually owns its own projects. By law, the PHAs can acquire or lease any real property appropriate for low-income housing. They also are authorized to issue notes and bonds to finance the acquisition, construction, and improvement of projects.

Until recently, Federal assistance to public housing projects was in the form of annual contributions used to defray the PHAs' debt. Beginning in fiscal year 1987, funding for development and modernization was provided through capital grants, rather than financing of long-term debt. Originally, funding of capital costs was the only form of Federal public housing assistance. It was assumed that tenants' rents would cover project operating costs for such items as management, maintenance, and utilities. Rents were originally set for each apartment regardless of income, then limited to 25 percent of adjusted income, and are now 30 percent of adjusted income. Tenant rents, however, have not kept pace with increased operating expenses.

Changes requiring greater targeting of benefits to the very low-income group, 50 percent of area median, have also decreased rental revenues for the public housing authorities. As a result of these shortfalls in PHA income, beginning in 1961 for limited special purposes and continuing after 1969 for general operating expenses, Congress provided an additional operating subsidy. The appropriation for this purpose in fiscal year 1993 is $2.3 billion. About three-fifths of the units in the Nation's 10,000 public housing projects are more than 20 years old, and many were built in the 1930's and 1940's. Much of the public housing stock is in need of major renovation, but the amount of funds needed to restore the housing to a safe and inhabitable condition has been a topic of much debate. A congressionally mandated study by Abt Associates released by HUD in April 1988, estimated the figure at approximately $21.5 billion. HUD disagreed with that, stating that the cost should be $9.2 billion, less than one-half the amount estimated by Abt Associates. Among the funds HUD considers excessive in the Abt Associates' estimate are $5.7 billion for repairs it claims are not essential, $1.4 billion for energy conservation efforts, and money allocated for the 73,000 units (and possibly as many as 168,000) that will be demolished or sold. HUD's figure has been

criticized by public housing supporters as grossly inadequate; a minimum of $18 billion was determined necessary by engineers and architects contributing to the Abt study.

About one-third of all the units in federally assisted housing were developed under and continue to be operated within the Public Housing Program. It has been by far the largest program for the production of housing for low-income families. In recent years, substantial dissatisfaction with the program has been voiced from several quarters, including Congress, about the condition of the projects and their management; from PHAs about their rising costs and the inadequate funding levels for operation and modernization; and from the OMB about ever-burgeoning outlays

Even its staunchest supporters admit that the program has been plagued by mismanagement in some cities. Recognizing the need for better managerial oversight, Congress included in the 1990 housing legislation, P.L. 101–625, a number of performance indicators for public housing agencies. Under the law, HUD developed and published standards to be used to assess the management performance of public housing agencies in all major areas of management operations, including the number and percentage of vacancies, the amount of funds obligated to the PHA which remain unexpended after 3 years, outstanding maintenance work orders and units not inspected for maintenance or modernization needs. The 1992 Act amends and expands the HUD oversight procedures for correcting management problems and dealing with excess vacancies in some of the projects.

Another critical problem in public housing is the lack of congregate services for tenants who have "aged in place" and need supportive services to continue living independently. A 1986 study on aging in place in public housing projects found that the elderly in public housing are more likely than other elderly to live alone, and that 15 percent of the elderly households had at least one disabled member.[1] About 70 percent of these households had annual incomes between $3,000 and $6,000; only about 25 percent had incomes over $6,000, with only 5 percent with incomes over $10,000. These households are heavily dependent on Social Security, and to a lesser extent, Supplemental Security Income (SSI). Only 10 to 15 percent had either wage or private pension income.

About 30 percent of PHAs will retain residents who have some supportive service needs; 10 percent require complete independence, and the rest will retain residents if they or others can arrange for the necessary services. About one-half of the elderly developments and 20 percent of the family developments reported operating under formal policies regarding the retention of residents. Of the 100 large PHAs surveyed (and a total of 204,800 elderly households), about 48 percent lived in units built for the elderly and handicapped, 15 percent lived in units built for the elderly but in mixed family/elderly developments, and 37 percent lived in unmodified family units in family developments.

About 50 percent of the PHAs surveyed did not regularly collect any information about their elderly residents' functional levels,

[1] Holshouser, William L., Jr., *Aging in Place: The Demographic and Service Needs of Elders in Urban Public Housing* (Boston, MA: Citizens Housing and Planning Association), 1986, p. 185.

medical histories, or service use or needs. PHAs provide some services directly or through contracts with provider agencies in about half of all elderly developments and about 30 percent of all family developments. Only about 40 percent of the developments have onsite tenant services staff provided by the PHA; 20 percent of the PHAs report that no services or referrals are available except on an emergency basis in elderly developments. While a high proportion of developments have some services available that are used by some residents, there is evidence that these services may often only reach a few residents, leaving a large unmet need.

Under the 1990 National Affordable Housing Act, Congress established service coordinators as eligible costs for operating subsidies. In addition, up to 15 percent of the cost of providing services to the frail elderly in public housing is an eligible operating subsidy expense. Services may include meal services, housekeeping and chore assistance, personal care, laundry assistance, transportation and health-related services. Although this is an eligible cost, it is not required and therefore does not have a separate authorization.

The Housing and Community Development Act of 1992 addresses the problem of housing mixed populations (elderly and disabled) in public housing projects. This seems to have become a concern in part because of the broadened definition of "disability" to include alcohol and drug abusers, and increasing numbers of mentally disabled persons who are not being treated in hospitals. Also, by definition, in Section 3 of the Housing Act of 1937 which authorized public housing, elderly families and disabled families were included in one term.

The 1992 Act provides separate definitions for elderly and disabled persons. It also permits public housing authorities (PHAs) to designate housing for separate or mixed populations within certain limitations to ensure that no resident of public housing is discriminated against or disadvantaged in any way.

Persons already occupying public housing units cannot be evicted in order to achieve this separation of populations. However, tenants can request a change to buildings designated for occupancy by just elderly or disabled persons. Housing authorities may also offer incentives to tenants to move to designated buildings, but they must ensure that tenants' decisions to do so are strictly voluntary.

4. Section 8

The Section 8 rental assistance program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Under this program, subsidies were paid to landlords on behalf of eligible tenants to not only assist tenants paying rents in existing housing, but also for promoting new construction and substantial rehabilitation. Section 8, however, came to be seen as excessively costly, particularly that attached to new construction and rehabilitation. As a result, authority to enter into new contracts for assistance to new or substantially rehabilitated units was eliminated in 1983.

The concern over the Federal deficit has forced the Federal Government to reassess the cost effectiveness of many housing-related programs, including the new housing construction programs. Sec-

tion 8 was not designed originally to provide any form of direct subsidy to project sponsors in meeting their costs of construction and financing, but was structured to stimulate construction by guaranteeing that low-income occupants would be subsidized through rental assistance programs, thereby assuring occupancy—and rental income—for the developed units.

Shortly after the start of the program, developers found they had difficulty in keeping their rents below those established by HUD's fair market rents, largely because of the high mortgage rates prevailing in the late 1970's. Consequently, effective rates were lowered for most projects, either by the Government National Mortgage Association's (Ginnie Mae) purchase of mortgages under its special function, or by financing from State housing financing agencies or from public housing agencies, both of which obtained funds from sale of tax-exempt bonds. Ginnie Mae exhausted its available funds, and it became evident in 1981 that increased rates in the tax-exempt market were threatening to halt assisted housing production. By the end of 1982, limited additional assistance had been provided to projects financed through State housing finance agencies by means of the finance adjustment factors which, in effect, raised permissible rents over the fair market rent level. The relatively high subsidy cost arising from both the high rent levels required to cover construction costs and the additional indirect subsidy to lower interest rates caused increasing concern in the administration and Congress. Finally, in the Housing Act of 1983, the Section 8 new construction program was repealed except for that attached to the Section 202 program.

While the production component of the Section 8 program has been viewed as unsuccessful because of its cost, the existing housing component of the Section 8 program generally has been alluded to as a successful form of assistance. Under the original Section 8 existing housing program, HUD payed the difference between 30 percent of an assisted-housing tenant's income and the fair market rent standard for the jurisdiction, with some exceptions permitting up to 120 percent of the fair market rent. Until 1983, these payments were made through what is called the "certificate" program. A variant, the "voucher" program, is now also used. The differences between the two are described below.

Data on the characteristics of assisted families, market areas in which the program operates, units assisted, and other information necessary for evaluation of the success of or difficulties in the Section 8 program have been extremely difficult or impossible to obtain from HUD records as they are currently maintained. P.L. 101–625 required HUD to maintain such information in an automated system, but work on its establishment is not yet complete. In addition, the findings from these data must be reported with recommendations for any appropriate legislative or administrative actions.

The program received $600 million for an estimated 17.6 thousand incremental Section 8 certificates and $581 million for an estimated 17.9 thousand vouchers in appropriations for 1993.

5. Section 8 Certificates and Vouchers

Traditional public housing assistance to low-income families offers few choices as far as the location and type of housing units desired. Section 8 certificates limit the market rent, and hence quality, of units which a family can obtain, even if it would prefer to pay more rent for a higher quality dwelling. As a solution to these problems, the Reagan Administration strongly pushed for a system under which low-income families received vouchers similar to food stamps. The Bush Administration continued this effort. Vouchers are intended to enable a family to rent housing in the private market of whatever quality it prefers, assisted by a Federal payment transmitted through a local public housing agency to a landlord.

The Housing Act of 1983 continued existing Section 8 certificates, but also established a Section 8(o) voucher demonstration program. Use of the 15,000 vouchers authorized by the act was limited primarily to HUD's Rental Rehabilitation and Development Program. However, 5,000 units were allocated to a free-standing program to provide an opportunity to compare the operation of the voucher program with the Section 8 existing certificate program.

Vouchers subsidize the difference between 30 percent of the family's income and a rent standard, equivalent to the fair market rent (FMR). The actual rent, however, is negotiated by the tenant and landlord, as in the private market; it may be higher or lower than the rent standard, and the tenant pays the difference between the HUD payment and the contract rent, which can be either more or less than 30 percent of income. The Section 8 certificate, in general, limits the tenant's rent payment to 30 percent of income, and the maximum contract rent to the HUD-determined FMR.

Advocates of the voucher program argue that, like the Section 8 certificate programs, the voucher system would avoid the segregation and warehousing of the poor in housing projects and would allow low-income families to choose where they live—all at less cost than new construction programs. Moreover, when vouchers started, since the contract was for 5 years rather than the 15 years then used for certificates, less budget authority needed to be appropriated in any 1 year for the same number of assisted families. However, the 1989 HUD appropriations bill reduced the contract term for Section 8 certificates to 5 years, in an effort to place the vouchers and existing certificate units on the same basis.

Shifting to voucher assistance presents potential problems for the elderly in need of housing assistance. It is important that vouchers not be looked to as a replacement for new construction of housing for the elderly that is built to accommodate their special needs, such as accommodation for wheelchairs and grab rails in bathrooms, in the private market.

The voucher system was met with skepticism by Congress and many housing advocates. Critics of the program pointed to a shortage of decent low-cost housing in the largest cities. They questioned whether vouchers would provide real help to those most in need or simply encourage private landlords to increase rents because they know tenants have additional funds available. Critics raised the point that since the vouchers are only authorized for 5 years, they

do not represent a commitment to providing housing for the poor. In addition, they predicted that the budget savings from the shortened term would be illusory, since the need would continue and, presumably, additional funds would be appropriated to continue assistance at the end of the 5-year period. Indeed, this has been the case. The appropriation for renewal of expiring certificates and vouchers was $7.7 billion for fiscal year 1991, $7.4 billion for fiscal year 1992, and $6.3 billion for fiscal year 1993.

There is also concern that vouchers are costing more than Section 8 certificates, which has been exacerbated by HUD's failure to adjust FMR's to reflect changing market conditions. HUD should explore methods of setting the FMR to more accurately reflect shifts in local housing markets as a means of reducing the inequities arising between voucher holders and certificate holders in various parts of the country.

The Cranston-Gonzalez National Affordable Housing Act, modified both the certificate and voucher programs to accommodate some of these positions. In the certificate program, tenants may pay more than 30 percent of income for rent for units renting above the FMR, if the public housing authority finds both the rent for the unit and the rental payment for the family are reasonable. It may not approve such excess payments for more than 10 percent of its incremental allotments in any one year. A report must be filed with HUD if the public housing authority approves more than 5 percent. In the voucher program, the public housing authority is required to determine for all new leases or lease renewals that the rent charged is reasonable in comparison with rents in comparable unassisted units or those assisted with certificates. If the rent is determined to be unreasonable, the PHA may disapprove the lease.

In addition, under the 1990 legislation, voucher assistance is now available to lower income families who utilize a manufactured home as their principal place of residence. Assistance could be used for the rental of real property on which the manufactured home owned by the family is located. The voucher may also be used to rent the manufactured home and the real property on which it is located.

In response to the controversy over the fair market rent calculation, Congress required GAO to conduct case studies to examine and report on the geographic dispersion of certificates and vouchers in market areas. The report must also address how FMR levels may inflate rents. The Housing Act also authorized HUD, upon request of a PHA, to approve separate fair market rents for "submarket" areas within a market area if the alternative FMR proposed accurately reflects rent variations between such areas and the established market area.

The conference report on the Housing and Community Development Act of 1992 contains authorizations for Section 8 certificates/vouchers of $1.98 billion for fiscal year 1993 and $2.05 billion for fiscal year 1994, of which not more than 50 percent may be utilized for voucher assistance. As mentioned earlier, the HUD appropriations legislation included $600 million for an estimated 17.9 thousand Section 8 incremental certificates and $581 million for an estimated 17.6 thousand vouchers. In addition, $6.3 billion was appropriated for expiring certificates.

6. The Farmers Home Administration

The Housing Act of 1949 authorized the Farmers Home Administration (FmHA), administered by the Department of Agriculture, to make loans and grants to farm owners to construct or repair farm dwellings and other buildings. Amendments to the Act made the programs available to rural residents, in general, to purchase or repair homes and for other purposes. The rural housing programs of FmHA are generally referred to by the section number under which they were authorized in the Housing Act of 1949 and its subsequent amendments.

Section 502 loans enable low-income rural residents to purchase or repair new or existing single-family housing. Borrowers may receive interest credit to reduce the interest rate to as low as 1 percent. The loans are repayable over a 33-year period. The loan term may be 38 years for borrowers with income below 60 percent of the area median. The borrowers must be unable to obtain credit elsewhere on reasonable terms.

Section 504 loans are made to rural homeowners who could not afford a Section 502 loan but need funds to make the dwellings safe and sanitary or to remove health hazards. Very-low income elderly homeowners may qualify for grants or some combination of loans and grants.

With Section 514 loans, farmers or organizations may obtain 33-year loans to provide "modest" living quarters and related facilities for domestic farm laborers. Qualified nonprofit organizations, Indian tribes, and public bodies may obtain Section 516 grants for up to 90 percent of the development cost of such housing.

Under Section 515, by far the largest and most important FmHA program serving the elderly, developers may obtain 50-year, 1-percent loans to build rental housing for rural residents or congregate housing for the elderly and handicapped. Except for public bodies, all borrowers must demonstrate that financial assistance from other sources will not enable the borrower to provide the housing at terms that are affordable to the target population.

Section 521 provides for rental assistance payments to borrowers to make up the difference between the tenants' payments and the FmHA-approved rents for the housing (financed under Section 514 or Section 515). Borrowers must agree to operate the property on a limited profit or nonprofit basis.

Section 533 preservation grants authorized FmHA to make grants to organizations for rehabilitating rural single family homes, rental properties, and cooperative housing.

Housing problems in rural America continue to be severe, particularly for those with low incomes. A 1989 report, "The Other Housing Crisis: Sheltering The Poor In Rural America," by the Center on Budget and Policy Priorities and the Housing Assistance Council, "some 27 percent of nonmetro[politan] elderly households were poor in 1985, compared with 19 percent of the elderly in metro areas." The report indicates that of these poor households, nearly 70 percent are those who live alone, and of these, most are women.

Housing assistance under FmHA received a total of $2.45 billion in appropriations for fiscal year 1993. Specifically, Section 502 re-

ceived $1.67 billion, Section 504 received $12.4 million for loan assistance and $21.1 million for grants, Section 514 was appropriated $16.8 million, and Section 515 received $739.5 million for 1993.

The Cranston-Gonzalez Act established a 2-year demonstration program for deferred mortgage payments. The 1992 Housing Act extends authority for this program through 1994. Under this program, the Secretary is permitted to defer Section 502 loan payments for families who do not have sufficient income to repay Section 502 loans, but who would otherwise qualify under Section 502. FmHA can defer up to 25 percent of Section 502 mortgage payments at 1-percent interest for very low-income families or persons otherwise deemed unable to afford the regular payment. The deferred mortgages would return to normal payment status when the borrower's ability to repay improves and deferred amounts are subject to recapture. Subject to appropriations, no more than 10 percent of the amount approved for Section 502 loans may be authorized for use in this demonstration program. Interim regulations to include the deferred payment option were adopted by FmHA on August 23, 1991.

Under Section 515, the 1992 Housing Act contains a provision which reserves 9 percent in fiscal year 1993 and 9 percent in fiscal year 1994 of Section 515 funds for nonprofit sponsors. Nonprofit sponsors are those organizations which are exempt from Federal taxes under section 501(c)(3) and section 501(c)(4) of the Internal Revenue Code, and whose principle purposes include the planning, development, and management of low-income housing. This set-aside will make it possible for those with minimal resources, but with the ability to plan and carry out an eligible project, to receive assistance. The 1992 Housing Act amends the Section 515 program by adding a new grant program. FmHA is authorized to make grants to Section 515 projects which have a sufficient number of frail elderly residents. The funds may be used to defray the cost of employing individuals to coordinate services provided to frail elderly residents.

On May 13, 1992, the Housing Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce heard testimony from the General Accounting Office (GAO) regarding the Section 515 program. GAO had been asked by the Subcommittee on Oversight and Investigations to examine two issues: (1) whether developers of Section 515 housing projects are being given more Federal financial assistance than needed to encourage construction of the housing, and (2) whether there is fraud and abuse in the program.

On the first issue, GAO concluded that developers are receiving more assistance than needed. The financial statements for three newly constructed Section 515 projects were examined. A 24-unit project, a 40-unit project, and a 44-unit project were included. GAO found that the developers received returns of 950, 780, and 970 percent, respectively, on their cash investments in these projects.

These results obtained because the developers were able to combine the low-downpayment and low-interest rate loans from FmHA with the Low Income Housing Tax Credit. Through the tax credit, the developers receive annual reductions in tax liability over a 10-year period. Ownership interests in the projects are sold to inves-

tors through syndicators, and the developers are able to convert future tax credits into immediate cash.

It was noted that about 90 percent of Section 515 housing projects receive the tax credits. Though FmHA agreed that use of the tax credits permits developers to obtain excessive assistance, present law did not permit FmHA to compensate for the tax credits by doing such things as requiring larger downpayments from borrowers.

The 1992 Housing Act contains provisions to address these issues. The term "development costs" for Section 515 housing has been redefined to specifically exclude any initial operating expenses for any nonprofit corporation or consumer cooperative that has been allocated low-income tax credits. FmHA is directed to develop procedures to coordinate housing assistance and tax credits. A 5-percent equity contribution is required for projects that are allocated low-income housing tax credits.

7. Prognosis

For advocates of a strong Federal role in meeting the housing needs of the Nation's low-income citizens, the passage of the Cranston-Gonzalez National Affordable Housing Act renewed optimism that the downward decline of the Federal role during most of the past decade would be reserved in the near future.

The Cranston-D'Amato legislation is a sweeping package of initiatives that address major facets of America's housing needs. The legislation includes rental assistance provisions to: tackle the affordability of rental housing, combine the best features of Section 8 certificates and vouchers; to revise the Section 202 program; and to increase incentives for loan eligibility under the Farmer's Home Administration for low-income households.

Of particular significance to the elderly is the new title, "Housing for Persons With Special Needs," to specifically address the needs of the elderly, persons with disabilities, and the homeless. For the elderly, the Section 202 program would continue with a new funding system that requires much less budget authority per unit, and the manner in which tenant rents are computed would be changed, which should help to ameliorate the "pipeline" problem. Elderly housing would be designed to (1) meet the special physical needs of the elderly, including those who are frail, and (2) accommodate supportive services needed by these individuals. The administration's HOPE initiative would also address the supportive services needs of the frail elderly, although on a much more limited basis. A demonstration program would be established that would link vouchers with other assistance to help the frail elderly to pay for needed services.

Although the new housing legislation authorized a number of new programs, appropriations for fiscal year 1991 were authorized only for existing housing programs. HUD may adopt expedited procedures for at least some of the programs, and make a request for a supplemental appropriation with which to get them underway. The request could be for additional funds; however, there is fear among some housing analysts that HUD will instead request reprogramming of funds from existing programs, such as public housing or

modernization, to the new programs. Aside from funding, HUD now faces the enormous task of developing regulations for these programs, overseeing their operation, and evaluating their efficiency.

B. HOMEOWNERSHIP

Rapidly escalating housing costs have contributed to the growing need for Federal support. This problem is expected to continue as the number of older Americans increases and the cost of housing rises in relation to other living expenses. Housing costs for the elderly are being driven up by taxes, rising utility bills, higher home repair costs, and insurance, as well as rent hikes and condominium conversions. The result is a serious lack of affordable and safe shelter for a large number of older Americans, especially for the low-income.

Homeownership rates have been declining since 1980, after rising steadily since the 1940's. Assistance to homeowners takes a myriad of forms, including tax reductions, Federal underwriting of mortgage markets, and the use of tax-exempt revenue bonds by local governments for first-time buyers. The pattern of homeownership has been consistent to many years; the older the members of a household, the more likely they are to reside in owned housing.

Approximately 75 percent of age 65 and older population own their homes. The cost of maintaining these homes, however, is often a heavy burden, due to the large portion of older homeowners with relatively low incomes. Their homes are often their only asset. The National Affordable Housing Act responded to this problem by increasing the number of available home equity conversion mortgages ten-fold, to 25,000. In addition, the new legislation contains numerous provisions relating to rural, public housing and the special needs of the elderly and homeless.

1. Home Equity Conversion

The homes of older Americans are their most commonly held and most valuable assets. Three out of every four elderly persons own their homes and recent statistics indicate that 80 percent of these do not have a mortgage. Equally significant, a large portion of older homeowners are likely to have relatively low incomes. For example, 6 out of every 10 elderly single homeowners have incomes of $5,000 or less.

Estimates of the amount of equity tied up in the houses of persons over the age of 65 have ranged from $700 billion to $1 trillion. Thus, a great deal of attention has been paid in recent years to financial arrangements that would permit aged homeowners to convert part of their equity into cash, without having to leave their dwellings. These home equity conversion (HEC) plans offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. HEC plans also could provide funds to allow older persons to pay for needed supportive services, home maintenance, and other needs. Before HECs, the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

There are two distinct types of conversion plans, debt and equity, on which a variety of models are based. Debt plans allow an older homeowner to borrow against home equity with no repayment of principal or interest due until the end of a specified term of years, or until the borrower sells the home or dies. These plans can provide a single lump-sum payout to the borrower, a stream of monthly payouts for a given term or—with the addition of a deferred life annuity—guaranteed monthly payouts for life. They are often referred to as reverse mortgages or reverse annuity mortgages.

Property tax deferral programs, popular in many States, are a form of debt plan in which older homeowners postpone paying their taxes until they sell their homes or die. In State-initiated deferral programs, the State pays taxes to the local government for the homeowner. These payments accrue with interest as a loan from the State to the homeowner, secured by equity in the home. Upon death or prior sale of the home, the loan is repaid to the State from the proceeds of the sale of the estate.

Equity plans involve sale of the home to an investor, who immediately leases it back to the seller. Land contract payments of the seller exceed term payments to the buyer, so the older person receives extra cash each month. In addition, the buyer pays the taxes, insurance, and maintenance. A deferred annuity or other investment purchased with the down payment can provide income beyond the land contract term. In light of recent tax reform efforts, these plans, referred to as sale/leasebacks, have been virtually eliminated.

The basic theoretical forms of HEC plans have been established for several years. In general, however, workable instruments have yet to become widely available to the public. One reason for the lack of substantial interest is that the combination of financial benefits and risks associated with the plans have not been sufficiently attractive to borrowers. Moreover, lenders have also been reluctant to accept the risks associated with HEC programs.

The Housing and Community Development Act of 1987 (HCDA) created a demonstration program to provide mortgage insurance for home equity conversion mortgages for the elderly. Under the demonstration, the FHA insures the mortgages and provides protections for both lenders and homeowners from the risks. The demonstration originally provided that a total of 2,500 mortgages could be insured by participating lenders through September 30, 1991. The National Affordable Housing Act amended this provision to extend the reverse mortgage program until September 30, 1995.

In addition, the new legislation requires disclosure of the extent of the liability of the homeowner under the mortgage and the projected total future loan balances for at least two projected loan terms. This provision increases the number of mortgages insured under this program to no more than 25,000. The mortgages are available to homeowners age 62 and older with little or no mortgage debt remaining on their homes. The new legislation and the rules issued by HUD to implement the program allow for the offering of three types of home equity conversion mortgages: (1) tenure; (2) term; and (3) line of credit. Any lender authorized to originate FHA-insured loans may originate FHA-insured reverse mortgages.

Under prior rules, only a few lenders in each State could originate reverse mortgages.

Tenure mortgages provide for monthly payments from lenders to homeowners for as long as they occupy the home as a principal residence. Term mortgages provide for monthly payments for a fixed period agreed upon between the lender and the borrower. Line of credit mortgages permit homeowners to draw money at times and in amounts of their own choosing. Under this demonstration program, the interest rate on the loans may be fixed or variable. However, effectively only variable rates are being offered under the FHA demonstration.

Homeowners retain ownership of their property and may sell and move at any time, retaining the sales proceeds in excess of the amount needed to pay off their mortgage. They cannot be forced to sell their homes to pay off their mortgage, even if the mortgage principal balance grows to exceed the value of their property. When the mortgage does come due, the lender's recovery from the borrower will be limited to the value of the home. There will be no deficiency judgment against the borrower or the estate.

HEC plan advocates of reverse mortgages stress that it is important that individuals and organizations maintain some perspective as they are developing plans to enable the elderly to convert their home equity into a form of income. The development of options for home equity conversion plans should be seen as a service that is provided to elderly homeowners and not as a product to be marketed. This is a portion of the population for whom financial mistakes may be devastating.

2. HOPE: Homeownership and Opportunity for People Everywhere

The Homeownership and Opportunity for People Everywhere (HOPE) program was a major housing initiative of the Bush Administration incorporated into the National Affordable Housing Act of 1990. HOPE programs provide the opportunity for tenants to purchase housing of various types, including public housing projects. There are three types of housing available under the HOPE programs. HOPE I addresses the sale of public housing to its occupants. Under HOPE II, resident or other low-income families may purchase multifamily properties owned or held by HUD or other Federal agencies or State or local governments, financed with a HUD-insured or HUD-held mortgage. HOPE III provides for grants to encourage the sale of publicly owned single-family properties to low-income families, who are not homeowners and who could not otherwise afford to buy a home.

With respect to the public housing, it in effect continues the program first established in 1987 under which resident management corporations had the right to purchase projects for resale to tenants. Parkside-Kenilworth in Washington, D.C., is the only project which had successfully taken advantage of the 1987 program, which has now expired. Under HOPE I, both the planning and implementation grants are authorized on a competitive basis to applicants from jurisdictions which have to develop and carry out plans for this purpose. "Applicants" include not only resident manage-

ment corporations, but also public housing authorities and Indian housing associations, resident councils, a cooperative association, a nonprofit organization, or a public body.

The grant applications must include not only specification of the activities for which the facility will be used, but also certification by the person responsible for the strategy's submission that the activities are consistent with the comprehensive housing affordability strategy of the appropriate jurisdiction.

The implementation grants may be used for acquisition and rehabilitation costs, counseling and training of homebuyers, and the relocation of tenants not wishing to purchase. In addition, the operating expenses and reserves may be acquired through the grants provided that the amount is not greater than would have been received for operating assistance if the project had continued to receive a public housing operating subsidy. The grant may also be used for economic development activities promoting "self-sufficiency" of the residents and homebuyers. Applicants must provide 25-percent matching funds, except for funds used for post-sale operating expenses, from non-Federal sources. Non-Federal sources do not include Federal tax expenditures or Community Development Block Grants (CDBG), except that CDBG funds may be used to match expenditures for administrative expenses.

The National Affordable Housing Act specifies requirements for applications for grants, criteria to be used in selecting grant recipients, and requirements to be met for the sale of housing to individual tenants or a cooperative association. The rights of tenants not wishing to purchase are outlined, including the provision of Section 8 assistance for those wishing to move. Critics of HOPE view the program as a means of selling off the Nation's limited public housing stock. As a means of keeping at least the existing public housing supply, the HOPE program includes a provision that prohibits the sale of public housing unless the Secretary has entered into an agreement with the local public housing agency to replace each unit of public housing with additional affordable housing. These replacement units may include newly constructed public housing projects, the rehabilitation of vacant public housing units, and the use of 5-year, tenant-based rental assistance. The latter, however, offers only a temporary solution, and many feel these "displaced" individuals could add to the already increasing number of homeless.

Restrictions are established on the rights of resale for purchasing tenants. After sale of a project by the public housing authority, payments under annual contribution contracts for the original development costs are required to continue, but public housing operating subsidies are to end. Any funds obtained from the sale to families or other approval entities are to be used for costs of the homeownership program, which include physical improvements, operating expenses, or economic development programs.

The HOPE programs grew out of a Bush Administration belief, shared by many community organizations, that homeownership gives low-income families a stake in society which boosts their morale and provides a basis for improving their skills and employability. The rationale for the HOPE programs is based on the belief that homeownership "empowers" the individual. Many questions,

however, have been raised as to the validity of this belief. Even with the subsidies provided by the HOPE program, many low-income tenants will not be able to afford to purchase. The debate in congress continued throughout the passage of the National Affordable Housing Act over spending large sums of money and HUD staff attention for the purpose of homeownership as opposed to the extension of and improvements in the federally assisted rental programs.

No appropriations were made for the HOPE programs in fiscal year 1991. Fiscal 1992 appropriations provided $161 million for HOPE I, and $95 million for both HOPE II and III. The same appropriation levels were made for fiscal 1993 as for fiscal 1992.

3. Prognosis

The prognosis for potential home buyers in the 1990's is mixed. Despite large amounts of homeownership tax expenditures during the 1980's, U.S. Census data show that homeownership rates for all household groups under age 40 have fallen significantly since 1980. For example, ownership rates of those in the 25 to 29 year age bracket fell nearly 9 percentage points (from 43 percent to 34 percent) between 1980 and 1990. However, since nearly 70 percent of those with heads of households age 40 to 44 are now owners, many analysts expect the overall homeownership rate to increase slightly during the 1990's as the tail end of the baby boomers move into their late 30's and early 40's. Housing analysts are more concerned with those who are least likely to ever become a homeowner: singles, the divorced, never-married, minorities, and those with incomes in the bottom quarter of the distribution. Few of the homeownership tax incentives are now geared toward these marginal buyers—people unlikely to become owners without concerted effort and assistance by government.

The program that is most geared to the marginal buyer, the Mortgage Revenue Bond program, provides below market rate mortgages to first-time buyers, and is scheduled to expire at the end of 1991. Studies have consistently shown that the chief problem of most young home buyers is the lack of a sufficient down payment. There have been many bills introduced in Congress that would allow a penalty-free withdrawal of funds from an Individual Retirement Account if used for the purchase of a first home. The National Homeownership Trust Act (Section 301 of NAHA 90) which would provide help with down payments and closing costs for first-time buyers with incomes of no more than 95 percent of the median area income, was not funded in the recent HUD appropriations act. Although NAHA 90 increased the amount of cash required under the FHA loan insurance program to shore up the financial condition of the fund, some point out that first-time buyers can still use the program to purchase with as little as a 3-percent down payment. Other home buyers can borrow as much as $184,000 with no down payment with a VA-guaranteed loan. Although the HOPE programs have appropriations of $350 million for fiscal year 1992, this is more a social experiment than a substantive effort likely to convert large numbers of low-income renters into owners.

The recently released HUD report, Not In My Back Yard—Removing Barriers to Affordable Housing, documented many expensive and unnecessary regulations "red tape" at all levels of government, but primarily those imposed locally. Many of these regulations make it very difficult, if not impossible, to build apartments and homes affordable by low- and moderate-income households.

Homeowners came through the 1986 tax reforms essentially unscathed (see section C2 of this chapter). They retain the right to deduct mortgage interest and property taxes against income for tax purposes. The law continues to disregard the implicit income an owner receives from occupying a potentially rentable property. The tax benefits are worth less, however, at the lower marginal rate of the 1986 act.

In the aggregate, homeowner deductions of mortgage interest and property and other preferences entail 1992 revenue losses to the Treasury of approximately $65 billion. Critics note that the benefits to homeowners are regressive, awarding larger deductions to high-income owners than to less affluent ones. For example, at least $15 billion of these homeownership subsidies go to households with incomes of $100,000 or more (the wealthiest 4 percent). Homeowner deductions are available on vacation homes and on home equity lines of credit increasingly used to purchase autos and other consumer goods. No comparable tax advantages are offered to renters, a group with must lower average incomes than homeowners. Some economists also argue that these preferential tax provisions not only contribute to over-consumption of housing by the wealthy, but also tend to push up home prices. These observers hold that the considerations of revenue costs, economic efficiency, and equity suggest a fresh look at the tax treatment of owner-occupied housing.

C. PRESERVATION OF AFFORDABLE HOUSING

Since its inception, housing policy in America has focused almost exclusively on the provision of standard units of low- and moderate-income housing for eligible individuals and families. This approach has been inadequate in that the Federal Government has been unwilling to treat housing assistance as an entitlement. As a result, many eligible households simply cannot obtain the assistance they need. Data indicates that the more than 4 million assisted units available at the end of fiscal year 1992 are enough for, at best, 25 percent of those eligible for assistance. Further, while there were 16 million elderly households in 1980, this number is projected to increase to 23 million in the year 2000. These figures suggest that the elderly will need 7 million more units in 2000 than they had in 1980—assuming that all elderly households in 1980 were decently housed and that the present housing stock will be maintained.

According to unpublished tables prepared by HUD from the data of the 1989 American Housing Survey, Federal housing efforts have fallen far short of meeting elderly housing needs. In 1989, there were 3.5 million elderly renter households with very-low incomes, that is, below 50 percent of the area median. Only 521,000, not quite 15 percent, of these households had no housing problem as

defined by HUD. Another 1.2 million, 35 percent, lived in subsidized housing. The remainder lived either in substandard housing or paid more for housing than they could afford, or both. In addition, there were 4.3 million elderly homeowners with very-low incomes, of whom 1.5 million had similar housing problems.

A 1988 study by the National Low Income Housing Preservation Commission found that as a result of expiring Federal housing support programs and the effects of the 1986 tax reform act, defaults and prepayments could remove as much as 81 percent of the stock from the inventory of low-income housing. If no action were taken, 523,000 of the 645,000 units subsidized under sections 221(d)(3) and 236 of the 1961 and 1968 Housing Acts (which was the focus of the Commission's study) were likely to be lost to low-income households at the end of 15 years. Owners of 280,000 units could be expected to default on their mortgages, allowing the properties to revert to the Federal Government for disposition. Owners of another 243,000 units were likely to convert them to market-rent apartments, sell them as condominiums, or use them for other higher income purposes. Only 122,000 would probably remain for use as low-income housing. According to the report, two groups—the elderly and large families—were most likely to be hurt by prepayments and defaults as they are least able to cope with displacement or find comparable replacement housing. It would also hurt those with the lowest incomes—70 percent of the tenants of the threatened housing stock have incomes below 50 percent of the median for their areas.

A report released in February 1988 by the National Housing Preservation Task Force states that the major threat to the inventory of low- and moderate-income housing came not from prepayment of mortgages, but rather from expiring Section 8 subsidy contracts. According to the report, over 700,000 units could be lost by 1995; if owners choose to opt out of their contracts early, the loss could approach 1 million units by 1995 and 1.4 million by 2000.

Although the present need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit continue to make these programs targets for budget savings. The net effect of these fiscal constraints resulted in a policy shift by the Reagan administration toward other approaches for meeting the housing needs of older persons. President Reagan was successful in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types of existing units leased in the open market. Under that Administration, the primary emphasis with regard to public housing for the elderly became preservation, maintenance, and rehabilitation of the existing housing stock.

The Bush Administration's emphasis on using existing housing is based not only on cost considerations but also on the belief that there is an adequate supply of low- and moderate-income rental housing in most areas of the country. The administration has contended that the need for housing assistance in America can be met most efficiently by providing Section 8 certificates or, preferably, vouchers to eligible families for existing rental housing.

Nonetheless, a large percentage of new construction of subsidized housing over the past 10 years has been for the elderly. The rela-

tive lack of management problems and local opposition to family units make elderly projects more popular. Yet, even with this preference for the construction of units for the elderly, in many communities there is a long waiting list for admission to projects serving the elderly. Such lists can be expected to increase as the demand for elderly rental housing continues to increase in many parts of the Nation.

1. HOME Investment Partnership Act

The HOME Investment Partnership Programs were the centerpiece of the National Affordable Housing Act. HOME provides grants to States and local jurisdictions to promote local initiatives in providing housing assistance.

"Participating jurisdictions" are those local governments and States which meet requirements by filing a housing strategy. Local jurisdictions must also meet threshold allocation amounts or alternative requirements. HUD establishes a HOME Investment Trust Fund for each participating jurisdiction. Funds are allocated by formula, with matching funds required in proportions depending on the use to which they are put.

Funds may be used for acquisition, new construction, rehabilitation, and tenant-based assistance. Rehabilitation of substandard housing will be the predominant use of HOME funds, however, some funding will go to new construction. Funds may not be used for public housing operating subsidies or modernization. Uses are to be targeted to assisting low and very low income families. For rental housing, at least 90 percent of the funds are for families with incomes no higher than 60 percent of median and the rest at no higher than 80 percent of median. This reaffirms the policy that Federal housing assistance should be directed, wherever feasible, toward rent for low-income beneficiaries to within 30 percent of the family's adjusted income.

For funds used for homeownership, all assisted units must be occupied by families with incomes not greater than 80 percent of median. Other requirements are established, as to price and rent levels, rent-income ratios, as well as others. Jurisdictions are required to maximize public-private partnerships, and at least 15 percent of each jurisdiction are to be reserved for 24 months as a set-aside for nonprofit community housing development organizations. If a participating jurisdiction is unable to identify within the first 24 months of receipt of HOME funds a sufficient number of community housing development organizations to participate in providing housing, then the jurisdiction may use up to 20 percent of its allocation, but no more than $150,000, for activities which will help such organizations develop the technical capacity necessary to participate in the program.

The Home Repair Service Grant program, under the HOME Investment Partnership Act, makes grants available to older and disabled individuals, as well as to eligible organizations, for home repair services. This model program would provide guidelines for a participating jurisdiction to repair primary residences only to those qualifying as low-income families. The services may include exami-

nation of homes, repair services, and follow-up to ensure continued effectiveness of the repairs provided.

Congress appropriated $1.5 billion in fiscal year 1992 and $1 billion in fiscal year 1993 for the HOME Investment Partnerships Act. Sixty percent of the Federal funds will go to local governments and 40 percent to the States. In addition, the Secretary must reserve 1 percent of the total amount appropriated by Congress to go to Indian tribes and the greater of $750,000 or 0.2 percent of the amount appropriated for the fiscal year for insular areas. HOME funds are allocated by formula designed to measure a participating community's need for an increased supply of affordable housing for low and very low income families. A participating jurisdiction must provide a 30 percent funding match, from non-Federal sources, for new construction activities and a 25-percent match for rehabilitation or tenant-based assistance. Bond or debt financing may be used to meet up to 25 percent of a participating jurisdiction's overall matching fund requirement. Communities whose annual poverty rate is 125 percent of the national rate or whose annual per capita income is 75 percent of the national per capita income may meet the definition of fiscally distressed and thus may have their matching fund requirement reduced by 50 percent. Participating jurisdictions that meet or exceed the poverty and per capita income thresholds are defined as in severe fiscal distress and will have their entire matching fund requirement waived. The fiscal year 1992 appropriations act included a 1-year waiver of the matching requirement.

2. Tax Reform and Tax Credits

The largest Federal housing programs do not concentrate on low-income households, but rather reward largely upper-income homeowners through the deduction of mortgage interest and property taxes. These two provisions are probably of little importance to most elderly homeowners since many have fully paid their mortgages and, rather than itemizing their deductions, take the standard deduction. Homeowners age 55 and older can exclude up to $125,000 of gain from the sale of a principal residence. The Joint Committee on Taxation estimates that homeowner tax expenditures will cost more than $75 billion in fiscal year 1993.

While property taxes remain fully deductible, under current law, the amount of mortgage interest that can be deducted on a principal or second residence (on loans taken out after Oct. 13, 1987) is now limited to the interest paid on the combined debt on these homes of up to $1 million. This limit, of course, is likely to be of little concern to most homeowners. However, with mortgage rates in 1992 at relatively low levels, the number of refinancings has increased sharply. It may be important to point out that for many owners, the amount of deductible mortgage debt is reduced as the mortgage is paid down and in general, the amount that can be refinanced with interest remaining deductible is the amount of outstanding debt just prior to the refinancing. Thus, some care should be made not to prepay the mortgage with funds that a homeowner may need in the near future. However, this concern is considerably

reduced for most owners since the current law also allows interest to be deducted on up to $100,000 of home equity debt.

Some tax incentives having to do with the provision of rental housing were made exceedingly generous by changes made to the tax laws in 1981. Partly in response to these changes, an excess of apartment and office buildings were built in the years that followed. A number of these tax incentives were reduced or eliminated under the Tax Reform Act of 1986, largely in response to abusive tax shelter activity. There is now a less-generous depreciation schedule and a much reduced preferential treatment of capital gains (limited to a maximum rate of 28 percent). There were also "passive loss" restrictions enacted that limit the amount of real estate "losses" that can be deducted by investors, although there was a small investor exception that allows many investors to take up to $25,000 a year of such losses.

To increase the supply of affordable rental units available to low-income households, including the elderly, the 1986 Tax Act created a new "low-income housing tax credit" (LIHTC). Under the LIHTC, investors can receive 10 years of tax credits for making funds available for new, substantially renovated, or existing rental units. These units must be kept affordable to low-income renters for at least 18 years and, in cases, up to 30 years. Rents are limited to 30 percent of household income.

Although this $3 billion-a-year program is not without its critics, supporters say the LIHTC has demonstrated its ability to produce affordable rental housing for low-income households. Data from the National Council of State Housing Agencies shows 428,098 low-income housing units attributable to the tax credit program over the period 1987–91. A number of housing analysts have pointed out, however, that the need to "syndicate" the tax credits (sell them to investors), and the program's complexity that requires lawyers, accountants, and other middlemen, make this a costly way to produce low-income housing. Some say a more cost-effective alternative would be for the Government to provide grants and other subsidies directly to nonprofit developers. An April 1992 report by the Congressional Budget Office (The Cost-Effectiveness of the Low-Income Housing Tax Credit Compared with Housing Vouchers) concluded that "the government can provide assistance of equal value to tenants through housing vouchers at a fraction of the cost of credits."

The LIHTC was originally authorized for 3 years, 1987 through 1989, and since then, because of tight Congressional budgets, has been extended a year at a time, and recently, for only 6 months. While the program's authority expired June 30, 1992, it is likely that it will be reauthorized in 1993, possibly made permanent.

3. Prepayment

Prior to the enactment of the 1987 authorization act, it was estimated by one group that by 2005 more than 360,000 units of federally assisted housing were at risk of being withdrawn from the affordable housing supply by their owners through prepayment of their mortgages. Others had different estimates, but the numbers were of the same order of magnitude. According to the National

Association of Home Builders, it would cost more than $130 billion to replace the existing stock of such housing. Contracts entered into by the Federal Government and private developers under low-interest loan programs during the 1960's (section 236 and section 221(d)(3) permitted certain owners to prepay the Federally assisted mortgage after the 20th year of the 30 to 40 year mortgage term. A mortgage prepayment and termination of the mortgage insurance contract ends Federal restrictions over the use of the property for the benefit of low- and moderate-income households. In addition, HUD estimated that 1,139,000 project-based Section 8 assisted units might choose to "opt-out" of their contracts, or their contracts would expire between 1990 and 1995.

The reasons for prepayment vary. The projects may be in a condition and/or location that permits profitable sale for conversion to condominiums or to nonresidential use. In some instances the borrowers argue that many projects are old and have suffered extensive deterioration as maintenance has been deferred. With many of these projects heavily in debt and unable to raise rents to support the cost of repairs, the project owners say that they have no way of rehabilitating the premises. Owners claim that if they were allowed to prepay their loans, the projects could be sold to profit-motivated owners who could afford private financing for needed repairs.

Housing activists feared that a monumental housing crisis was in the making. They noted that this potential reduction came at a time when it would be difficult to replace the lost units, since Federal subsidies to add new units and households to the assistance roles had been reduced by more than 70 percent since 1981. Furthermore, tax reform had eliminated much of the incentive to invest in low-income housing construction.

The Housing and Community Development Act of 1987 established a temporary measure to give Congress time to develop a permanent program for the preservation of this housing. During this time, much was learned about the financial, tax, and regulatory aspects of the prepayment issue. More importantly, according to the National Affordable Housing Act conference report, a consensus finally emerged on how best to strike the balance of interests of owners, the tenants and the communities most affected by the consequences of prepayment. The fundamental principle of the 1987 Act was that the housing should be preserved for its intended beneficiaries and that owners should be guaranteed a fair and reasonable return on their investment through new incentives. While the principle of the 1987 Act is retained, the legislation transforms the goal of a fair and reasonable return into a set of concrete economic alternatives for the owner that can be pursued through a more objective streamlined process.

The 1990 Housing Act permits prepayment in the very limited circumstance, also applicable in the 1987 act, that HUD finds that the removal of a project from the federally assisted housing stock will not materially increase hardship for current tenants. In addition, tenants cannot be involuntarily displaced as a result of prepayment for a project unless comparable housing is readily available without rental assistance. Owners seeking to prepay must ensure that the result of such action will not materially affect the

availability of affordable housing to other low and very low income families and minorities near their employment opportunities because sufficient vacancies exist. Prepayment is also permitted if HUD cannot fund sufficient subsidies, referred to as "incentives," to provide owners with a fair return on their equity when low-income use is continued, or if a buyer willing to continue such use, with HUD subsidies, cannot be found to purchase at a fair market price. Tenants are given a number of protections in the determination process, and assistance is provided if the owner is allowed to prepay.

The prepayment plan under the 1990 Housing Act provides complex paths of procedures to be followed by the owner, by HUD, and by a possible purchaser. In all cases, it begins with the filing of a statement of intent by an owner already eligible or who will become eligible to prepay his mortgage, that he wishes to prepay, to continue operation with additional subsidy, or to sell. After the statement process, the procedures vary.

If an intent to prepay was indicated, but denied, or if one of the other alternatives was chosen, an appraisal process is established, and fair market rents, fair return on equity, fair market price, and Federal cost limits, as defined in the Act, are determined. HUD may offer a variety of "incentives," sufficient to cover the operating expenses and a fair return of profit, which is defined as 8 percent on equity. If HUD is able to offer the owner that fair market return, the owner would be required either to maintain affordability restrictions on the housing or to transfer the housing to a qualified purchaser that will.

These incentives may take on many forms such as increases access to residual receipts, increased rents, additional Section 8 assistance, financing of improvements, as well as other. When a project is for sale, tenant councils and nonprofit and public agencies are given first priority for a period of time. If no sale results, the purchase is opened to any qualified buyer who will maintain the low-income rental unit. This process, due to the established time limits, could take several years to complete.

The prepayment of any projects carries with it many restrictions and financial requirements to serve as protective measures for tenants. Tenants must be offered Section 8 assistance, subject to fund availability, and if owners, after prepaying continue the project as a market rental, they must accept Section 8 tenants. Three-year extensions of leases are to be given to tenants with special needs, and to all tenants in low-vacancy areas. If a tenant must be relocated, the owner is required to pay 50 percent of relocation costs. State or local law can require this amount to be greater.

On May 2, 1991, HUD issued a proposed rule for implementing the NAHA provisions. It was received with some criticism, with charges that some of the provisions were unworkable and that some violated congressional intent. HUD consequently, received many comments for review, and has not yet issued a final regulation to put the NAHA Low-Income Housing Preservation and Resident Homeownership Act of 1990 into effect. Requests received under the 1987 act, which are still being processed, are primarily for continuation with additional subsidies or sale to nonprofits or public agencies for continued low-income use.

Physical deterioration or financial difficulty can result in the loss of a project to the assisted housing stock. Under the Sections 221(d)(3) and 236 programs, rents are controlled by HUD, in accordance with a prescribed formula in each program. Many owners have been discouraged from proper maintenance and additional investment for improvements by insufficient rents to permit an adequate return. HUD is authorized to permit rent increases sufficient to allow a return of advanced capital with interest, provided that rents do not exceed the lower of 30 percent of income or the Section 8 fair market rent for comparable housing. Section 8 assistance is to be provided for adversely affected tenants.

4. Prognosis

The Housing Act of 1990, which was the first major housing legislation since 1974, continues, with some amendment, the major ongoing programs such as public housing and Section 8, and it created a number of new programs as well, such as the HOME Investment Partnership Act which establishes a block grant to localities and States. Essentially, a Home Investment Trust Fund will offer a line of credit to each participating jurisdiction for assistance. Both the Congress and the Administration have indicated their commitment to this effort, recognizing that the Nation's housing problems, including those faced by the elderly, are not going to resolve themselves and cannot be handled by the Federal Government alone. States, local communities, and the private sector must play active roles in assuring assisted housing for those in need.

In light of the limited new housing construction, the preservation of affordable housing stock is essential if the goal of providing affordable, decent, and safe housing is to be met.

D. INNOVATIVE HOUSING ARRANGEMENTS

Alternative housing options are necessary to meet the needs of the elderly population that does not require institutional care, but is unable to live independently, due to financial or health reasons. Several types of solutions to the problems of those elderly living in houses too large for their needs and too costly to maintain have surfaced. In addition, concern about meeting the needs of those older persons who have become too frail to live independently without adequate supportive services has led to increased attention to developing and utilizing alternatives. Among the housing alternatives that continue to receive attention are continuing care retirement communities, shared housing and ECHO, or "granny flat" arrangements.

1. Continuing Care Retirement Communities

Continuing care retirement communities (CCRCs), also called life-care communities, typically provide housing, personal care, nursing home care, and a range of social and recreation services as well as congregate meals. Residents enter into a contractual agreement with the community to pay an entrance fee and monthly fees in exchange for benefits and services. The contract usually remains in effect for the remainder of a resident's life.

The definition of CCRCs continues to be confusing and inconsistent due to the wide range of services offered, differing types of housing units, and the varying contractual agreements. According to the American Association of Homes for the Aging (AAHA), "continuing care retirement communities are distinguished from other housing and care options for older people by their offering of a long-term contract that provides for housing, services and nursing care, usually all in one location." In its study on life care, the Pension Research Council of the University of Pennsylvania developed a definition of life-care communities. It includes providing specified health care and nursing home care services at less than the full cost of such care, and as the need arises.

There are approximately 700–800 continuing care retirement communities with an estimated 230,000 residents, which represents about 1 percent of the elderly population. While most life-care communities are operated by private, nonprofit organizations and some religious organizations, there has been an increasing interest on the part of corporations in developing such facilities.

Continuing care retirement communities are often viewed as a form of long-term care insurance, because communities protect residents against the future cost of specified health and nursing home care. Like insurance, residents who require fewer health and nursing home care services in part pay for those who require more such services. Entrance fees are usually based on actuarial and economic assumptions, such as life expectancy rates and resident turnover rates, which is also similar to insurance pricing policies.

In 1990, the median CCRC entrance fees ranged from approximately $32,800 for a studio, $47,500 for a one-bedroom and $68,250 for a two-bedroom unit. The median monthly fees ranged from $695 for a studio, $830 for a one-bedroom to $938 for a two-bedroom. This wide range results from such factors as the social and health care services provided, the size and quality of independent living units, and the amount of health care coverage provided. CCRCs do not usually cover acute health care needs such as doctor visits and hospitalization. Studies have shown that the average age of persons entering life-care communities is 75. In independent living units, personal care units, and nursing home units the average ages are 80, 84, and 85, respectively.

Problems have been discovered in some communities, such as those using lifespan and health projections that are not actuarially sound, as well as incorrect revenue and cost projections. Some contracts are written in such a way that if a person decides, even within a reasonable period of time, that he or she does not want to stay at the facility, the entire endowment is lost and not returned, even on a pro-rated basis. According to AAHA's guidebook to CCRCs, the many variations of contracts can be grouped into three types: extensive, modified, and fee-for-service. All three types of contracts include shelter, residential services, and amenities. The difference is in the amount of long-term nursing care services. The extensive contract includes unlimited long-term nursing care. A modified contract has a specified amount of long-term nursing care. This specified amount may be 2 months, for example, after which time the resident will begin to pay a monthly or per diem rate for nursing care. The fee-for-service contract guarantees access to the

nursing facility, but residents pay a full per diem rate for all long-term nursing care required. Emergency and short-term nursing care may, but not always, be included in the contract. (The consumer guidebook for CCRCs is available from the American Association of Homes for the Aging.)

Recently, there has been a growth in the number of private nonprofit corporations which sponsor life care facilities. While the individual facility is clearly nonprofit, the corporation that organizes and develops the project is often a for-profit organization. The profitmaking goals of the developer may conflict with the financial stability of the nonprofit corporation. For example, to attract consumers and quickly raise funds, the pricing structure may be established too low to provide both profit and future financial stability.

While most life-care communities are managed effectively, some have faced financial and other problems. A growing phenomenon, life care is just beginning to be understood and regulated. California, in 1939, was the first State to regulate life care. Today, more than 30 States regulate the operation of life care communities. There is little uniformity, however, in the way these facilities are regulated by the States. Some States require operators to make public ownership and financial disclosures, others do not. Similarly, some States regulate resident rights and others do not. Few, if any, of the States offer adequate protection from the operator who deliberately seeks to use complex profit/nonprofit business structures to enhance his personal wealth at the expense of the CCRC residents.

Problems in some life care communities raised concerns by many in Congress that participants be allowed to recoup entrance fees under certain circumstances. The Internal Revenue Code, however, treated refundable entrance fees as "loans" to the life care community and imputed interest on the down payment as income received by the elderly resident. This was viewed as a hardship to life care community residents, and in 1985 Congress enacted a proposal by the late Senator John Heinz which exempted the first $90,000 of an entry fee from the IRS's imputed interest rules as part of Public Law 99-121. The House version of the 1987 reconciliation bill contained a provision to repeal the exemption and reinstate the imputed tax treatment on the entire amount of a refundable entrance fee. This proposal was rejected by the conference committee and was not contained in the bill as passed (P.L. 100-202).

Supporters of continuing care retirement communities contend that there are a number of benefits associated with this concept. For example, the pooling of resources and risks may help to reduce the uncertainties of future costs of care, and there are greater opportunities for residents to maintain their health as health care and other services are provided on a regular basis. Continuing care retirement communities are an option for some elderly, but it is unlikely that many with low and moderate incomes would be able to afford it.

2. Shared Housing

Shared housing can be best defined as facilities housing at least two unrelated persons where at least one is over 60 years of age,

and in which common living spaces are shared. It is a concept which targets single and multifamily homes and adapts them for elderly housing. Shared housing can be agency-sponsored, where 4 to 10 persons are housed in a dwelling, or it may be a private home/shared housing situation in which there are usually 3 or 4 residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with the means to maintain these homes. In some instances, elderly who otherwise would be overhoused can help families who may be having difficulties in finding adequate housing arrangements.

According to census statistics, some 670,000 people over 65 (excluding those who are institutionalized or in nursing homes) share housing with nonrelatives; a 35-percent jump over a decade ago. From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned houses and buildings could be made suitable for shared housing with very little renovation. Shared housing is extremely cost effective when compared to new construction. The per unit capital costs could be 50 to 60 percent lower using shared housing.

There are various impediments to shared housing. Among the most prominent are zoning laws and reduced SSI and food stamp payments to participants. Congress has recognized and begun to act on the need to overcome them. The Housing Act of 1983 included a provision allowing the existing and moderate rehabilitation programs of Section 8 rental assistance to be used to aid elderly families in shared housing.

There are a number of shared housing projects in existence today. Anyone seeking information in establishing such a project or looking for housing in a project can contact two knowledgeable support services. One is Operation Match, which is a growing service now available in numerous communities throughout the country. It is a free public service open to anyone 18 years of age with no sex, racial, or income requirements. Operation Match is a division in the housing offices of many cities. It helps match people looking for an affordable place to live with those who have space in their homes and are looking for someone to aid with their housing expenses. Some of the people helped by Operation Match are single working parents with children, those in need of short-term housing, elderly people hurt by inflation or health problems, and the handicapped who require live-in help to remain in their homes.

The other source of information in shared housing is the Shared Housing Resource Center in Philadelphia. It was founded in 1981, and acts as a link between individuals, groups, churches, and service agencies that are planning shared households.

3. Accessory Apartments and Granny Flats

Accessory apartments have been accepted in communities across the Nation. These apartments were occupied by members of the homeowner's family, and, therefore, accepted into the neighbor-

hood. Now, with affordable rental housing becoming more difficult to find, various interest groups, including the low-income elderly, are taking a closer look at this type of housing.

Accessory apartments are another form of shared housing, except that each unit has its own kitchen. As a result, this form of housing undergoes the same zoning restrictions and impediments previously mentioned in the shared housing discussion. Approximately 40 percent of the single family housing stock in the country is now zoned to permit accessory apartments. Once zoning is changed in a community, there are typically a number of applications to legalize existing accessory apartments, but very few applications for new ones. The reason is that the homeowners must deal with local government zoning and building regulations, as well as with contractors, banks, and tenants. Unfortunately, the process is intimidating for many people and it is difficult to find reliable advice. A basic partnership between real estate agents and remodelers to market accessory apartments could provide some assistance in understanding this often complex issue.

Another innovative housing arrangement under discussion is the "granny flat" or "ECHO" flat, first constructed in Australia and recently introduced in this country. Granny flats were constructed as a means of providing housing for elderly parents or grandparents where they can be near their families while maintaining a measure of independence for both parties. In the United States, we refer to such living arrangements as ECHO units, an acronym for elder cottage housing opportunity units. ECHO units are small, freestanding, barrier free, energy efficient, and removable housing units that are installed adjacent to existing single-family houses. Usually they are installed on the property of adult children, but can also be used to form elderly housing cluster arrangements on small tracts of land. They can be leased by nonprofit corporations or local housing authorities.

A demonstration program is set up through which elder cottage housing opportunity units (ECHO) can be included in the Section 202 program. These are small, energy-efficient, freestanding, removable living units which would be installed adjacent to existing one- to four-family dwellings. These units would be considered manufactured housing for purposes of FHA insurance. The purpose of the demonstration program is to determine whether the durability of such units is appropriate for inclusion in the Section 202 program. The Secretary of HUD is to carry out this demonstration program and report to Congress on his findings. The Housing and Community Development Act of 1992 authorized a reservation of sufficient funds to provide 100 ECHO units for the demonstration program.

4. Prognosis

Innovative housing programs are essential to providing basic housing and supportive services for our Nation's elderly, handicapped, and poor. Congress, however, must take a serious look at the development and expansion of many of these programs as they continue to increase in number. Additional studies are needed to

look at the promising aspects of these alternative housing options, as well as the prevalence of fraud and abuse.

The life care industry, as well as the development of other private retirement facilities, is expected to grow over the next several years, mainly appealing to the upper-middle and upper-income groups. Some are examining options for developing life care facilities for lower-income Americans, primarily those that have been able to purchase a home and have built up equity during their lifetime. This effort will evolve slowly, however, and will be undertaken primarily by nonprofit life care interests.

Shared housing will become a more necessary option for older Americans in future years as the cost of maintaining a single residence becomes a larger burden than many elderly can afford. The need for quality accessory apartments and granny flats, and other innovative approaches, will only continue to grow with the increase in the number of older Americans. The focus will be on reinvigorating the overall Federal role in meeting the housing needs of America's low-income citizens, and in providing ways for the disabled and those who have "aged in place" to obtain services, so that they can continue to live semi-independently.

E. HOMELESS SERVICES

The plight of the homeless continues as one of the Nation's most pressing concerns. One of the most frustrating and troubling aspects of the homeless issue is that no reliable statistics exist to determine the number of homeless persons. Current estimates of the number of homeless persons range from 250,000 to 5 million.

The impact of the current economic recession on the prevalence of homelessness is difficult to determine, but budget cuts at the State and local level are reportedly exacerbating the problem. A survey conducted in February 1992 for the Federal Emergency Management Agency's (FEMA) Emergency Food and Shelter Program found that 92 percent of those local boards and local recipient organizations interviewed, experienced an increased demand for services since August 1991. The respondents pointed to State and local cuts in general assistance and social services, plant closings, and other unemployment as contributing factors.

Homelessness stems from a variety of factors, including unemployment, social service and disability cutbacks, lack of aftercare services for the deinstitutionalized mentally ill, noninstitutionalization (the failure to treat people who need a hospital environment), personal crises, substance abuse, and housing shortfalls in urban areas. The homeless with chronic mental illness comprise between 20 and 40 percent of the estimated homeless population. In some cities, veterans of Vietnam or earlier conflicts are thought to make up approximately one-third to one-half of the homeless. The fastest growing segment among the homeless, however, is unemployed individuals and their families. Recent studies also have documented a new category of homeless—the suburban homeless, or the working poor. Members of this population may live in relatively affluent suburban communities, but with rising housing costs, families who earn the minimum wage, or barely above it, cannot afford apartments or houses. Instead, they are living on the streets, in publicly funded shelters, or in their automobiles.

Homelessness among the elderly stems largely from the lack of affordable housing due to skyrocketing rents, the elimination of single-room-occupancy hotels, and a shrinking supply of low-income housing. Given the decline in Federal housing assistance, the housing needs of low-income households currently cannot be met. In the meantime, the number of people on waiting lists for low-income public housing continues to rise.

During the early 1980's, the policy of deinstitutionalization was credited as a leading cause of homelessness in America. However, deinstitutionalization was initiated over 25 years ago, and most surveys report that only a modest percentage of homeless persons are former residents of mental hospitals. Today, many observers believe that "noninstitutionalization" (individuals lack of access to or choice of mental health treatment) is a critical factor contributing to homelessness.

1. Stewart B. McKinney Homeless Assistance Act

(A) Legislative Background

The primary response of the Federal Government to the plight of the homeless has been through the Stewart B. McKinney Homeless Assistance Act of 1987. This act, however, authorized programs only through fiscal year 1988. Consequently, an omnibus measure authorizing a 2-year extension of the programs was introduced in the House of Representatives on March 31, 1988, as H.R. 4352. The conference report on H.R. 4352 passed in the House on October 19, 1988, and in the Senate on the following day. The bill was signed by the President on November 7, 1988, and became Public Law 100-628.

In addition to reauthorizing existing programs under the McKinney Act, the new law incorporated provisions for homeless veterans and the "Jobs for Employable Dependent Individuals Act" (JEDI) to improve job training and placement for long-term welfare recipients.

Fiscal year 1992 appropriations and fiscal year 1993 proposals for major programs of the McKinney Act are outlined in Table 1. President Bush proposed in his fiscal year 1992 budget that most of the McKinney social service programs be consolidated and shifted to HUD. Specifically, the President requested that the Education Department Adult Literacy and Homeless Children and Youth programs, and the Department of Labor Job Training for the Homeless program be superseded by a proposed HUD program of grants to States, localities, and nonprofits for services targeted to hard-to-serve homeless people. (See Table 1.) This year the Administration proposed that these same programs be folded into a $14.6 billion consolidated grant to States that included a variety of social service, education, health, and income maintenance programs.

Those advocating consolidation of the McKinney programs argued that the McKinney programs are fragmented in a way that impedes local service providers. They maintained that funds for homeless assistance should be distributed as a block grant so that discretionary choices are left to State and local policymakers. Supporters of the consolidated approach pointed out that the nature and scope of homelessness vary across the country and that priorities for the delivery of these services should be made at the State and local level. Those who favored the current panopoly of pro-

grams express the view that homeless people have special needs that are best handled by targeted services. Advocates of the categorical programs asserted that if money is not earmarked at the Federal level for these programs, the varied needs of homeless people will be lost in the competing demands for limited resources.

The 102nd Congress passed, with some amendments, the reauthorization of the McKinney Act HUD programs, FEMA program, and Interagency Council on the Homeless (P.L. 102-550). Other features included a rural homeless assistance program, "safe havens" (a demonstration program to provide a stable living environment for the mentally ill homeless who are not able to commit to existing treatment programs), and language that provides, to the extent practical, for the consultation, representation, and employment of homeless or formerly homeless individuals in activities or projects funded by the McKinney Act.

Legislation that reauthorized the McKinney programs targeted to homeless veterans (P.L. 102-405) was enacted as well. Additionally, legislation to reauthorize the runaway and homeless youth programs was incorporated in the Juvenile Justice and Delinquency Prevention Amendments (P.L. 102-586). For FY 1993, Congress appropriated approximately $925 million for McKinney Act programs. As newer programs such as HUD's Shelter Plus Care gained increased appropriations, the older programs, particularly those providing emergency services, experienced cuts.

TABLE 1.—COMPARATIVE FUNDING FOR MAJOR McKINNEY PROGRAMS: FISCAL YEAR 1992 APPROPRIATIONS, 1993 BUSH REQUEST, AND 1993 APPROPRIATIONS

[Dollars in millions]

Program	1992 appropriation	Bush request	House passed	Senate passed	As enacted
FEMA Emergency Food and Shelter	$134.0	$100.0	$109.0	$134.0	$129.0
HHS Emergency Community Services	25.0	0.0	12.4	24.6	19.8
HHS PATH (mental health/drug abuse)	30.0	30.0	29.7	30.0	29.5
HHS Alcohol/Drug Demonstrations	16.0	16.0	15.8	[1] 21.8	[1] 21.5
HHS Mental Health Demonstrations	5.9	10.9	5.8	([1])	([1])
HHS Health Care for Homeless	55.8	67.7	55.2	61.8	55.0
HHS Family Support Centers	5.5	0.0	6.9	7.0	6.9
DVA Mentally Ill Veterans	16.5	17.3	[2] 44.6	[2] 44.6	[2] 44.6
DVA Veterans Domiciliary Care	16.5	17.3	([2])	([2])	([2])
ED Adult Literacy Initiative	9.8	9.8	9.7	9.7	9.6
ED Homeless Youth and Children	25.0	25.0	29.7	25.0	24.8
DOL Job Training for Homeless	9.3	17.0	12.9	12.6	12.5
HUD Emergency Shelter Grants	73.2	17.5	17.5	67.5	50.0
HUD Supportive/Transitional	150.0	203.9	150.0	150.0	150.0
HUD Supplemental Assistance (SAFAH)	11.3	0.0	0.0	0.0	0.0
HUD Section 8 (SRO)	105.0	0.0	103.9	105.0	105.0
HUD Shelter Plus Care (SPC)	110.5	265.9	265.9	266.6	266.6
Total	799.3	798.3	869.0	954.2	924.9

[1] The Senate proposed to consolidate the substance abuse and mental health demonstration grants for homeless people so that services can be coordinated, and the conference report concurred.

[2] Traditionally, the appropriations for DVA homeless assistance programs are divided equally between the two DVA McKinney programs; however, Conf. Rept. 102-902 specifies that any subsequently authorized DVA homeless assistance program may receive some of the additional $10 million appropriated in FY 1993.

Note: The FY 1992 appropriations laws are P.L. 102-139 (Conf. Rept. 102-226) for DVA, HUD, and FEMA and P.L. 102-170 (Conf. Rept. 102-282) for ED, DOL and HHS. The FY 1993 appropriations bills are H.R. 5679 for DVA, HUD, and FEMA (H. Rept. 102-710 and S. Rept. 102-356) and H.R. 5677 for ED, DOL and HHS (H. Rept. 102-708 and S. Rept. 102-397). The FY 1993 amounts presented are from the conference reports: Conf. Rept. 102-902 for H.R. 5679 (P.L. 102-389) and Conf. Rept. 102-974 for H.R. 5677 (P.L. 102-394).

(B) FY 1993 FUNDING FOR MC KINNEY ACT PROGRAMS

The President's FY 1993 budget request surpassed $1 billion for homeless assistance programs as it did in FY 1992, and the FY 1993 total for McKinney Act programs was $798.5 million. In addition to the McKinney Act programs listed in table 1, the $1 billion request included an estimated $128 million for the U.S. Department of Agriculture (USDA) Food and Nutrition Service programs that serve homeless people as well as other needy people. This $1 billion total also reflected $3 million for activities to assist homeless people that the Department of Defense contributes, $1 million for the Interagency Council on the Homeless, and $63.1 million for the Department of Health and Human Services Runaway and Homeless Youth programs.

In terms of the HUD McKinney programs, the President would have shifted funds away from Emergency Shelter grants and to the Transitional Housing Program. The Administration also proposed to strike the "supportive" portion of HUD's Transitional and Supportive Housing Program. The supportive portion was also known as the Permanent Housing for the Handicapped Homeless which dedicates about 90 percent of its funding for housing for severely mentally ill homeless people. The Administration instead offered the new idea of "safe havens," a $50 million initiative to provide a stable living environment for the mentally ill homeless who are not able to commit to existing treatment programs, which was ultimately authorized in H.R. 5334.

The budget request for the HHS McKinney programs was in keeping with previous actions. Notably, the President sought the same amount as the FY 1992 appropriation ($30 million) for the Projects to Aid Transition from Homelessness (PATH) which provides comprehensive services for severely mentally ill homeless people. Once again, President Bush was requesting more funding for the Health Care for the Homeless than Congress has appropriated in the previous year, and this year the budget request was $67.9 million, up from a request of $63 million in FY 1992. As always, however, the President asked that no funds be appropriated to the Emergency Community Services Block Grant for the Homeless.

As in past years, the FY 1993 budget request would have cutback the FEMA Emergency Food and Shelter program to $100 million, less than the amount Congress has annually appropriated. Several McKinney Act programs were included in the President's request for a $14.6 billion consolidated grant to States that included a variety of social services, education, health, and income maintenance programs. The programs recommended for inclusion in this block grant were the Education for Homeless Children and Youth, the Adult Literacy for the Homeless, and the Job Training for the Homeless. Last year, the President had requested zero funding for these three programs, but indicated that the services they provided would have been folded into the SAFAH program administered by HUD.

The budget agreement reached at the close of the 101st Congress limited the parameters of the appropriation debate, but did not necessarily lessen its intensity. Indeed, some maintained that the appropriations process became a zero-sum game, and the various McKinney Act programs appeared to compete among themselves. The House passed the FY 1993 appropriations bills that contain the McKinney Act programs (H.R. 5679 for DVA, HUD, and FEMA and H.R. 5677 for ED, DOL, and HHS) with recommended levels totaling $869 million. As Table 1 indicates, the FY 1993 funding shifted away from emergency services for homeless people, as indicated by the House recommended cuts totaling $93.3 million among FEMA Emergency Food and Shelter program, the HHS Emergency Community Services program, and the HUD Emergency Shelter Grants program.

Ultimately, $33.4 million was cut from the emergency services programs even though the overall McKinney funding levels increased by $125.3 million. Congress more than doubled the appropriations of the Shelter Plus Care program, increasing its appropriation by more than $155 million, and gave modest increases to the DVA programs for homeless veterans.

2. Private and Public Sector Roles

Although homelessness is a problem that deserves the attention of policymakers, Federal responsibility for the homeless continues to be a matter of considerable debate. The administration and others maintain that the problem is best addressed at the local level through religious and charitable groups. Others maintain that the problem would be better addressed through a comprehensive set of federally assisted programs and benefits. The pro-active approach to homelessness views the problem as prevalent across America and beyond the capacity of State and local responses. Those adhering to this approach maintain that the Federal Government should assume responsibility for alleviating the problems that contribute to homelessness because the causes can best be addressed nationally.

Current responsibility for the homeless is dispersed among all levels of government. The Federal programs generally require local and State-level planning and integration. The largest single Federal appropriation is coordinated, dispersed, and monitored by a national board of local charities and religious organizations. However, it is administered by FEMA.

Another issue concerning the role of the government is the extent to which the Federal Government can or should be involved in addressing homelessness issues. Even if services were readily available, an unknown portion of the population may be reluctant to accept them, raising essential questions of what can or should be done to deliver services to them. An indication of this problem has emerged in a few major cities which have or are considering new ordinances to temporarily detain mentally ill homeless or others who refuse to accept shelter from the elements. And because so

much of the homeless problem is thought by many to involve the chronically mentally ill, questions have been raised about whether more control can be exerted over patient releases and long-term institutionalization.

Private and public resources have been mobilized to attempt to meet the immediate needs for food and shelter. Shelters and other facilities available to the homeless generally are provided by private groups, sometimes with financial help from local governments. In addition to emergency shelters, some localities provide families or individuals with certificates or vouchers to help pay the rent. Vouchers may also be given to destitute people to enable them to rent rooms in single-room occupancy buildings or hotels.

A new frontier in the law recently has begun to develop concerning the rights of homeless individuals. In the face of housing shortages, homeless people are increasingly turning to the courts for assistance, and judges have started to define their rights. While the Constitution does not explicitly guarantee a right to shelter, judges have ordered State and local officials to provide shelter based upon State constitutions and statutes, and upon provisions in the Federal laws. It can be expected that advocates for the homeless will continue to use the courts to obtain and to enforce the basic rights of the homeless.

3. Federal Housing Programs

Advocates for the homeless, as well as some researchers and housing experts, argue that the lack of affordable housing is the chief cause of homelessness. Federal expenditures for low-income housing continues to decrease while the number of people needing such housing has increased (as discussed earlier in this chapter). In addition, much of the public housing that has been built over the past half century is obsolete and deteriorating.

Homeless advocates argue for a national housing policy that includes a resurgence of Federal spending for the construction and renovation of public housing and for a larger housing voucher program. Some express the belief that reversing to the shortage of low- and moderate-income housing is the only lasting solution to homelessness.

Critics of an expansion of federally assisted housing maintain that such spending cannot be accomplished in a time of Federal deficits and budget constraints, expressing the view that incentives to the private sector are a better way to stimulate housing growth. They also assert that the changes in the Federal Government's housing programs have not caused homelessness. Furthermore, they argue that where there are shortages of low- and moderate-income housing units, it is largely due to local government policies, particularly rent control.

Despite the nearly 4.7 million households receiving renter subsidies through HUD and Farmer's Home Administration programs, approximately 11 million additional rental households are eligible for housing subsidies, but, due to lack of funds, receive no assistance. These households are often described as "on the verge of homelessness" and are frequently the focal point of the homeless-

ness prevention programs that are emerging on the local and State levels.

4. Emergency Shelters and Welfare Hotels

When homelessness originally was thought to be a temporary crisis, it was generally agreed that shelters were a reasonable response. Some now fear that what is called a "shelter industry" has emerged, created in large part by Federal money. This argument states that shelters are transforming from temporary facilities to self-perpetuating institutions. Some maintain that the growth of these shelters has attracted people to homelessness, making nomadic street life and panhandling a viable alternative for those who choose not to be productive members of society.

The use of Emergency Assistance (EA) and Aid to Families with Dependent Children (AFDC) money to house families in commercial, transient accommodations, commonly referred to as "welfare hotels," is an especially controversial practice. Reports indicate that the costs of housing families in hotels far exceed the normal housing allowance for welfare recipients.

At one end of the spectrum are those who would forbid the use of these funds for such purposes, maintaining that the practice is inappropriate and wasteful. At the other end of the spectrum are those who view the practice as problematic but essential, given the currently available range of programs and services. They point out that AFDC housing allowances often are insufficient, even for low-income housing. Emergency shelter providers also report that they cannot meet the demand for space and that welfare hotels are a last resort.

5. Shelter Plus Care Program

A Shelter Plus Care Program is authorized to provide rental housing assistance in connection with support services funded from matching funds from other sources. This assistance is to be used primarily for homeless persons, or families of homeless persons, who are seriously mentally ill, have chronic problems with alcohol or drugs, have AIDS or some related disease. To the extent practicable, HUD is to reserve 50 percent of all funds provided for homeless individuals who are seriously mentally ill or have chronic problems with alcohol or drugs.

Applicants who are chosen for participation in the Shelter Care Plus Program will be nonprofit entities who will be chosen through national competition. An applicant wishing to participate in this program must submit forms showing proof of need in the community to be served, a description of the population to be served, a description of the supportive services to be provided, and the mechanisms for their delivery. These organizations will then enter into 5 year contracts with HUD for rental housing assistance. Each contract will provide that the recipient will receive amounts not to exceed aggregate Section 8 existing housing fair market rents.

Before any assistance is provided, each unit will be inspected to determine that the unit meets Section 8 housing quality standards and the rent for the unit is reasonable. Each tenant will pay 30

percent of his income, or the portion of welfare payment designated for housing expenses, as rent.

The occupancy agreement between the tenant and owner must be for at least 1 month. However, where necessary to assure that the provision of supportive services to persons is feasible, an owner may require a tenant participating in the program to live in a particular structure or unit for up to 1 year, and within the geographic area for the full period of participation.

The Housing and Community Development Act of 1992 revised the Shelter Plus Care Program so that it now offers leased housing in the community for severely disabled single homeless persons through tenant-based, project-based, or sponsor-based assistance. The tenant-based assistance is provided through vouchers which are distributed by States, local governments, or PHAs to those who need assistance. Applicants may subcontract the distribution of these vouchers to nonprofit organizations for distribution.

Under the sponsor-based component of the shelter plus care program, nonprofit organizations will receive rental assistance payments to house homeless persons aided by the program.

Project-based assistance is to be provided through 5-to-10-year contracts between HUD and owners of rental units (not necessarily nonprofits) for rental assistance tied to units which will be occupied by homeless individuals with chronic problems. An example of a project-based assistance would be an SRO (single room occupancy) living situation.

Congress has appropriated $267 million for the Shelter Plus Care Program in FY 1993. Because of the different types of assistance available under this program, it is difficult to estimate the number of units which will be provided.

6. Supportive Housing for the Homeless

The Housing and Community Development Act of 1992 creates a new supportive housing program which combines transitional housing, permanent housing for the disabled homeless, and the SAFAH (Supplemental Assistance for Facilities to Assist the Homeless) program.

Under the new program, at least 25 percent of the allocated funds must be used for families, and another 25 percent must be used to aid disabled homeless persons. The rest of the funding is to be used to create innovative housing arrangements with supportive services for the homeless. Funds may also be used for an "outreach" program through which services unattached to housing can be provided for the homeless.

The appropriation for this program in FY 1993 is $150 million.

7. Section 8 Moderate Rehabilitation for Single Room Occupancy

Under this program HUD provides Section 8 assistance for the moderate rehabilitation of single room occupancy (SRO) units in an effort to preserve existing housing and prevent homelessness. The assistance provides a vehicle to upgrade rental properties in the early stages of deterioration and maintain them in standard condi-

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tion, while providing rental subsidies on behalf of lower income tenants.

The Housing and Community Development Act of 1992 requires that fire and safety improvements be made in buildings to be used as SROs for the homeless. Such buildings will be required to have sprinkler systems installed in all major spaces, such as hallways and large common areas. In addition, hard-wire smoke detectors and any fire safety improvements required by State or local law must also be in place before any housing assistance payments from HUD can be made.

The appropriation for the moderate rehabilitation of SRO apartments in FY 1993 is $105 million.

8. Safe Havens for the Homeless

The Housing and Community Development Act of 1992 set up a new program designed to provide low-cost housing known as "safe-havens" for homeless persons who are unwilling or unable to participate in mental health treatment programs or to receive supportive services.

The Act authorizes HUD to make grants to nonprofits, States, or local governments to provide 24-hour housing, not simply sleeping facilities or day care. To the extent possible, volunteer services or homeless individuals and families should be employed in constructing, renovating, maintaining, or operating such facilities, as well as in providing services for occupants of the facility.

No funding has been provided for this program in FY 1993.

9. Institutionalization

Some communities are enacting laws that allow local authorities to institutionalize the chronically mentally ill homeless without their permission. For example, a homeless woman sued New York City over her involuntary commitment to a mental hospital. Although the hospital ultimately released the woman, a higher court upheld the local law which provides for involuntary confinement in such cases.

The debate extends beyond the mentally ill homeless to include ordinances that detain any homeless person who refuses to accept shelter from the elements. Questions of civil liberties and rights of the homeless will increasingly become an issue within the judicial system.

As public awareness of homeless issues increased in the early 1980's, deinstitutionalization was credited as the leading cause of homelessness. This conclusion was based, in part, upon national statistics documenting the dramatic decline in number of mental hospital patients, followed by a notable increase in the number of homeless. This move toward deinstitutionalization, however, was initiated more than 25 years ago, and more recent surveys report that only a modest percentage of homeless people are former residents of mental hospitals.

10. Health, Social, and Welfare Services

The homeless would clearly benefit from the delivery of health, social, and welfare services. Some maintain that many of the McKinney programs are not necessary because they duplicate existing programs. Community primary health and mental health centers are available to low-income people, including the homeless. When Congress removed requirements that recipients have permanent addresses to obtain certain benefits, it lifted the major legal barrier to providing services to the homeless. Thus, it is argued that instead of special public welfare programs for the homeless, which complicate the provision of services at the local level and are potentially wasteful, local service providers should conduct more outreach to the homeless, thus aiding them with existing programs.

A widely held perspective maintains that funds for the homeless should be distributed as a block grant. This would enable State and local policymakers to make discretionary choices according to the varying needs of individual communities.

Another important policy option is the concept of supportive services within the context of public housing to those who have previously been homeless. The provision of supportive services also serves as a preventive measure. The Bush Administration advocated a version of this concept in the Homeownership and Opportunity for People Everywhere (HOPE) proposal which would be handled by HUD. Many believe, however, that such human services should be administered by the Department of Health and Human Services (HHS) through local family support centers. The HOPE proposal was included in both the Cranston-Gonzalez National Affordable Housing Act (P.L. 101-625) and the Stewart B. McKinney Homeless Assistance Amendments Act (P.L. 101-645). No funds were appropriated, however, for these new programs.

11. Prognosis

Homelessness cannot be addressed as if it were simply an emergency situation; homelessness is a chronic condition plaguing this Nation. In the past, legislation provided assistance in the form of emergency shelters and meals, but Congress must take a pro-active approach to the problem and address the causes of homelessness.

The lack of affordable housing and increasing rental rates are major factors contributing to the rising number of homeless persons. This has resulted in a new category of the homeless population—the working poor. Congress must work with the States to ensure that a sufficient amount of low-income housing is available to meet the needs of the population. Although the passage of the Cranston-Gonzalez National Affordable Housing Act of 1990 and the Housing and Community Development Act of 1992 addressed many of the Nation's housing needs, much more remains to be done to make up for the drastic decrease in funding that housing programs experienced throughout the 1980's.

The Stewart B. McKinney Homeless Assistance Amendments Act of 1990 provided a modest increase in authorization levels and some redefinition and expansion of services. A key issue of debate in recent housing proposals has been provisions regarding social services within the context of public housing. Congress has recog-

nized the need for supportive services by incorporating language into legislation, but they must now work to ensure that these programs receive adequate appropriations.

Homelessness will continue to increase unless significant attention is paid to the shortage of adequate housing, social services programs are initiated, and the issue of noninstitutionalization is addressed. Congress made moderate strides in improving homeless assistance in 1990, but even more must be done in the future. Congress must make homelessness a priority in order to improve the current situation.

Chapter 9

OLDER AMERICANS ACT

OVERVIEW

For the past 25 years, the Older Americans Act (OAA) has provided a wide array of community services to older persons. The OAA was created during a time of rising societal concern for the needs of the poor. Its enactment marked the beginning of a variety of programs specifically designed to meet the social and human needs of the elderly.

The OAA was one in a series of Federal initiatives that were part of President Johnson's Great Society programs. These legislative initiatives grew out of a concern for the large percentage of older Americans who were impoverished, and a belief that greater Federal involvement was needed beyond the existing health and income-transfer programs. Although older persons could receive services under other Federal programs, the OAA was the first major legislation to organize and deliver community-based social services exclusively to older persons.

The OAA followed similar social service programs initiated under the Economic Opportunity Act of 1964. The OAA's conceptual framework was similar to that embodied in the Economic Opportunity Act and was established on the premise that decentralization of authority and the use of local control over policy and program decisions would create a more responsive service system at the community level.

When enacted in 1965, the OAA established a series of broad policy objectives designed to meet the needs of older persons. Although the OAA then lacked both legislative authority and adequate funding, it did establish a structure through which the Congress would later expand aging services.

Over the years, the essential mission of the OAA has remained very much the same: To foster maximum independence by providing a wide array of social and community services to those older persons in the greatest economic and social need. The key philosophy of the program has been to help maintain and support older persons in their homes and communities to avoid unnecessary and costly institutionalization. Services supported under the OAA include congregate and home-delivered meals, senior centers and nursing home ombudsman activities, and community service employment programs.

During the 1970's, Congress significantly improved the OAA by broadening its scope of operations and establishing the foundation for a "network" on aging under a Title III program umbrella. In 1972, a national nutrition program for older Americans was cre-

ated. One year later, area agencies on aging (AAAs) were authorized. AAAs, along with the State units on aging (SUAs), provide the administrative structure for programs under the OAA. In addition to funding specific services, these entities act as advocates on behalf of older persons and help to develop a service system that will best meet older Americans' needs. As originally conceived by the Congress, this system was meant to encompass both services funded under the OAA, and services supported by other Federal, State, and local programs. The purpose of the community service employment program, for example, is to subsidize part-time community service jobs for unemployed persons aged 55 and over who have low incomes. This program, which is administered by the Department of Labor, awards funds to national organizations and to State agencies for its operation.

Increased funding during the 1970's allowed for the further development of AAAs and for the provision of other services, including access (transportation, outreach, and information and referral), in-home, and legal services. Expansion of OAA programs continued until the early 1980's when, in response to the Reagan Administration's policies to cut the size and scope of many Federal programs, the growth of OAA spending was slowed substantially, and for some programs was reversed. For example, between fiscal years 1981 and 1982, Title IV funding for training, research, and discretionary programs in aging was cut by approximately 50 percent. Because of the debilitating Federal deficit, funding for OAA services and programs remained stagnant through the early 1990's. However, widespread congressional support for OAA programs, especially nutrition and senior employment, continues to protect them.

In 1991 both the House and Senate passed reauthorization legislation (S. 243 and H.R. 2967 respectively). Formal conference of House and Senate Members, however, was not held during the 102nd Congress. The conference was delayed due to the addition of proposals to eliminate and liberalize the Social Security earnings test.

An amendment to eliminate the earnings test, offered by Senator John McCain (R–AZ), was added to the Senate bill (S. 243) when it first passed the Senate floor in November 1991. When the House passed a compromise reauthorization package in April 1992, it included a proposal by Representative Dan Rostenkowski (D–IL) to liberalize the earnings test. The earnings test amendments are referenced in more detail in Chapter 1—Social Security.

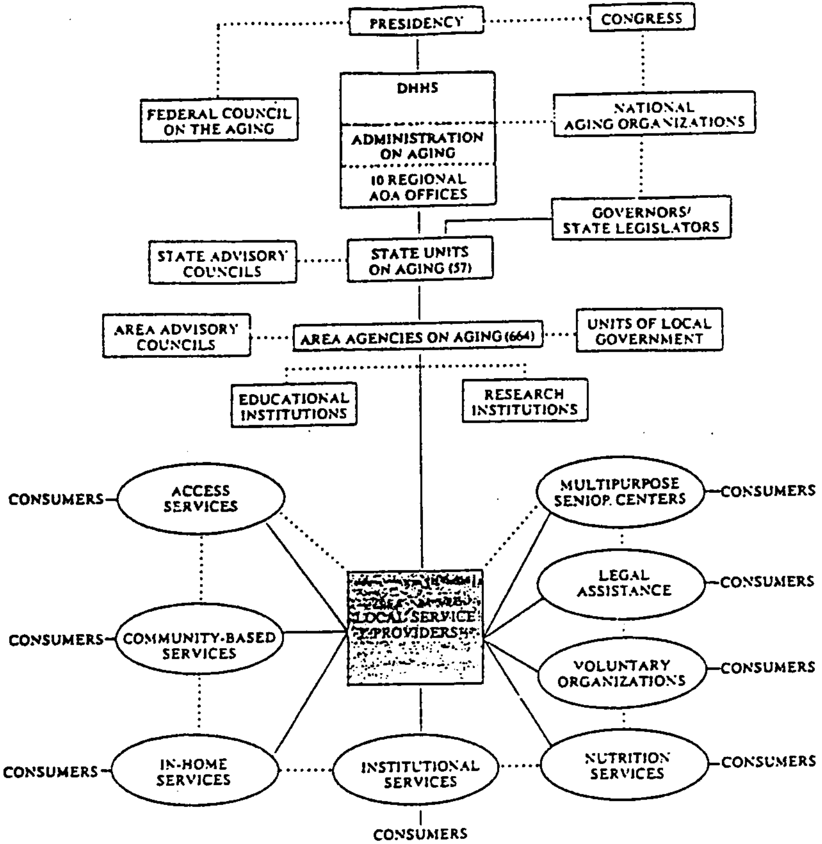
In July 1992, the Senate introduced S. 3008 containing the provisions adopted by the House passed bill of April 1992. S. 3008 was approved by the Senate on September 15, 1992, and passed by the House (H.R. 2967) on September 22, 1992. The bill which reauthorizes the Act through FY 1995 was signed by the President on September 30, 1992 (P.L. 102–375, Older Americans Act Amendments of 1992).

Although broad congressional support for OAA programs continued during the 1991 reauthorization, these programs will continue to face decreases or stagnant funding until the Federal deficit problem can be addressed. With a new administration, however, advo-

cates remain hopeful that defense savings will be shifted to such vital domestic programs.

Chart 1

OLDER AMERICANS ACT NETWORK



SOURCE: National Association of State Units on Aging

A. THE OLDER AMERICANS ACT 1991 AMENDMENTS TITLES

The following is a brief description of each title of the Older Americans Act of 1965, as amended through 1995:

1. Title I—Objectives and Definitions

Title I outlines broad social policy objectives aimed at improving the lives of all older Americans in a variety of areas including income, health, housing, long-term care, and transportation.

2. Title II—Administration

Title II establishes the Administration on Aging (AoA) to administer most OAA programs and to act as the chief Federal agency advocate for older persons. It also authorizes the Federal Council on Aging to advise the President and Congress regarding the needs of older persons.

3. Title III—State and Community Programs on Aging

Title III authorizes supportive and nutrition service programs through a nationwide network of State and area agencies on aging and receives most of the Act's total Federal funding (68% in 1992). The program supports 57 State agencies on aging, 670 area agencies on aging, and over 25,000 service provider organizations.

Funds for supportive, nutrition, and home care services are distributed to States by AoA based on a formula which considers a State's population aged 60 or over as compared to all States. The majority of Title III funding is for congregate and home-delivered meals (65% in 1992). In addition to formula grant funds awarded to States by AoA, States also receive assistance from the U.S. Department of Agriculture (USDA) in the form of commodities or cash-in-lieu of commodities. In FY 1991 the program provided supportive services to 7 million persons, and supported 238 million meals (57 percent in congregate settings and 43 percent home-delivered).

State agencies set a minimum percentage of funds to be used by each area agency on aging for the three categories considered as priorities under the area plan. These are (1) access services (transportation, outreach and information and referral), (2) in-home services (homemaker and home health aide, visiting and telephone reassurance, chore maintenance, and supportive services for families of elderly victims of Alzheimer's and related diseases), and (3) legal assistance.

Several provisions require the coordination of Title III services on behalf of specific groups of older individuals. Various provisions focus on the needs of persons with mental illness, victims of Alzheimer's disease and their families, persons with disabilities, and those in need of community-based long-term care services.

Other Title III provisions require State and area agencies on aging to focus on the needs of older Indians, and require that the distribution of this group be considered when planning services with the State and the planning and service area. In addition, the law requires area agencies to conduct outreach activities to identify older Indians and inform them of services under the OAA if their population is significant within the planning and service area.

4. Title IV—Training, Research, and Discretionary Projects and Programs

The Title IV program authorizes the Commissioner to award funds for a broad array of training, research and demonstration programs in the field of aging.

Title IV supports a wide range of demonstration projects, including, for example, projects on community-based long-term care, intergenerational programs, health promotion, legal assistance, career preparation and continuing education in the field of aging, housing, and transportation.

5. Title V—Community Service Employment for Older Americans

The Community Service Employment Program authorizes funds to subsidize part-time community service jobs for unemployed, low-income persons 55 years of age or older. Funds are awarded to 10 national organizations and to State agencies, which received 78 percent and 22 percent of funds, respectively. For FY 1992-93, these organizations include Associacion Nacional Pro Personas Mayores, the National Center on Black Aged, Inc., National Council on the Aging, American Association of Retired Persons, National Council of Senior Citizens, National Urban League, Inc., Green Thumb, Inc., National Pacific/Asian Resource Center on Aging, National Indian Council on Aging, and the U.S. Forest Service. The Secretary of Labor and Title V grantees are required to distribute information to help program participants identify age discrimination and understand their rights under the Age Discrimination in Employment Act.

Enrollees are paid the higher of Federal or State minimum wage or the local prevailing rate of pay for similar employment, and work in a wide variety of community service activities, such as health care, senior centers, and education. Title V wages are not considered when determining eligibility for Federal housing and food stamp programs.

6. Title VI—Grants for Native Americans

Title VI authorizes funds for supportive and nutrition services for older Indians, under Part A, and for older Native Hawaiians under Part B.

Under Part A, a tribal organization is eligible for Title VI funds if it has at least 50 older Indians. The law allows older Indians to receive assistance under Title VI, as well as under Title III programs.

Part B, the Native Hawaiian Program, retains a separate authorization under Title VI. Like tribal organizations, the Native Hawaiian organizations are eligible for funds if they represent at least 50 Native Hawaiians who are 60 years of age or older.

In FY 1992, 216 Indian Tribal organizations received Title VI funds; one grant was made to a Native Hawaiian organization.

7. Title VII—Vulnerable Elder Rights Protection Activities

Title VII consolidates provisions regarding elder abuse, the long-term care ombudsman program, legal assistance, and outreach and public benefit and insurance counseling programs.

8. Title VIII—Amendments to Other Laws; Related Matters

Title VIII includes provisions requiring the Secretary of Labor and the National Center for Health Statistics to prepare reports containing certain prescribed information regarding Home Health Aides; and the Native Americans Programs Act Amendments of 1992.

9. Title IX—General Provisions

Title IX includes miscellaneous provisions, technical amendments, and provisions outlining the White House Conference on Aging.

B. MAJOR ISSUES IN THE 1991-92 REAUTHORIZATION AND CONGRESSIONAL RESPONSE

In preparation for the 1991 reauthorization, the second session of the 101st Congress and the 102nd Congress convened a number of hearings and legislative workshops to examine changes that may be necessary or desirable as part of the process.

On the Senate side, the Special Committee on Aging held a series of workshops in 1990 which focused on a number of reauthorization issues, including information systems and information flow within the Aging network; legal assistance and the ombudsman program; and the role of the Administration on Aging. In addition, in February 1991, the Committee conducted a nutrition workshop which focused in part on OAA-funded nutrition programs.

Based on the findings of these workshops, the Chairman of the Special Committee on Aging, Senator David Pryor (D-AR) introduced three separate bills to amend the Act: (1) S. 974 to improve information and assistance, legal assistance, the long-term care ombudsman program, data collection, and transportation services for the elderly; (2) S. 1477, to improve the quality, safety and wholesomeness of meals served by OAA-supported nutrition programs; and (3) S. 1740, to redistribute Title III funds to alleviate the burden placed on States with a disproportionate number of low-income elderly persons. Most of the major provisions of these bills have been incorporated into P.L. 102-375.

In addition, Senator Pryor sponsored two other initiatives which are included in the new legislation: (1) Provisions for special projects in comprehensive long-term care, and for several long-term care resource centers including one devoted exclusively to long-term care issues affecting the rural elderly; and (2) grants to States for developing comprehensive and coordinated senior transportation systems, and grants to area agencies on aging to assist them in leveraging additional resources to deliver transportation services.

In 1991 and 1992, the Senate Aging Committee also held two hearings on the health benefits of music, art, and dance for older Americans. These hearings led to the introduction of legislation by

Senator Reid that was included in P.L. 102–375 to authorize funding for music, art, and dance/movement therapies under the Older Americans Act. Specifically, the legislation authorized funding for these therapies as supportive services, preventive services, and for research, demonstration, and education projects. In addition, the Senate Committee on Appropriations recommended that $825,000 be allocated for research and demonstration projects in the fiscal year 1993 Labor, Health and Human Services appropriations bill.

In 1991, the Committee on Labor and Human Resources, Subcommittee on Aging, chaired by Senator Brock Adams (D–WA), conducted its series of reauthorization hearings (three in Washington, D.C. and three field hearings in Washington State) which examined such topics as the OAA's ability to protect the rights of vulnerable elderly persons; targeting services to low-income minority elders; long-term care and the aging network; and the Native American programs.

On the House side, the Education and Labor Subcommittee on Human Resources, chaired by Congressman Matthew Martinez (D–CA), convened six Washington hearings on the reauthorization and four field hearings. These hearings focused on topics such as the Title V Senior Community Service Employment Program (SCSEP), targeting services to needy elderly, Native American programs, and the role of the Administration on Aging. The Subcommittee on Human Services of the House Select Committee on Aging also conducted hearings on senior transportation, the SCSEP, and AoA.

1. Cost-Sharing

Cost-sharing by older persons for receipt of Title III services has been a recurring issue in past reauthorizations. While current law prohibits mandatory fees, nutrition and supportive services providers are allowed to solicit voluntary contributions from older persons toward the cost of services. Service providers, however, are required to protect older persons' privacy with respect to their contributions. Older persons may not be denied a service because they will not or cannot make a contribution. Funds collected from voluntary contributions are to be used to expand services. Because the Older Americans Act was intended to be the major vehicle for the organization and delivery of community-based services to all older Americans regardless of income, Congress has consistently rejected any attempts to introduce means-testing.

In an effort to obtain more information on cost-sharing, in its review of the Act during the course of the 1987 reauthorization, the Senate Committee on Labor and Human Resources requested the General Accounting Office (GAO) to study current State cost-sharing systems. GAO issued the report ("In-Home Services for the Elderly, Cost-Sharing Expands Range of Services Provided and Population Served") in October 1989 which found: (1) cost-sharing is used for in-home services in at least 36 States; (2) the services commonly subject to cost-sharing were adult day care, home health care, and personal care services; (3) the majority of State and area agencies on aging surveyed supported cost-sharing, principally because it permitted them to serve greater numbers of clients and to offer a broader range of services; (4) self-reported income was the

most commonly used determinant for establishing cost-sharing fees; and (5) cost-sharing fees, in the three States GAO examined closely, were generally a small percentage of client incomes and service costs.

Given the reality of limited funding, the issue of cost-sharing was thought to be a key issue for the 1991 reauthorization. In October 1990, at the Commissioner on Aging's request, the Inspector General (IG) issued a report which assessed the cost-sharing experience of State programs for the elderly that provide in-home and adult day care services ("Cost-Sharing for Older Americans"). The report found: (1) cost-sharing is considered fair and appropriate; (2) recipients were satisfied with the services provided and found them worth the cost; (3) money from cost-sharing programs helps states to expand programs and serve more recipients; and (4) cost-sharing programs operate efficiently. State officials surveyed recommended that any cost-sharing plan be carefully planned, flexible in its implementation, and provide a sliding fee scale for services based on recipients' self-declared disposable income.

In response to the IG report, the Commissioner on Aging recommended that the Department of Health and Human Services propose to Congress that the OAA be amended to permit States to use cost-sharing for Title III services, particularly Part B services provided to older persons with incomes of at least 200 percent above the poverty level. This recommendation was included in the Administration's 1991 reauthorization proposal.

Another study of State cost-sharing practices, compiled by the Subcommittee on Human Services of the House Select Committee on Aging "Cost Sharing for the Elderly: A Survey of Current Incidence and Practice," June 1991, found that 24 States had some form of mandatory cost-sharing. Like the 1989 GAO report, this study found that mandatory cost-sharing is frequently applied to home care services, including adult respite care and homemaker services, and adult day care services. The most frequent advantage to cost-sharing cited by respondents was the ability to expand services with revenues collected. However, disadvantages noted included the administrative burden associated with the collection of fees.

Some observers, including representatives of State and area agencies on aging, continued to advocate that the Title III voluntary contributions policy be changed in the 1991 amendments so that contributions for certain services would be mandatory. Although Congress considered the various proposals, neither the House or Senate reauthorization bills made changes in the current contributions policy. This may be attributed in part to a number of factors among which include, (1) lack of adequate data on how mandatory cost-sharing would affect the participation rates of special populations, especially low-income minority older persons; (2) fear of turning the OAA into a welfare program overlooking the fact that some older persons have needs unrelated to their income status; (3) concern that mandatory fees may diminish the participation of low-income older persons who may not be able to pay fees, but are nonetheless in need of services; and (4) concern that the administrative burdens associated with collection of mandatory fees may be high relative to the total amount collected through fees.

2. Targeting

Congress always intended that services provided under Title III of the Older Americans Act be available to all older persons who need assistance, and that program participation not depend on income status alone. Successive amendments have suggested that nutrition and supportive services be focused on those persons in greatest social or economic need, with particular attention to low-income minority older persons.

How to improve targeting and outreach to certain subgroups of older persons, particularly low-income minority persons, remained a major focus of the 1991 reauthorization process. Although the OAA has required that State and area agencies on aging give preference to the elderly with the greatest economic or social need, especially low-income minority individuals, some advocates stress that all relevant sections of the OAA should specify this preference in order to emphasize the importance of serving these groups.

The 1991 reauthorization hearings documented that participation by minorities in Title III programs continues to decline. Reasons cited for the decline included that minority persons often felt that OAA programs were not responsive to their needs and priorities, meals were not culturally appropriate, non-English publications seldom were available, and there was insufficient publicity about OAA programs and referral services. Additional reasons given were that outreach to minority older persons by area agencies on aging was poor and that minorities were absent or excluded from the service delivery planning process on local advisory councils.

A June 1990 GAO report examined whether Title III intrastate funding formulas are considering the needs of elderly minorities when distributing Title III funds and whether they contain factors that are discriminating against minorities. ("Older Americans Act Administration on Aging Does Not Approve Intra-state Funding Formulas") The study found that 45 States use intrastate funding formulas to distribute Title III funds. Forty-four formulas had one or more economic need factors, and 38 had one or more minority factors. Twenty-seven States used formulas that contained a factor found by the U.S. District Court in Florida to discriminate against elderly minorities—i.e., persons 75 years or older or living alone. The report also stated that AoA believes that the OAA does not authorize it to approve or disapprove formulas. Given AoA's position on the issue, the report recommended that Congress clarify whether AoA has authority to approve State formulas.

In addition, AARP released a study in March 1990 examining the difficulty of obtaining accurate data on minority participation in Title III programs. ("Reporting of Minority Participation Under Title III of the Older Americans Act") Problems cited in the report include: (1) The difficulty in most States in reporting an unduplicated count of participants, the sole measure upon which minority participation is evaluated; (2) lack of consistent definitions of services provided and unclear mechanisms for classifying minority group members; and (3) the inability of the current data collection system to measure the level of services provided.

During the 1991 reauthorization, attention focused on the use of intrastate funding formulas to target services to those in greatest

economic or social need and methods for improving AoA's data collection methods. P.L. 102-375 requires State and area agencies to set specific objectives for serving low-income minority persons, and that program development, adovacy, and outreach efforts be focused on these groups. In addition, the new law requires improvements in the Administration on Aging's data collection methods, including data on participation of low-income and minority older persons.

3. Data Collection

An overriding concern during the 1991 reauthorization was the lack of adequate data regarding OAA services and the inability of network agencies to effectively share information among themselves. For example, no adequate national data exist regarding funding levels for services authorized under the Act. In addition, AoA has failed to disseminate throughout the aging network information about innovative programs and best practices. Information sharing touches upon all levels of the aging network and is vital to the success of particular programs. Moreover, it is essential for policymakers who are shaping the future direction of the Act.

Some reports have concluded that the absence of accurate data has made assessment of the Title III program's impact on serving those in greatest need difficult. An AARP study pointed to a number of problems with AoA's data collection efforts. ("Reporting of Minority Participation Under Title III of the Older Americans Act", March 1990) These include large fluctuations in State reporting on minority participation from year to year resulting in data volatility at the national level; lack of consistent definitions of services; unclear ways to classify minority groups; and lack of expertise among service providers in data collection procedures.

A GAO analysis of AoA's data collection system completed in connection with the 1991 reauthorization concluded that minority participation in Title III programs cannot be adequately measured. GAO recommended that AoA modify its current data collection instrument and methodology to ensure accurate participation data and to develop specific standards to ensure comparability of data across States. (GAO, Statement before a hearing conducted by the Subcommittee on Aging, Senate Committee on Labor and Human Resources, March 15, 1991, Minority Participation in Administration on Aging Programs.)

P.L. 102-375 not only contains provisions designed to strengthen AoA's data collection methods with respect to data on participation of low-income and minority older persons, but also with respect to information concerning characteristics of program participants, as well as data regarding monetary expeditures for Title III services. In addition, the new law contains provisions for streamlining current data collection procedures.

4. Public-Private Partnerships

In recent years State and area agencies have developed a variety of cooperative arrangements with private organizations with the aim of improving services for older persons. Functions performed by state and area agencies for private sector organizations include

training of older workers, educating employees on the needs of and resources available to older persons, sponsoring conferences on aging, and developing materials and media on aging services. Some of these state and local activities have included workplace elder care—programs in which employers are involved in assisting families who provide care to their older relatives.

At the Federal level, the Administration on Aging has used some of its discretionary funds under Title IV of the Older Americans Act to encourage private sector initiatives. A significant ongoing project involves an award to the Washington Business Group on Health, a national membership organization representing about 200 local business and health coalitions.

The purpose of this Title IV grant is to establish model partnerships between business communities and State and area agencies on aging to promote policies and programs to meet the needs of employed caregivers.

Clearly, some cooperative relationships between the aging network and the private sector fall within the goals and intent of the Older Americans Act. Two provisions under Title II of the OAA require the Administration on Aging to work with private sector organizations, including profitmaking organizations. Other sections of the law may be interpreted in a way that discourages efforts by the Title III State and area agency services network to develop contractual fee-for-service arrangements with private, for-profit organizations. In April 1990, AoA issued a program instruction to State and area agencies, recognizing their role in assisting private corporations to develop elder care programs. Pursuant to this program instruction, States were asked to develop policies on workplace elder care and to submit these policies to the Commissioner by November 1990.

Concerns surrounding the issue of private sector involvement include: (1) The extent to which area agencies should be in the business of direct service provision; (2) whether contractual arrangements with private sector organizations can comport with the targeting requirements of the Older Americans Act; (3) how contractual arrangements with private sector organizations are to be viewed in the context of the OAA's prohibition on mandatory fees for services; and (4) how State and area agencies' involvement in private sector initiatives will impact on their current statutory responsibilities.

P.L. 102–375 includes provisions requiring Title III agencies to disclose the nature of public/private activities they undertake, and to assure that such activities are consistent with the public-purpose mission of the Act. In addition, the new law prohibits the use of Title III funds to subsidize contractual arrangements that do not implement the Title III program. While Title II of the Act requires the Commissioner on Aging to provide assistance to private, for-profit organizations, prior to enactment of P.L. 102–375, the Act did not directly address the role of Title III agencies in conducting activities with the private sector.

5. Restructuring of the Administration on Aging

The organizational status of AoA has been a recurring issue in a number of reauthorizations. During the 1991 reauthorization, however, the push for elevating the status of AoA quickly dissipated following a reorganization within the Department of Health and Human Services (HHS). Under the reorganization, the Commissioner on Aging is to report directly to the Secretary on policy matters and receive administrative and logistics services from the Office of the Secretary. Nonetheless, the issue of the autonomy of AoA and the adequacy of its resources remained unresolved. As this report was going to press, the new Administration announced plans to elevate the status of the Commissioner to Assistant Secretary.

Concerned about the lack of evaluative information on how effective AoA has been in meeting the objectives incorporated in the OAA, in 1990, Congress requested that GAO conduct a study to examine: (1) the impact of AoA's resources on minority elderly; (2) how AoA has provided technical assistance to and oversight of programs under the OAA through State and area agencies on aging; and (3) the extent to which the provision of services through AoA has been hampered by budgetary, organizational constraints, and administrative procedures applicable to AoA. The study was released at a hearing conducted by the House Select Committee on Aging, Subcommittee on Human Services in June 1991.

Among other things, the GAO report confirmed advocates' concerns that the mission of AoA, as mandated under the OAA, has grown without a commensurate growth in resources to carry out that mission. In addition, the interaction between local aging service programs and the AoA is sharply constrained by a low travel and regional office staff budget.

To address these concerns, P.L. 102–375 authorizes specific levels of appropriations for AoA salaries and expenses: $17 million in FY 1992; $20 million in FY 1993; $24 million in FY 1994; $29 million in FY 1995; and such additional sums as may be necessary to enable the Commissioner to provide for at least 300 full-time equivalent staff. In FY 1992, AoA had a full-time equivalent staff of 185; its salary and expense level was $16.2 million. FY 1993 appropriations legislation provides $16 million for AoA program administration.

6. Elder Rights

A number of Title III programs are specifically directed at promoting services that protect the rights, autonomy, and independence of older persons. These programs include the long-term care ombudsman program; services to prevent abuse, neglect, or exploitation of older persons; and legal assistance services. Each of these programs currently receive Title III funds. An additional Title III program, not currently funded, is designed to assist older persons secure certain rights to which they may be entitled under other Federal programs. Under this authority, States are to develop outreach services to persons who may be eligible for assistance under the Medicaid, Food Stamp, or the Supplemental Security Income (SSI) programs. Except for legal assistance services, each of these separate functions carries a separate authorization of appropriations under Title III.

P.L. 102-375 consolidates, amends, and expands under a new Title VII, programs that focus on the protection of the rights of older persons. The new Title VII is designed to expand the responsibility of State offices on aging for the development, coordination, and management of statewide activity to assist older persons secure rights and services.

The new law shifts authorizations of appropriations for the long-term care ombudsman and elder abuse prevention programs from Title III to Title VII. In addition, P.L. 102-375 creates a new authorization of appropriations for an elder rights and legal assistance program, and expands the functions of an outreach program designed to assist older individuals in obtaining services from public and private sources.

P.L. 102-375 also establishes within the AoA an office of Long-Term Care Ombudsman Programs to be headed by an Associate Commissioner. The Associate Commissioner will be responsible for serving as an advocate for residents in long-term care facilities, supervising activities related to the ombudsman program, and reviewing and making recommendations on Federal legislation, regulations, and other policies affecting the program.

The law establishes a National Ombudsman Resource Center to be administered by the Associate Commissioner. The functions of the Resource Center include performance of research and training on long-term care ombudsman activities.

In addition, the new law creates a National Center on Elder Abuse which is required to annually compile, publish, and disseminate research and training materials on abuse, neglect, and exploitation. The Center is required to serve as a clearinghouse on abuse, neglect, and exploitation of older individuals.

Amendments to Title III set forth requirements on the protection of rights of older persons as well. These rights include the right to be fully informed about services, to voice grievances, and to have confidentiality protected.

7. 1994 White House Conference on Aging

The 1987 amendments authorized the President to call a White House Conference on Aging in 1991 (a) to increase public awareness of the contributions of older individuals to society, (b) to identify problems as well as the well-being of older individuals, (c) to develop recommendations for the coordination of Federal policy with State and local needs, (d) to propose specific and comprehensive recommendations for both executive and legislative action to maintain and improve the well-being of older individuals, and (e) to review the status of recommendations adopted at previous White House Conferences on Aging. The conference is intended to bring together representatives of Federal, State, and local governments, persons working in the field of aging, and the general public, particularly older persons.

Although the 1987 amendments authorized funds for fiscal years 1989, 1990, and 1991, there was a delay in calling the conference. In June 1991, President Bush announced that a conference would be held in 1993. Congress had approved $2 million in FY 1992 funding for the conference. Unfortunately, because legislative authority

for the conference had expired, the FY 1992 funding was reprogrammed from OAA programs. When FY 1992 funding expired on June 30, 1992, Dr. Louis Sullivan, Health and Human Services Secretary, closed down conference planning activities.

P.L. 102–375 includes authorization for the WHCOA, and requires the President to call the conference no later than December 31, 1994. FY 1993 appropriations legislation, however, does not contain any funding for the conference.

The 1994 WHCOA is to focus on intergenerational issues. Although planning of the Conference remains under the direction of the Secretary of Health and Human Services, P.L. 102–375 requires the involvement of the Congress in selection of appointees to a conference policy committee. The purpose of the policy committee, comprised of 25 members, 12 of whom are to be appointed by Congress, is to formulate and approve a conference agenda and the conference report.

8. Nutrition Programs

TRANSFER OF FUNDS BETWEEN NUTRITION AND SUPPORTIVE SERVICES

The annual appropriations process allows Congress to identify separate amounts under Title III for congregate and home-delivered nutrition services for supportive services. The actual amount available for these three service categories varies, however, because States are allowed to transfer funds among them. Prior to enactment of P.L. 102–375, States were allowed to transfer up to 30 percent of their allotted funds between supportive and nutrition services components. Regulations allow transfers of up to 30 percent of funds between congregate and home-delivered services allotments, with higher percentage increases approved by the Commissioner.

In recent years, States have increasingly transferred funds from the congregate nutrition program into home-delivered nutrition or supportive services. (In FY 1990, for example, approximately $58 million was transferred out of the congregate meal program, a 17-percent reduction in the original amount allotted.) The trend in transfers away from congregate nutrition services and the flexibility in the law to allocate funding with the allotments have concerned elderly nutrition organizations.

P.L. 102–375 incorporates in law current regulatory provisions which allow States to transfer up to 30 percent of allotted funds between the congregate and home-delivered nutrition programs. The law also specifies amounts in addition to 30 percent that could be transferred between the nutrition programs—for FY 1993, States may transfer an additional 18 percent; for fiscal years 1994 and 1995, an additional 15 percent; and for FY 1996, an additional 10 percent. The law also prohibits State offices on aging from delegating transfer authority to area agencies on aging, either between supportive and nutrition services or between congregate and home-delivered.

CONSUMER PRICE INDEX (CPI) ADJUSTMENT FOR COMMODITIES OR CASH-IN-LIEU OF COMMODITIES PROGRAM UNDER TITLE III

State agencies receive commodities or cash-in-lieu of commodities from USDA to supplement congregate and home-delivered meals served under Title III nutrition programs. The USDA per-meal reimbursement rate has been set at 56.76 cents since 1986.

P.L. 102-375 sets the FY 1992 USDA reimbursement rate at 61 cents or the total amount appropriated divided by the number of meals served during the prior fiscal year, whichever is higher, and reinstates an inflation adjustment. The reimbursement amount estimated to be available to pay for FY 1992 meals is $61.93 cents which will be available retroactively. In future years the law sets the per-meal reimbursement at 61 cents adjusted for changes in the CPI, or the amount appropriated divided by the number of meals served in the prior fiscal year, whichever is higher.

ADDITIONAL AMENDMENTS

P.L. 102-375 contains a number of other amendments to the Title III nutrition program including: (1) liberalizing requirements on daily dietary allowances when a nutrition project serves more than one meal per day; (2) liberalizing requirements on the number of weekly meals to be provided by projects operating in rural areas; (3) requiring State offices on aging to develop nonfinancial eligibility criteria for receipt of home-delivered meals; (4) requiring meal programs to comply with Dietary Guidelines for Americans published by the Secretary of Agriculture and the Secretary of Health and Human Services; (5) requiring the Commissioner on Aging to designate a full-time Federal officer to administer the nutrition program; (6) requiring the Commissioner to conduct a national evaluation of the program; and (7) establishing a program for providing meals to older volunteers in public elementary and secondary schools.

9. GRANTS TO NATIVE AMERICAN AND NATIVE HAWAIIAN ORGANIZATIONS

Previous law specified that in the event of an increase of appropriations over the FY 1987 level for Title VI, a specific amount of funds in excess was to be reserved for Part B (Hawaiians) up to its authorized amount. This caused concern among advocates that Part B would receive its fully authorized funding amount, but Part A (Indians) would not. Thus representatives of older Indians recommended the creation of separate authorization levels for American Indians/Alaskan Natives and Native Hawaiians. P.L. 102-375 addresses these concerns by specifying that of funds authorized for Title VI, 90 percent will be for Part A and 10 percent will be for Part B.

C. OLDER AMERICANS ACT AUTHORIZATION AND APPROPRIATIONS

1. Older Americans Act Authorization

P.L. 102-375 provides the following authorization levels from fiscal year 1992 through fiscal year 1995:

TABLE 1.—AUTHORIZATION OF APPROPRIATIONS FOR OLDER AMERICANS ACT, WHITE HOUSE CONFERENCE ON AGING, AND SPECIAL LONG-TERM CARE STUDIES, AS CONTAINED IN PUBLIC LAW 102-375, FISCAL YEARS 1992-95

[Dollars in thousands]

	Fiscal year—			
	1992	1993	1994	1995
Title II: Administration on Aging:				
Federal Council on Aging	$300	(1)	(1)	(1)
AOA program administration	[2] 17,000	[2] $20,000	[2] $24,000	[2] $29,000
Board and care facility quality study [3]	1,500	(1)	(1)	(1)
Home care quality study [3]	1,000	(1)	(1)	(1)
Title III: Grants for State and community programs on aging:				
Supportive services and centers	461,376	(1)	(1)	(1)
Disease prevention and health promotion [4]	25,000	(1)	(1)	(1)
Nutrition services:				
Congregate meals	505,000	(1)	(1)	(1)
Home-delivered meals	120,000	(1)	(1)	(1)
USDA commodities	[5] 250,000	[5] 310,000	[5] 380,000	[5] 460,000
School-based meals/multigenerational activities	15,000	(1)	(1)	(1)
In-home services for the frail elderly	45,388	(1)	(1)	(1)
Assistance for special needs	(1)	(1)	(1)	(1)
Supportive activities for caretakers	15,000	(1)	(1)	(1)
Title IV: Training, research and discretionary projects and programs	72,000	(2)	(2)	(2)
Training of Service Providers	450	450	450	450
Title V: Community service employment for older Americans	[6] 470,671	(1, 6)	(1, 6)	(1, 6)
Title VI: Grants for Native Americans	[7] 30,000	(7)	(7)	(7)
Title VII: Vulnerable elder rights protection activities: [8]				
Long-term care ombudsman	40,000	(1)	(1)	(1)
Elder abuse prevention	15,000	(1)	(1)	(1)
Elder rights and legal assistance	10,000	(1)	(1)	(1)
Outreach, counseling, and assistance	15,000	(1)	(1)	(1)
Native Americans elder rights program	5,000	(1)	(1)	(1)
White House Conference on Aging	(1)	(1)	(9)	(9)

[1] "Such sums as may be necessary."
[2] Plus additional sums to employ not fewer than 300 full-time equivalent employees.
[3] This study is to paid for by the Secretary of HHS in cooperation with the National Academy of Sciences. The authorization for this study is not an amendment to the Older Americans Act.
[4] Under prior law, this program was called Health Education and Promotion.
[5] Requires the Secretary of Agriculture to maintain for FY 1992 a per meal reimbursement rate equal to the amount appropriated divided by the number of meals served in the prior fiscal year, or 61 cents, whichever is greater. For FY 1993 and subsequent years, the per meal rate is to be adjusted for inflation.
[6] Plus such sums to provide at least 70,000 part-time employment positions.
[7] Ninety percent of this amount is authorized for grants to Indian tribal organizations and 10 percent for Native Hawaiian organizations.
[8] New title created by the 1992 amendments to the Older Americans Act.
[9] None.

2. Older Americans Act Appropriations

FY 1993 appropriations for OAA programs total $1.372 billion. Although this is slightly less than the $1.375 billion appropriated in FY 1992, it exceeds the Administration's request of $1.332 billion. The following table shows each program's funding for FY 1992 and FY 1993. Funding for Title III nutrition and supportive services, the largest program under the Act, was reduced by 1.5 per-

cent. In addition, funding for the Community Service Employment Program was reduced by 1.3 percent.

TABLE 2.—OLDER AMERICANS ACT APPROPRIATIONS, FISCAL YEARS 1992–93

[Dollars in thousands]

	Fiscal year—	
	1992 [1]	1993
Title II: Administration on Aging:		
Federal Council on Aging	$181	$178
AOA program administration	([2])	[2] 16,041
Title III: Grants for State and community program on aging	938,644	916,590
Supportive services and centers	299,238	313,708
Disease prevention and health promotion	17,000	([3])
Nutrition services:		
Total	607,162	595,807
Congregate meals	(366,067)	(363,236)
Home-delivered meals	(89,603)	(89,659)
USDA commodities	(151,492)	(142,912)
School-based meals/multigenerational activities	([4])	None
In-home services for the frail elderly	6,898	7,075
Assistance for special needs	None	None
Elder abuse prevention	4,416	([5])
Long-term care ombudsman	3,930	([5])
Outreach for SSI, Medicaid and food stamps	None	([5])
Supportive activities for caretakers	([4])	None
Title IV: Training, research and discretionary projects and programs	25,941	25,973
Training of Service Providers	([4])	None
Title V: Community service employment for older Americans	395,181	390,060
Title VI: Grants for Native Americans	15,086	15,110
Title VII: Vulnerable elder rights protection activities		8,218
Long-term care ombudsman	([5])	[5] 3,870
Elder abuse prevention	([5])	[5] 4,348
Elder rights and legal assistance	([4])	[4] None
Outreach, counseling and assistance	([5])	[5] None
Native Americans elder rights program	([4])	[4] None
Total	1,375,033	1,372,170
White House Conference on Aging	2,000	None.

[1] P.L. 102–170 provided $2 million for the White House Conference on Aging. This amount was reprogrammed from various Older Americans Act programs, with the exception of Titles IV and V. Amounts shown are FY 1992 appropriated amounts less funds reprogrammed for the White House Conference as presented in AOA's FY 1993 budget justification.

[2] Identified as a separate appropriation item for the first time in FY 1993. Various FY 1993 budget documents show amounts assigned to AOA for program administration, salaries, and related expenses before OHDS reorganization. The amount shown for FY 1992 is $16.237 million.

[3] Consolidated in funding for supportive services and centers. Amount for this program is $17 million.

[4] P.L. 102–375 authorized this program for the first time beginning in FY 1993.

[5] FY 1992 funding shown under title III. The 1992 amendments shifted this program to title VII beginning in FY 1993 and made program modifications and/or expansions.

D. PROGNOSIS

Fiscal year 1991 marked the 11th reauthorization of the Older Americans Act. When first enacted in 1965, the OAA set out a series of objectives aimed at improving the lives of older Americans in such areas as income, health, housing, employment, community services, and gerontological research and education. Since its inception, the gradual evolution of the programs and services authorized by the OAA has been remarkable. Although progress has been made, it has not been without some growing pains.

As originally conceived, the congressional intent underlying the OAA was to establish a coordinated and comprehensive system of services at the community level. Such a system, it was asserted, would provide opportunities for and assistance to vulnerable older

persons who, despite advancements in income security and health programs, still needed social services support. Additionally, the structures would provide the supports necessary to promote independent living and reduce the risk of costly institutionalization.

To that end the Older Americans Act has been successful. The needs of older persons have been identified and the means for meeting those needs have evolved. There is now an "aging network" of 57 State units on aging, about 670 area agencies on aging, and more than 25,000 local supportive and nutrition service providers. Additionally, the OAA has been the vehicle for the education and training of thousands in the field of aging.

Despite the increase in appropriations for existing programs in 1992, the programs operated under the Older Americans Act continue to be overextended and underfunded. Area agencies on aging out of necessity must raise funds from many other sources to support the programs.

Targeting available resources to specific categories of older persons—those most in need—is a natural consequence of limited funding. It is also inevitable that those who are most pressed for funding resources on the State and local levels will continue to advocate cost-sharing. However, even if cost-sharing is implemented in the next reauthorization, it is unlikely to generate sufficient funds to finance services necessary to successfully address the many unmet needs of numerous older Americans.

Although the OAA prohibits the direct provisions of services by an area agency on aging, a waiver may be obtained where the State unit on aging determines either that there is no other agency or organization in the area to provide the services or that the area agency on aging can provide the service more economically. Emphasis on the development of long-term care strategies and increasing responsibilities for case management and preadmission assessment have propelled State and area agencies into new areas. It is likely that this trend will continue in the future. This trend may raise difficult issues, such as potential conflicts of interest, that must be resolved in the years to come.

Without question, future demographic changes can only place increasing burdens on the programs provided by the Older Americans Act. The challenge for State and area agencies on aging will be not only to maintain necessary services, but also to assure the quality and accessibility of these services. As the past has shown, with continued broad support from the Congress, the OAA can be expected to adapt to and be strengthened for new challenges.

P.L. 102–375 provides a solid foundation for revitalizing the strength and importance of OAA programs and services. In the upcoming years the aging network will be presented with the arduous task of implementing these changes. It will be the job of Congress to monitor and foster a speedy implementation.

Chapter 10

SOCIAL, COMMUNITY, AND LEGAL SERVICES

OVERVIEW

Social service programs funded by the Federal Government support a broad range of services to older Americans. These programs provide funds to operate a variety of community and social services including home health programs, legal services, education, transportation, and volunteer opportunities for older Americans.

In the 1980's, two basic themes emerged with respect to the delivery of social services for the elderly. States were given greater discretion in the administration of social services as part of "New Federalism" initiatives. This shift toward block grant funding was accompanied by a general trend toward fiscal restraint and retrenchment of the Federal role in human services. As a result, the competition for scarce resources accelerated between the elderly and other needy groups.

In addition to cuts accompanying the block grants, the 1980's brought reduced spending for education, transportation, and attempts to eliminate entirely legal services. Older Volunteer Programs, by contrast, enjoyed strong support.

More recently, following the war in the Persian Gulf and the continuing changes in the Soviet Union, advocates of human service programs were hopeful that the reduced pressures to finance large defense requirements would result in greater Federal resources being devoted toward social service programs. Despite the changing political climate, the economy and the budget deficit prevented significant policy changes in 1991 and 1992. Advocates, however, are hopeful that a new administration will revitalize important social programs.

A. BLOCK GRANTS

1. Background

(A) SOCIAL SERVICES BLOCK GRANT

Social services programs are designed to protect individuals from abuse and neglect, help them become self-sufficient, and reduce the need for institutional care. Social services for welfare recipients were not included in the original Social Security Act, although it was later argued that cash benefits alone would not meet all the needs of the poor. Instead, services were provided and funded largely by State and local governments and private charitable agencies. The Federal Government began funding such programs under the Social Security Act in 1956 when Congress authorized a dollar-for-

dollar match of State social services funding; however, this matching rate was not sufficient incentive for many States, and few chose to participate. Between 1962 and 1972, the Federal matching amount was increased and several program changes were made to encourage increased State spending. By 1972, a limit was placed on Federal social services spending because of rapidly rising costs. In 1975, a new Title XX was added to the Social Security Act which consolidated various Federal social services programs and effectively centralized Federal administration. Title XX provided 75 percent Federal financing for most social services, except family planning which was 90 percent federally funded.

In 1981, Congress created the Social Services Block Grant (SSBG) as part of the Omnibus Budget Reconciliation Act. Under the block grant program, States no longer are required to provide a minimum level of services to AFDC, SSI, or Medicaid recipients, nor are Federal income eligibility limits imposed. Non-Federal matching requirements were eliminated and Federal standards for services, particularly for child day care, also were dropped. The block grant allows States to design their own mix of services and to establish their own eligibility requirements.

Block grant funds are used for such diverse activities as child day care, home-based services for the elderly, protective and emergency services for children and adults, family planning, transportation, staff training, and program planning.

(B) COMMUNITY SERVICES BLOCK GRANT

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

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

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

In 1981, the Reagan Administration proposed elimination of the CSA and the consolidation of its activities with 11 other social serv-

ices programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and a congressional oversight committee had criticized the agency as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus Reconciliation Act of 1981 (P.L. 97-35) abolished the CSA as a separate agency, but replaced it with the CSBG to be administered by the newly created Office of Community Services under the Department of Health and Human Services.

The CSBG Act requires States to submit an application to the Department of Health and Human Services, promising the State's compliance with certain requirements, and a plan showing how this promise will be carried out. States must guarantee that legislatures will hold hearings each year on the use of funds. States also must agree to use block grants to promote self-sufficiency for low-income persons, to provide emergency food and nutrition services, to coordinate public and private social services programs, and to encourage the use of private-sector entities in antipoverty activities. However, neither the plan nor the State application is subject to the approval of the Secretary. States may transfer up to 5 percent of their block grant allotment for use in other programs, such as the Older Americans Act, Head Start, and low-income energy assistance. No more than 5 percent of the funds may be used for administration.

Since States had not played a major role in antipoverty activities when the CSA existed, the Reconciliation Act of 1981 offered States the option of not administering the new CSBG during fiscal year 1982. Instead, the Department of Health and Human Services would continue to fund existing grant recipients until the States were ready to take over the program. States which opted not to administer the blocks grant in 1982 were required to use at least 90 percent of their allotment to fund existing community action agencies and other prior grant recipients. In the Act, this 90 percent pass-through requirement applied only during fiscal year 1982. However, in appropriations legislation for fiscal years 1983 and 1984, Congress extended the grandfather provision to ensure program continuity and viability. The extension was viewed widely as an acknowledgement of the political stakes inherent to community action agencies and the programs they administer.

In 1984, Congress made the 90 percent pass-through requirement permanent and applicable to all States under Public Law 98-558. Currently, over 1,145 eligible service providers receive funds under the 90 percent pass-through. Three-fourths of these entities are community action agencies, the remainder includes limited purpose agencies, migrant or seasonal farmworker organizations, local governments or councils of government, and Indian tribes or councils.

In November 1991, the National Association for State Community Services Programs released a 50-State survey of programs funded by CSBG. Among the principal findings were: (1) 90 percent of CSBG funds are received by local agencies eligible for the con-

gressionally mandated pass-through; (2) 76 percent of such eligible agencies are community action agencies established under the original CAP; (3) 94 percent of the funds received by CSBG-funded agencies come from Federal programs; (4) 6 percent of funds received by CSBG-funded agencies come from State government sources; and (5) CSBG money constitutes only 8 percent of the total funds received by CSBG-funded agencies.

Agencies from 46 States and the District of Columbia reported detailed information about their uses of CSBG funds. Those agencies used CSBG money in the following manner: emergency and homeless services (14%), nutrition programs (11%), employment programs (13%), education initiatives (9%), income management programs (6%), and housing initiatives (10%).

2. Issues

(A) NEED FOR COMMUNITY SERVICES BLOCK GRANTS

After 2 years of existence, the administration proposed to terminate the CSBG entirely for fiscal year 1984, and to direct States to use other sources of funding for antipoverty programs, particularly SSBG dollars. In justifying this phaseout and suggesting funding through the SSBG, the administration maintained that States would gain greater flexibility because the SSBG suggested fewer restrictions. According to the administration, States then would be able to develop the mix of services and activities that were most appropriate to the unique social and economic needs of their residents.

However, a 1986 General Accounting Office (GAO) report on the operation of Community Action Agencies (CAA's) which was funded by the CSBG refuted this claim. Specifically, the GAO addressed the administration's position that:

(1) The type of programs operated under CSBG duplicated social service programs under the SSBG;

(2) CAA's can find other Federal and State funds to cover administrative activities; and

(3) Funding under CSBG is not essential to the continued operation of CAA's.

The report found that, in general, CSBG-funded services often were short-term and did not duplicate those provided under SSBG. Primarily, CSBG funds are used to provide services that fulfill unmet local needs and to complement those services provided by other agencies. Unmet local needs cited by GAO include temporary housing, transportation and services for the elderly. CSBG-funded agencies provided such complementary programs as the training of day care personnel for SSBG-funded day care programs and temporary shelter for clients awaiting more permanent housing financed by other sources. The most predominant CSBG-funded services found by GAO were information, outreach, and referral, as well as emergency and nutritional services.

GAO also found that CSBG funds often are used for administration of other social service programs, which may have limitations on the use of their own funds for administrative expenses. Consequently, CAAs are not in a position to find other Federal and State funds to cover administrative costs. According to GAO, the Federal

Government in 1984 provided 89 percent of the total funds received by CAAs in 32 States. The remaining 11 percent of the 1984 budgets of reporting CAAs were provided by CSBG funds. Several other Federal programs, including Head Start, the Community Development Block Grant, and Low Income Home Energy Assistance, provide substantial CAA funding.

The GAO report also did not support the administration's claims that CSBG funding is nonessential to continued program operation. State and local governments are under such fiscal duress that they may not be able to replace lost CSBG funds.

In every budget package submitted to Congress since its inception, the Reagan and Bush Administrations have proposed phasing out the CSBG. Congress, however, has consistently rejected these proposals. Despite this support, funding for the CSBG and related programs has not grown significantly.

(B) ELDERLY SHARE OF SERVICES

The role that the Social Services Block Grant plays in providing services to the elderly had been a major concern to policymakers. Supporters of the SSBG concept have noted that social services can be delivered more efficiently and effectively due to administrative savings and the simplification of Federal requirements. Critics, on the other hand, have opposed the block grant approach because of the broad discretion allowed to States and the loosening of Federal restrictions and targeting provisions that assure a certain level of services for groups such as the elderly. In addition, critics have noted that any future reductions in SSBG funding could trigger uncertainty and increased competition between the elderly and other needy groups for scarce social service resources.

Under Title XX, the extent of program participation on the part of the elderly was difficult to determine because programs were not age specific. States had a great deal of flexibility in reporting under the program, and, as a result, it was hard to identify the number of elderly persons served, as well as the type of services they received. The elimination of many of the reporting requirements under SSBG has made efforts to track services to the elderly even more difficult. States are required to file yearly pre-expenditure reports, but these do not adhere to a standardized format and are of limited value in determining the impact of program and funding changes on specific populations.

In 1990, the American Association of Retired Persons released a survey of States regarding the amount of SSBG funds being used for services to the elderly. The survey showed that 44 States use some portion of their SSBG funds to provide services to older persons. The percentage of Federal funds used for seniors ranged from 0 to 90 percent in 39 States that were able to provide age-specific estimates. Most States indicated that they have held service levels relatively constant by a variety of devices, including appropriating their own funds, cutting staff, transferring programs to other funding sources, requiring local matching funds, or reducing the frequency of services to an individual. The most frequently provided services were home-based, adult protective, and case management/access. Other uses include family assistance, transportation, nutri-

tion/meals, socialization and disabled services. All but 3 of the 47 States responding to the survey reported that services for older people have suffered from the absence of increases in Federal SSBG funding. As a result, States have raised the eligibility criteria so that they provide fewer and less comprehensive services to fewer people, and except with respect to protective services, they serve only the very low-income elderly. In addition, some States reported that shrinking funds make it necessary to consider the costs of services more than the quality of services.

It seems clear that while funding for the SSBG has remained relatively constant, there is a strong potential for fierce competition among competing recipient groups. Increasing social service needs along with declining support dollars portends a trend of continuing political struggle between the interests of elderly indigent and those of indigent mothers and children. In the coming years, a fiscal squeeze in social service programs could have massive political reverberations for Congress, the administration, and State governments as policymakers contend with issues of access and equity in the allocation of scarce resources.

The proportion of CSBG funds that support services for the elderly and the extent to which these services have fluctuated as a result of the block grant also remains unclear. When the CSBG was implemented, many of the requirements for data collection previously mandated and maintained under the Community Services Administration were eliminated. States were given broad flexibility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSBG, there is very little information available at the Federal level regarding State use of CSBG funds.

A 1991 report by National Association for State Community Services Program (NASCSP), on State use of fiscal year 1988 CSBG funds provides some interesting clues. Although the survey was voluntary, all jurisdictions eligible for CSBG allotments answered all or part of the survey. Thus, NASCSP received data on CSBG expenditures broken down by program category and number of persons served which provides an indication of the impact of CSBG services on the elderly. For example, data from approximately 41 States show expenditures for employment services, which includes job training and referral services for the elderly, accounted for 10 percent of total CSBG expenditures in those States and served over 1 million persons. Housing programs, in fiscal year 1988, including home ownership counseling, shelters for the homeless, and construction of low-cost housing, also served over 1 million persons, many of whom are elderly. A catchall linkage program category supports a variety of services reaching older persons, including transportation services, medical and dental care, senior center programs, legal services, homemaker and chore services, and information and referrals. Emergency services such as donations of clothing, food, and shelter, low-income energy assistance programs and weatherization are provided to the needy elderly through CSBG funds. Unfortunately, data related to the age, sex, race, and income levels of program participants were not reported in the survey. Until such data are available, a definitive picture of the role CSBG programs play in assisting the needy elderly is unclear.

3. Federal Response

(A) SOCIAL SERVICES BLOCK GRANT APPROPRIATIONS

The SSBG program is now permanently authorized and States are entitled to receive a share of the total according to their population size. By fiscal year 1986, an authorization cap of $2.7 billion was reached.

Congress appropriated the full authorized amount of $2.7 billion for fiscal year 1989 (P.L. 100-436). Effective in fiscal year 1990, Congress increased the authorization level for the SSBG to $2.8 billion (P.L. 101-239). This full amount was appropriated for both fiscal year 1990 and fiscal year 1991 (P.L. 101-166 and P.L. 101-517). In 1992, Congress again approved $2.8 billion for the SSBG in fiscal year 1993.

(B) COMMUNITY SERVICES BLOCK GRANT REAUTHORIZATION AND APPROPRIATIONS

As established in the 1981 Omnibus Budget Reconciliation Act, the Community Services Block Grant (CSBG) was scheduled to expire at the end of fiscal year 1986. The Human Services Reauthorization Act of 1986 (P.L. 99-425) extended the CSBG Act through fiscal year 1990 and P.L. 101-501 subsequently extended the Act through fiscal year 1994 at the following funding levels: $451.5 million in fiscal year 1991, $460 million in fiscal year 1992, $480 million in fiscal year 1993, and $500 million in fiscal year 1994. Of the total appropriated each year, the Secretary of the Department of Health and Human Services is authorized to reserve up to 9 percent for discretionary use. The remaining funds are allotted to States in the same proportion as the amounts that the States received in fiscal 1981 from CSA. Ninety percent of the State allotments must be used to fund eligible service providers.

The act also authorizes the following amounts for the Community Food and Nutrition Program: $10 million in fiscal year 1991, $15 million in fiscal year 1992, $20 million in fiscal year 1993, and $25 million in fiscal year 1994. In addition, the following amounts are authorized for demonstrations of innovative antipoverty approaches: $10 million in fiscal year 1991, and such sums as necessary for fiscal years 1992, 1993, and 1994. The Stewart B. McKinney Homeless Assistance Act authorized appropriations for grants to States for services to the homeless.

For fiscal year 1993, the Bush Administration requested no new funds for CSBG or related programs. Congress, however, approved a total of $441 million for CSBG, of which $21 million is for community partnerships, and $7 million is for community food and nutrition services.

B. EDUCATION

1. Background

State and local governments have long had primary responsibility for the development, implementation, and administration of primary, secondary, and higher education, as well as continuing education programs that benefit students of all ages. The role of the

Federal Government in education has been to ensure equal opportunity, to enhance the quality, and to address national priorities in training.

Federal and State interest in developing educational opportunities for older persons grew out of a paper prepared for the 1971 White House Conference on Aging which cited a list of educational needs for older persons. These range from the need to acquire the basic skills necessary to function in society, to the need to engage in activities throughout one's life which are enjoyable and meaningful and which benefit other people. The 1981 White House Conference on Aging report, entitled "Implications for Educational Systems", noted that as our society ages at an accelerated rate, it must assess and redefine the teaching and learning roles of older persons and assure a match between the needs of older adults and the training of those who serve them.

While many strong arguments exist for the importance of formal and informal educational opportunities for older persons, it has traditionally been a low priority in education policymaking. Public and private resources for the support of education have been directed primarily at the establishment and maintenance of programs for children and college age students. This is due largely to the perception that education is a foundation constructed in the early stages of human development.

While formal education is viewed as a finite activity extending only through early adulthood, learning continues throughout one's life in experiences with work, family, and friends. Thus, it is a relatively new notion that the elderly have a need for learning beyond the informal environment. This need for structured learning may appeal to "returning students" who have not completed their formal education, older workers who require retraining to keep up with rapid technological change, or retirees who desire to expand their knowledge and personal development.

At the end of 1991, the Special Committee on Aging released a publication entitled "Lifelong Learning for An Aging Society". This report, which has been updated for 1992 (Publication No. 102-R), provides an introduction to the concept of lifelong learning as well as to the laws that affect education for the older adult.

2. Issues

(A) ADULT LITERACY

Conventional literacy means the ability to read and write. The Census Bureau estimated that the Nation's conventional illiteracy rate was 0.5 percent in 1980, which would place the estimated number at over 1 million. However, literacy means more than the ability to read and write. The term "functional illiteracy" began to be used during the 1940's and 1950's to describe persons who were incapable of understanding written instructions necessary to accomplish specific tasks or functions.

Definitions of functional literacy depend on the specific tasks, skills, or objectives at hand. As various experts have defined clusters of needed skills, definitions of functional literacy have proliferated. These definitions have become more complex as technology and information has increased. For example, the National Literacy

Act of 1991 defines literacy as "an individual's ability to read, write, and speak in English, and compute and solve the problems at levels of proficiency necessary to function on the job and in society, to achieve one's goals, and develop one's knowledge and potential".

Statistics on illiteracy have revealed cause for concern. For 1988, the Census Bureau estimated that 152 million persons were 25 years old and over; of these 2.4 percent had completed less than 5 years of school (4 million), and 23.7 percent had completed less than 12 years of school (36 million). The use of these data to estimate functional literacy rates, however, has the drawback that the number of grades completed does not necessarily correspond to the actual level of skills of adult individuals.

In addition, an estimated two-thirds of the Nation's colleges find it necessary to provide remedial reading and writing courses. When the inherent problems associated with illiteracy are considered—unemployment, crime, homelessness, alcohol and drug abuse—the social consequences of widespread illiteracy in this country are particularly disturbing.

Of all adults, the group 60 years of age and older has the highest percentage of people who are functionally illiterate. Results of one study showed that 35 percent of adults 60 to 65 years of age lack the skills and knowledge necessary to cope successfully in today's society. According to 1982 census data, nearly one-third of all illiterate adults are age 60 and over. These figures reflect the direct correlation between educational attainment and literacy. As would be expected, there is a heavy concentration of older persons among the group of adults 16 years of age and over with less than a high school education. According to the DOE statistics for 1989, 60 percent of the adult population have never gone beyond a high school education.

President Bush and the Nation's Governors adopted six national education goals to be achieved by the year 2000, including that every adult American will be literate and will possess the knowledge and skills necessary to compete in a global economy and exercise the rights and responsibilities of citizenship. To accomplish these goals, the President announced a new education strategy entitled "AMERICA 2000." The strategy proposed various initiatives addressing four broad areas including: (1) the reform of current schools; (2) the development of new model schools; (3) the enhancement of workers' skills; and (4) the enlistment of communities in support of the strategy.

The 102nd Congress considered and passed a number of alternatives to implement the AMERICA 2000 strategy. Because there was no final agreement on the various proposals, no legislation was enacted.

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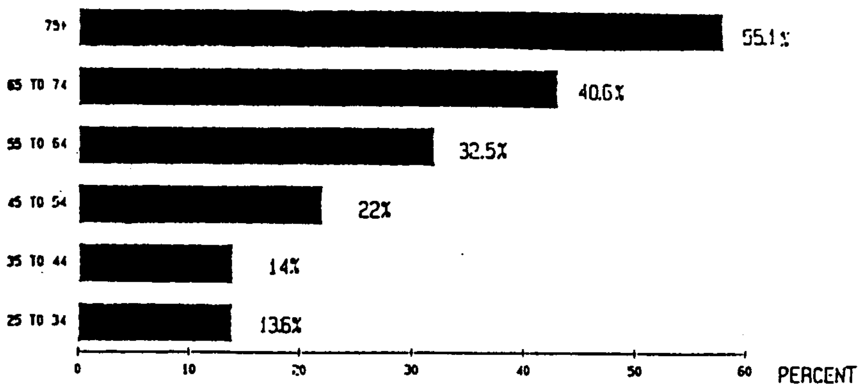
CHART 1

PERCENT OF AGE GROUPS WITH LESS THAN 12 YEARS OF EDUCATION: 1987



Source: U.S. Bureau of Census, Current Population Survey, March, 1988

(B) PARTICIPATION IN ADULT EDUCATION

The Department of Education is authorized under the Adult Education Act (AEA) to provide funds for educational programs and support services benefiting all segments of the eligible adult population. The purpose of the act is to: (a) establish adult education programs to help persons 16 years and older to acquire basic literacy skills necessary to function in society, (b) enable adults to complete a secondary school education, and (c) make available to adults the means to secure training and education that will enable them to become more employable, productive, and responsible citizens. Funds provided for adult education are distributed by a formula to States based on the number of adults in a State without high school diplomas who currently are not enrolled in school. The AEA served approximately 4 million participants in 1991.

Data from the Office of Vocational and Adult Education within the Department of Education (ED), shows that in 1986 of the total eligible adult population receiving Adult Basic Education services (ABE)—basic literacy and English as a second language instruction, 7.4 percent or 217,488 were in the 60-plus age group, as compared to 185,000 the previous year, an 11.8-percent increases. By 1989, only 5 percent of participants (or 165,000) in these programs were over age 60. At the State level, the percentages of older adult participation in literacy instruction varied from less than 1 percent to 20 percent. The reasons for participation in literacy programs most often cited by this group were a desire: (1) to read to their grandchildren, (2) to read the Bible, (3) to read medicine labels, (4) to accomplish a lifetime goal of earning a General Education Development (GED) certificate, (5) to learn more about money and banking, and (6) to learn more about available community resources.

In 1977, a major change began in adult education. Enrollment of persons aged 16 to 44 decreased while the enrollment of persons 45 to 65 increased. A 1984 survey conducted by the National Center for Education Statistics revealed that 866,000 persons age 65 and older, or 3.3 percent of all older Americans, participated in educational activities. Although the majority of adult education participants are under 35, this marked the highest number and percentage of older people involved in adult education ever recorded by the National Center for Education Statistics. However, this represents an increase of only 0.2 percent from a similar 1981 study.

With less than 4 percent of the elderly population enrolled in an educational institution or program today, older Americans continue to be underrepresented in education programs in relation to the percentage of the total U.S. adult population they comprise. This is due partly to the fact that while the elderly certainly have the ability to learn, the desire to learn is a function of educational experience. A 1984 Department of Education report supports the correlation between years of schooling completed and participation in adult education.

The existence of special classes and programs geared to older adults within structured adult education programs is still relatively rare except in community senior centers. Most of the classes focus on self-enrichment and life-coping skills and gradually are shifting to educational programs on self-sufficiency. Few programs

currently exist to meet the growing demand to acquire the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, and older persons look to continued employment as a source of economic security, adult education programs may need to shift emphasis from personal interest courses to courses on job-training skills.

Although States use various methods for reaching the eligible aging population, reports indicate that there are problems in carrying out this effort. The major problems most often mentioned by states are transportation and recruitment. Reaching older persons, especially in rural areas, is complicated because of distance, low population density, and lack of public transportation.

3. Federal and Private Response

(A) Programs

(1) Literacy

(a) Public efforts.—The Adult Education Act was enacted as part of the Elementary and Secondary Education Amendments of 1966 (P.L. 89-750). The Act has been amended several times since 1966, but the basic purpose and structure have remained similar since its enactment.

Much of the public effort by States and localities to address literacy problems is organized under the AEA program, which is funded primarily by the States. Section 353 of the Adult Education Act requires States to set aside 15 percent of their Federal funds for special experimental demonstration and teacher training projects. The section calls for coordinated approaches to the delivery of adult basic education services to promote effective programs and to develop innovative methods. Some of the States developed projects targeted to improve literacy services to the older population. For example, Louisiana developed a set of basic skills curricula for adults reading at the 0-4 grade levels and West Virginia used cable television to reach the disadvantaged who live in rural areas, as well as those who are institutionalized, homebound, or isolated.

(b) Private efforts.—Literacy programs are operated by a multitude of private groups including churches, businesses, labor unions, civic and ethnic groups, community and neighborhood associations, museums and galleries, and PTA groups. Two national groups provide voluntary tutors and instructional materials for private literacy programs, the Laubach Literacy Action (50,000 tutors) and Literacy Volunteers of America (30,000 tutors). At the instigation of the American Library Association, a group of 11 national organizations, including Laubach and Literacy Volunteers, created the Coalition for Literacy to deliver information and services at the national and local levels.

The Business Council for Effective Literacy is a foundation which was established in 1984 to foster "corporate awareness of adult functional illiteracy and to increase business involvement in the literacy field." The council's quarterly newsletters contain descriptions of many current public and private literacy efforts.

In 1985, ABC Television and the Public Broadcasting System began Project Literacy U.S. (PLUS), an ongoing effort to produce media programs on literacy in conjunction with expanded local community services.

(2) Higher Education

Older persons bring insight, interest, and commitment to learning that can generate similar enthusiasm from younger classmates, and can add to the personal satisfaction of learning. A logical extension of the success of intergenerational school programs is the intergenerational classroom at the college level. One study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and enabled them to identify their older classmates as their peers. This finding rebukes the myth that older students somehow take away learning opportunities from younger students, and indicates a growing need to think of older adults as a vital part of the college classroom.

Some colleges have designed continuing education programs to provide the flexibility and support older students often need when reentering college after several years. Today over 100 colleges and universities participate in the College Centers for Older Learners (CCOL) program (also known as Institutes/Learning In Retirement Centers). The two most common variations of this program are either those curricula that are planned and implemented exclusively by older persons, or those that are designed and managed by the institution with involvement of older students in the program planning.

Other colleges recognize experience as credit hours. At American University in Washington, D.C., for example, the Assessment of Prior Experiential Learning (APEL) program allows older students to translate their years of work or life experience into as many as 30 credits toward a bachelor's degree.

For those older students who cannot afford the cost of a private college, some States are beginning to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer a full tuition waiver and allow participants to take regular courses for credit in State-supported institutions. The Older Americans Act (OAA) Amendments of 1987 (P.L. 100–175) included a provision which requires area agencies on aging to conduct a survey on the availability of tuition-free post-secondary education in their area, supplement the data where necessary, and disseminate this information through senior centers, congregate nutrition sites, and other appropriate locations. Providing access to such information aimed at increasing the enrollment of old persons in higher education programs.

(3) Intergenerational Programs

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasingly age-segregated society in which few opportunities exist for meaningful contact between older adults and youth. Initially, programs were designed and implemented with an emphasis toward provid-

ing the support, teaching, and caring that would enhance the learning and development of school children. Eventually, intergenerational school programs emerged as a viable means of enriching the lives of older persons as well. There are now more than 100 intergenerational school programs nationwide. More than 250,000 volunteers participate in grades kindergarten through 12.

Intergenerational school programs range from informal and haphazard to large, centrally organized projects spanning several school districts. One example of a successful intergenerational program is the Teaching Learning Community, established by an elementary art teacher in 1971 in Ann Arbor, Michigan. Teaching Learning Community links older persons with a small group of student-apprentices. They work together on joint activities on a regular, weekly basis. The focus is to teach the student a new skill and create a product, while communicating with and developing respect for others. The program has spread to many States, including Florida, Pennsylvania, Idaho, Texas, and New York.

Whatever the size or scope, intergenerational school programs contribute immeasurably toward improving older persons' self-esteem and life satisfaction. School volunteering provides an opportunity for older persons to develop meaningful relationships with children and to better cope with their own personal traumas, such as the death of a spouse or friend. These programs also allow school children to develop a more positive view of the elderly while benefiting from the social and academic experience of their older tutors.

The Federal role in promoting intergenerational school programs has expanded recently through a joint initiative sponsored by the Administration on Aging and the Administration for Children, Youth, and Families in the Department of Health and Human Services. This Federal effort consists of four major components:

(1) Establishing an information bank for intergenerational programs across the country;

(2) Disseminating this information to organizations interested in establishing such programs;

(3) Working with professional organizations to stimulate interest; and

(4) Funding intergenerational demonstration projects. For example, the Administration on Aging, working cooperatively with 12 foundations, has funded 9 intergenerational projects throughout the country. These projects include intergenerational child care programs; a telephone help line operated by frail elderly for latch key children; senior homesharing; and a senior mentor program.

The Older Americans Act Amendments of 1987 included a provision that allows the Commissioner on Aging to award demonstration grants to provide expanded, innovative volunteer opportunities to older persons and to fulfill unmet community needs. These projects may include intergenerational services by older persons to meet the needs of children in day care and school settings. The 1992 OAA Amendments also promote intergenerational programs. More specifically, the amended Act includes provisions which require the Commissioner on Aging to establish a program for making grants to States for establishing projects in public schools

which, among other things, provide hot meals to older individuals and provide multigenerational activities in which volunteer older individuals and students interact.

In November 1992, the Special Committee on Aging convened a roundtable on intergenerational mentoring in order to study the direction that mentoring programs might take. This roundtable was the first step in exploring possible legislation for a National Mentor Corps, a public-private partnership that can provide mentors in our public school system.

(B) LEGISLATION

The 102nd Congress considered and passed a number of comprehensive proposals to improve the Nation's literacy which were enacted into law. The most significant for older adults was the National Literacy Act of 1991 (P.L. 102-73) which was signed into law in July 1991. This legislation, which extends the AEA for an additional 2 years to 1995, contains a comprehensive set of amendments to assist State and local programs in providing literacy skills to adults. Programs include:

(1) Establishment of an interagency National Institute for Literacy, together with a National Institute Board, to conduct basic and applied research (authorized at $15 million for FY 1992);

(2) AEA grants for State Literacy resource centers to stimulate the coordination of local literacy services (authorized at $25 million for FY 1992);

(3) A National Workforce Literacy Assistance collaborative at the U.S. Department of Labor to assist small and medium-sized businesses operate literacy programs to meet the needs of the workforce ($5 million);

(4) Grants for national workforce literacy strategies under the AEA workforce literacy program ($60 million);

(5) Amendment and extensions of the AEA basic State grant program, with an increased emphasis on the provision of literacy services to adults ($260 million);

(6) Technical amendments to the Even Start program ($60 million);

(7) A family literacy public broadcasting program ($2 million);

(8) Education programs for commercial drivers ($3 million);

(9) Literacy challenge grants under special volunteer programs of the Domestic Volunteer Service Act of 1973 ($2.5 million); and

(10) A mandatory State program under the AEA of literacy services for incarcerated adults.

P.L. 102-73 authorized a total of $482.5 million for literacy programs for FY 1992—more than $200 million higher than the FY 1991 appropriation of $276.5 million for similar programs. For most programs, such sums as may be necessary are authorized for fiscal years 1993 through 1995.

C. ACTION PROGRAMS

1. BACKGROUND

ACTION was established in 1971 through a Presidential reorganization plan that brought together under one independent agency several existing volunteer programs. The programs transferred to ACTION in 1971 include Volunteers in Service to America [VISTA] and the National Student Volunteer Program, both previously administered by the Office of Economic Opportunity; the Foster Grandparent Program (FGP); and the Retired Senior Volunteer Program (RSVP), which had been part of the Administration on Aging.

ACTION was given statutory authority under the Domestic Volunteer Service Act of 1973, which placed all domestic volunteer programs under a single authorizing statute. The act was reauthorized in 1989 through fiscal year 1993.

Today, programs administered by ACTION include the Title I-A VISTA program, the Title I-B student community service programs, the Title I-C special volunteer programs, and the Title II Older American Volunteer Programs (FGP, RSVP, and the Senior Companion Program (SCP)). ACTION programs are directed toward reducing poverty and poverty related problems, helping the physically and mentally disabled, and assisting in a variety of other community service activities. ACTION also supports demonstration projects for testing new initiatives in voluntarism, and advocates and promotes voluntarism in the public and private sectors.

(A) OLDER AMERICAN VOLUNTEER PROGRAMS

The Older American Volunteer Program (OAVP), which includes the RSVP, the FGP, and the SCP, is the largest of the ACTION program components. For fiscal year 1992, OAVP funding constitutes approximately 67 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 years and older to work part time in a variety of community service activities. Grants are awarded to local private nonprofit or public sponsoring agencies that recruit, place, supervise, and support older volunteers.

A significant facet of the OAVP is the extent to which Federal funding is supplemented by State and local governments, as well as private sector resources. According to ACTION estimates, non-Federal funding to support ACTION-sponsored volunteer projects is estimated at more than $60 million annually. In the past few years, State funds to support each of the programs have exceeded the Federal requirements for matching funds. Because these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services, they are enormously popular with both Congress and the Administration.

(1) Retired Senior Volunteer Program

The Retired Senior Volunteer Program (RSVP) was authorized in 1969 under the Older Americans Act. In 1971, the program was

transferred from the Administration on Aging to ACTION and in 1973 the program was incorporated under Title II of the Domestic Volunteer Service Act. RSVP is designed to provide a variety of volunteer opportunities for persons 60 years and older. In fiscal year 1992, there were 746 projects and 427,000 RSVP volunteers who were assigned to 55,700 community agencies nationwide. This includes volunteers supported by non-Federal funds as well as federally funded volunteers. Volunteers serve in such areas as youth counseling, literacy enhancement, long-term care, refugee assistance, drug abuse prevention, consumer education, crime prevention, and housing rehabilitation. Current RSVP projects emphasize prescription drug abuse, education, latchkey children in afterschool library programs, and respite care for frail elderly. Program sponsors include State and local governments, universities and colleges, community organizations, and senior service groups.

Each project is locally planned, operated and controlled. Although volunteers do not receive hourly stipends as under the Foster Grandparent and Senior Companion Programs, they receive reimbursement for out-of-pocket expenses incurred as a result of their volunteer activities.

(2) Foster Grandparent Program

The Foster Grandparent Program (FGP) program originated in 1965 as a cooperative effort between the Office of Economic Opportunity and the Administration on Aging. It was authorized under the Older Americans Act in 1969 and 2 years later transferred from the Administration on Aging to ACTION. In 1973, the FGP was incorporated under Title II of the Domestic Volunteer Service Act.

The FGP provides part-time volunteer opportunities for low-income persons 60 and older to assist them in providing supportive services to children with physical, mental, emotional or social disabilities. Foster grandparents are placed with nonprofit sponsoring agencies such as schools, hospitals, day-care centers, and institutions for the mentally or physically handicapped. Volunteers serve 20 hours a week and provide care on a one-to-one basis to 3 or 4 children. A foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming age 21.

The FGP was originally intended for low-income volunteers who received an hourly stipend. The Domestic Volunteer Service Act exempts stipends from taxation and from being treated as wages or compensation. Foster grandparent volunteers must have an income below the higher of 125 percent of the Department of Health and Human Services poverty guidelines or 100 percent of those guidelines plus the amount each State supplements the Federal Supplemental Security Income payment. In 1992, this annual income level was $6,810 for an individual in most States, and $9,190 for a two-person family.

In an effort to expand volunteer opportunities to all older Americans, Congress added an amendment to the 1986 Amendments (P.L. 99–551) which permitted non-low-income persons to become foster

grandparents. The non-low-income volunteers are reimbursed for out-of-pocket expenses only.

For fiscal year 1992, ACTION estimates that about 23,300 federally and nonfederally funded foster grandparents assisted approximately 21 million children with special or exceptional needs.

(3) Senior Companion Program

The Senior Companion Program (SCP) was authorized in 1973 by Public Law 93-113 and incorporated under Title II, section 211(b) of the Domestic Volunteer Service Act of 1973. The Omnibus Budget Reconciliation Act of 1981 amended section 211 of the Act to create a separate Part C containing the authorization for the Senior Companion Program. This program is designed to provide part-time volunteer opportunities for low-income persons 60 years and older to assist them in providing supportive services to vulnerable, frail older persons. Like the FGP, the 1986 Amendments (P.L. 99-551) amended SCP to permit non-low-income volunteers to participate without a stipend, but reimbursed for out-of-pocket expenses. The volunteers help homebound, chronically disabled older persons to maintain independent living arrangements in their own residences. Volunteers also provide services to institutionalized older persons and seniors enrolled in community health care programs. Senior companions serve 20 hours a week and receive the same stipend and benefits as foster grandparents. To participate in the program, low-income volunteers must meet the same income test as for the Foster Grandparent Program.

In fiscal year 1992, about 11,900 SCP volunteers served in 143 projects, including volunteers in non-federally funded projects. ACTION estimates that these volunteers served almost 30,000 persons.

(B) VOLUNTEERS IN SERVICE TO AMERICA

Volunteers in Service to America (VISTA) was originally authorized in 1964, conceived as a domestic peace corps for volunteers to serve full-time in projects designed to reduce poverty. Today, VISTA still holds this mandate. Volunteers 18 years and older serve in community activities to reduce or eliminate poverty and poverty-related problems. Activities include assisting the handicapped, the homeless, the jobless, the hungry, and the illiterate or functionally illiterate. Other activities include addressing problems related to alcohol abuse and drug abuse, and assisting in economic development, remedial education, legal and employment counseling, and other activities that help communities and individuals become self-sufficient. Volunteers also serve on Indian reservations, in federally assisted migrant worker programs, and in federally assisted institutions for the mentally ill and mentally retarded.

Volunteers are expected to work full-time for a minimum of 1 year, but they may serve for up to 5 years. To the maximum extent possible, they live among and at the economic level of the people they serve. Volunteers are reimbursed for certain travel expenses and receive a subsistence allowance for food, lodging, and incidental expenses. The subsistence allowance may not be less than 95 percent of the poverty line for the area in which the volunteer is

serving. They also receive health insurance and a monthly stipend not to exceed $75 ($90 in fiscal year 1991; $95 in subsequent years) that is paid in a lump sum at the end of their service. The 1989 reauthorization legislation requires that at least 20 percent of the volunteers fall into each of two age categories: (a) persons 55 years and older and (b) persons 18-27 years old.

2. Issues

In recent years, there has been a strong resurgence of interest in the role that volunteers can play in both the public and the private nonprofit community service delivery system. Volunteer service has been a traditional means by which individuals and organizations have helped to meet social and cultural needs in society. Historically, voluntarism has been thought of as a commitment of time and resources to institutions and organizations such as hospitals, nursing homes, shelters for the homeless and abused, schools, churches, and other social service agencies. More recently, volunteer service has included activities for grassroots political advocacy and community improvement programs. In many communities, the need to address the problems of poverty and to utilize the skills and experiences of elderly volunteers continues, notably the elderly. Despite the interest among volunteer programs to utilize elderly volunteers, there has been relatively little structured evaluation of ways to achieve this goal.

In the Domestic Volunteer Service Act Amendments of 1984 (P.L. 98-288), Congress authorized senior companion demonstration projects to explore ways in which the Senior Companion Program could serve the growing population of frail homebound older persons at high risk of institutionalization. To accomplish this, SCP was authorized to recruit unpaid community volunteers to train senior companions and to use senior companion volunteer leaders (SCVLs) to assist other older persons in need. Grants were awarded to 19 new SCP projects and 17 new components of existing SCP projects at the beginning of fiscal year 1986.

In a search for public policy to meet the long-term care needs of the rapidly increasing older population, Congress mandated an evaluation of the demonstration projects, identifying five issues:

(1) The extent to which the costs of providing long-term care are reduced by using SCP volunteer companions, who receive modest stipends, to assist the frail elderly living at home;

(2) The effectiveness of long-term care services provided by volunteers;

(3) The extent to which the health care needs and health-related costs of the volunteer companions are affected by their participation in SCP;

(4) The extent of SCP project coordination with other Federal and State efforts aimed at enabling older individuals to receive care in their own homes; and

(5) The effectiveness of using Senior Companion Volunteer leaders and volunteer trainers.

The evaluation of the new projects, completed in 1988, points out that SCP services supplement and augment long-term care services from other sources, rather than replace them. Nevertheless, the

projects proved to be a relatively low-cost means of providing needed services to frail older persons who generally could not afford to purchase them. However, cost containment is not the only rationale for developing long-term care policy. Improving the quality of life and well-being of the elderly are also major long-term care goals.

The value of the program to the senior companions is demonstrated by the economic benefit of the stipend and the senior companions' high degree of social integration and well-being. Senior companions generally benefit from training by volunteers. Preservice as well as in-service training is already a requirement of the Senior Companion Program. It is unclear whether the benefits of utilizing volunteer trainers differ significantly from paid staff trainers.

The position of Senior Companion Volunteer Leaders (SCVL) was not successfully implemented in many of the projects due to a concern among project staffs that the position created a hierarchy among the volunteers, that jeopardized senior companion relationships. Senior companions were generally found to provide informal support services for each other regardless of the presence of SCVLs. The evaluation also found that the most significant impediment to matching companions and clients in the projects, urban or rural, was the lack of access to transportation, another issue to be addressed in implementing long-term care policy.

A major concern for successful continuation of the programs is the need for increased funding support for administration of the projects. Due to administrative restrictions, past cost-of-living increases for the Older Americans Volunteer Programs have resulted in an expansion of volunteer services without a corresponding increase for administrative costs. Consequently, for over 10 years, project directors have been faced with the increasingly difficult task of supervising a greater number of volunteers without additional support.

3. Federal Response

Congress enacted the Domestic Volunteer Service Act Amendments of 1989 (P.L. 101-204). These amendments reauthorized all ACTION agency programs through 1993 and made several minor changes in existing law. Two major provisions designed to increase volunteer recruitment specifically require ACTION to establish a VISTA recruitment program and to reserve a portion of its annual budget for recruitment activities.

The 1989 Amendments established the following authorization levels for older American volunteer programs through 1993: VISTA ($30.6 million, FY 1990; $39.9 million, FY 1991; $47.8 million, FY 1992; $56 million, 1993), RSVP ($39.9 million, FY 1990; $43.9 million, FY 1991; $48.3 million, FY 1992; $53.1 million, FY 1993), Foster Grandparents Program ($70.8 million, FY 1990; $80.9 million, FY 1991; $91.7 million, FY 1992; $98.2 million, FY 1993), and the Senior Companion Program ($36.6 million, FY 1990; $39 million, FY 1991; $44.7 million, FY 1992; $48.7 million, FY 1993).

FY 1993 appropriations for older American volunteer programs are as follows: VISTA ($34.9 million), RSVP ($33.7 million), Foster

Grandparents Program ($65 million), and Senior Companion Program ($28.5 million).

Congress did not make any changes in the ACTION programs in 1992. Advocates and policymakers will continue to monitor how well ACTION implements the 1989 Amendments, particularly the VISTA recruitment provisions and work toward the 1994 reauthorization.

D. TRANSPORTATION

1. BACKGROUND

Transportation is a vital connecting link between home and community. For the elderly and nonelderly alike, adequate transportation is necessary for the fulfillment of most basic needs—maintaining relations with friends and family, commuting to work, grocery shopping, and engaging in social and recreational activities. Housing, medical, financial, and social services are useful only to the extent that transportation can make them accessible to those in need.

Transportation serves both human and economic needs. It can enrich an older person's life by expanding opportunities for social interaction and community involvement, and it can support an individual's capacity for independent living, thus reducing or eliminating the need for institutional care.

Three strategies have marked the Federal Government's role in providing transportation services to the elderly:

(1) Direct provision (funding capital and operating costs for transit systems);

(2) Reimbursement for transportation costs; and

(3) Fare reduction.

In fiscal years 1981–89, the Reagan Administration proposed to eliminate or substantially reduce Federal operating subsidies to states for transportation programs. This proposal was indicative of the trend to shift fiscal responsibility for transportation programs to the States and of a general retrenchment on the part of the Federal Government to support further transportation systems. The Bush Administration continued to substantially reduce operating subsidies in its annual budgets.

The major federally sponsored transportation programs that provide assistance to the elderly and handicapped are administered by the Department of Health and Human Services (HHS) and the Department of Transportation (DOT). Under HHS, a number of programs provide specialized transportation services for the elderly, including Title III of the Older Americans Act (OAA), the Social Services Block Grant Program (SSBG), the Community Services Block Grant Program (CSBG) and Medicaid, which will to a limited extent reimburse elderly poor for transportation costs to medical facilities. Under CSBG, more dollars (approximately 32 percent) have been spent on so-called linkages with other programs—including transportation for the elderly and handicapped to senior centers, and community and medical services—than on any other program category.

The passage of the OAA of 1965 has had a major impact on the development of transportation for older persons. Under Title III of the Act, States are required to spend an adequate proportion of their Title III-B funds on three categories: access services (transportation and other supportive services); in-home, and legal services. According to an Administration on Aging report, in fiscal year 1991, 1,067,480 persons were recipients of transportation services under the OAA. Approximately 10 percent of OAA funds are used for transportation services. This level of participation and funding indicates the demand for transportation services by the elderly at the local level and the extent to which this network of supportive services provides assistance and relief to needy elderly nationwide.

The passage of the 1970 amendments to the Urban Mass Transit Act (UMTA) of 1964 (P.L. 98-453), which added Section 16, marked the beginning of special efforts to plan, design, and set aside funds for the purpose of modifying transportation facilities to improve access for the elderly and handicapped. Section 16 of UMTA declares a national policy that elderly and handicapped persons have the same rights as other persons to utilize mass transportation facilities and services. Section 16 also states that special efforts shall be made in the planning and design of mass transportation facilities and services to assure the availability of mass transportation to the elderly and handicapped persons, and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. The goal of Section 16 programs is to provide assistance in meeting the transportation needs of elderly and handicapped persons where public transportation services are unavailable, insufficient or inappropriate.

Another significant initiative was the enactment of the National Mass Transportation Assistance Act of 1974 (P.L. 93-503) which amended UMTA to provide block grants for mass transit funding in urban and nonurban areas nationwide. Under the program, block grant money can be used for capital operating purchases at the localities' discretion. The Act also requires transit authorities to reduce fares by 50 percent for the elderly and handicapped during offpeak hours.

In addition, passage of the Surface Transportation Assistance Act (STAA) of 1978 (P.L. 95-549) provided Federal funding under Section 18 which supports public transportation program costs, both operating and capital, for nonurban areas. Elderly and handicapped people in rural areas benefit significantly from Section 18 projects because they generally are more isolated and in greater need of transportation assistance. Section 18 has received annual appropriations of approximately $65 to $75 million since fiscal year 1979.

The STAA of 1982 (P.L. 97-424) established Section 9 in its amendments to the UMTA Act. Section 9, a block grant program, replaces the former Section 5 program (urban formula grants) and incorporates funding to continue the Section 18 program. Section 9 provides assistance to the public in general, but some of its provisions are especially important to elderly and handicapped persons. Section 9 continues the requirement that recipients of Federal mass transit assistance offer half-fares to elderly and handicapped people during nonpeak hours. Each year, between $10 million and

$20 million of Section 9 funds have been transferred to the Section 18 program.

Through FY 1992, Congress has appropriated approximately $5 million each year for the Rural Transit Assistance Program (RTAP) which was set up to provide training, technical assistance, research and related support service for providers of rural public transportation. The Federal Transit Administration allocates 85 percent of the funds to the States to be used to develop State rural training and technical assistance programs. By the end of fiscal year 1989, all States had approved programs underway. The remaining 15 percent of the annual appropriation supports a national program, which is administered by a consortium led by the American Public Works Association and directed by an advisory board made up of local rural providers and State program administrators.

The programs administered by the Department of Health and Human Services have proven to be highly successful in providing limited supportive transportation services necessary to link needy elderly and handicapped persons to social services in urban and suburban areas. The Department of Transportation programs have been the major force behind mass transit construction nationwide and continue to provide basic funding for primary transportation services for older Americans. Recognizing the overlapping of funding and services, and the need for increased coordination, HHS and DOT established an interdepartmental Coordinating Council on Human Services Transportation in 1986. The Council is charged with coordinating related programs at the Federal level and promoting coordination at the State and local levels. As part of this effort, a regional demonstration project has been funded, and transportation and social services programs in all States are being encouraged to develop better mechanisms for working together to meet their transportation needs.

Despite these programs initiatives, federal strategy in transportation has been essentially limited to providing seed money for local communities to design, implement, and administer transportation systems to meet their individual needs. In the future, the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

With the reauthorization of the STAA (renamed the Intermodal Surface Transportation Act of 1991, ISTEA) in 1991, the importance of transportation was brought to the forefront of congressional and aging advocates' agendas. ISTEA created the Transit Cooperative Research Program (TCRP), the first federally funded cooperative research program exclusively for transit. The program is governed by a 25-member TCRP Oversight and Project Selection (TOPS) committee jointly selected by the Federal Transit Administration, the Transportation Research Board (TRB), and the American Public Transit Association (APTA). To date, the TOPS Committee has selected 32 issues to be researched among which include ADA transit service and delivery systems for rural transit, and demand forecasting for rural transit.

In July 1991, AARP and the National Association of Area Agencies on Aging released findings of a survey of area agencies regarding transportation services. The report revealed that a lack of financing compounded by the high cost of operating transportation systems is the largest barrier to meeting elderly transportation needs. Other barriers reported included high service provider costs, lack of client funds, high insurance costs, lack of client awareness, and area agencies reporting requirements.

In addition, the Administration on Aging (AoA) awarded a cooperative agreement to the Community Transportation Association of America to establish a National Eldercare Institute on Transportation. This initiative is a part of a National Eldercare Campaign initiated by AoA to help older persons maintain their independence and dignity.

In 1992, dominant topics in public transportation were accessibility and mobility. At the 6th International Conference on Mobility and Transport for Elderly and Disabled Persons (June, Lyon, France), participants agreed that mobility for the elderly and disabled is a basic civil right. The challenge remains to maximize scarce public resources and thereby increase the overall level of transit service.

2. Issues

(A) TRANSPORTATION AS ACCESS SERVICE

Medicare's Prospective Payment System (PPS) has placed increasing demands on transportation services. Under PPS, predetermined fixed payment rates are set for each Medicare hospital inpatient admission, based on the diagnosis-related group (DRG) into which that admission falls. This fixed payment is an incentive for hospitals to limit costs spent on Medicare patients either by reducing lengths of stay or the intensity of care provided. As a result, many older persons are being released from the hospital earlier and in need of more follow-up care than before the introduction of PPS. Consequently, State and area agencies on aging now are spending more of their transportation funds to transport older persons to dialysis and chemotherapy and less for grocery store and senior center transportation. One State, Kentucky, characterizes transportation as its top priority. This State conducted a survey which found that lack of transportation is a major barrier to mental health and social support services. Of those who had difficulty attending social activity programs, 52 percent cited the lack of transportation as the reason. This barrier results in less socialization and less satisfaction with life in general. It is anticipated that the demand for transportation services will increase.

TABLE 1.—LATENT DEMAND FOR TRANSPORTATION SERVICES OF POPULATION 65 AND OVER IN 2000

	Number of nondrivers	Trips per capita per year	Total annual trips
Urban		1,734.4	
Activity limitation:			
Unable to conduct major activity	821,730		1,425,208,582

TABLE 1.—LATENT DEMAND FOR TRANSPORTATION SERVICES OF POPULATION 65 AND OVER IN 2000—Continued

	Number of nondrivers	Trips per capita per year	Total annual trips
Limited in major activity	986,592		1,711,145,388
Limited but not in major activity	297,116		515,317,417
Unlimited	1,753,335		3,040,984,073
Suburban		1,734.4	
Activity limitation:			
Unable to conduct major activity	1,211,704		2,101,578,756
Limited in major activity	1,454,805		2,523,214,312
Limited but not in major activity	438,120		759,874,835
Unlimited	2,585,426		4,484,162,956
Rural		1,679.3	
Activity limitation:			
Unable to conduct major activity	1,058,500		1,777,538,568
Limited in major activity	1,270,864		2,134,162,587
Limited but not in major activity	382,725		642,710,544
Unlimited	2,258,533		3,792,754,649
Total number of trips taken because of lack of transportation			24,908,652,616

The lack of adequate transportation to social activities, the grocery store and the doctor can have serious consequences for the well-being and independence of many elderly. It also may set back some of the advancements in health that have been achieved through better access to services.

(B) RURAL TRANSPORTATION NEEDS

Generally, Federal transportation policy has not recognized the specialized needs of rural elderly. Specific recommendations were made during the 1971 White House Conference on Aging directed at improving transportation for the rural elderly. A mini-conference on transportation for the aging, which preceded the general conference, recommended that State transportation agencies play a central role in developing responsive rural systems, and that implementation of such systems be initiated at the local level. The conference also recommended greater citizen participation at the policymaking level, as well as at the advisory and implementation levels of transportation programs.

Transportation was cited as one of the major barriers facing the rural elderly in a 1984 report published by the Senate Special Committee on Aging. According to the report, an estimated 7 million to 9 million rural elderly lack adequate transportation, and as a result, are several limited in their ability to reach needed services. Lack of transportation for the rural elderly stems from several factors. First, the dispersion of rural populations over relatively large areas complicates the design of a cost-effective, efficient public transit system. In addition, the incomes of the rural elderly generally are insufficient to afford the high fares necessary to support a rural transit system. Also, the rising cost of operating vehicles and inadequate reimbursement have contributed to the decline in the numbers of volunteers willing to transport the rural elderly. Further, the physical design and service features of public transporta-

tion, such as high steps, narrow seating, and unreliable scheduling, discourage participation.

Lack of access to transportation in rural areas leads to an underutilization of programs specifically designed to serve older persons, such as adult education, congregate meal programs, and health promotion activities. Thus, the problems of service delivery to rural elderly are essentially problems of accessibility rather than program design.

In August 1990, the Special Committee on Aging conducted a field hearing in Little Rock, Arkansas. The hearing, chaired by Senator Pryor, addressed a number of long-term care issues, including the transportation programs under Title III of the Older Americans Act. The hearing further highlighted the need for senior transportation services, particularly in rural communities.

(C) SUBURBAN TRANSPORTATION NEEDS

The graying of the suburbs is a phenomenon that has only recently received attention from policymakers in the aging field. Since their growth following World War II, it has been assumed that the suburbs consisted mainly of young, upwardly mobile families. The decades that have since elapsed have changed entirely the profile of the average American suburb, resulting in profound implications for social service design and delivery. In 1980, for the first time, a greater number of persons over age 65 lived in the suburbs (10.1 million) than in central cities (8.1. million).

This aging of suburbia can be attributed to two major factors. First, migration has contributed to the growth of the older suburban population. It is estimated that for every person age 65 and older who moves back to the central city, three move from the central city to the suburbs. Second, many older persons desire to remain in the homes and neighborhoods in which they have grown old, i.e., "aging in place." The growth of the suburban elderly population is expected to continue to increase at an even more rapid rate in the future due to the large number of so-called pre-elderly (ages 50–64) living in the suburbs.

A 1988 national study conducted by the U.S. Conference of Mayors (USCM) and the National Association of Counties (NACo) of the 260 metropolitan statistical areas identified three priority concerns of the suburban elderly: home and community-based care, housing, and transportation. The availability of transportation services for the elderly suburban dweller is limited. Unlike large cities where dense population patterns can facilitate central transit systems, the lack of a central downtown precludes development of a coordinated mass transit system in most suburbs. The sprawling geographical nature of suburbs makes the cost of developing and operating mass transportation systems prohibitive. Private taxi companies, if they operate in the outlying suburban areas at all, are usually very expensive. Further, the trend toward retrenchment and fiscal restraint by the Federal Government has impacted significantly on the development of transportation services. Consequently, Federal support for primary transit systems designed especially for the elderly suburban dweller is almost nonexistent. State and local governments have been unable to harness sufficient re-

sources to fund costly transportation systems independent of Federal support. Alternative revenue sources, such as user fees, are insufficient alone to support suburbanwide services, and are generally viewed as penalizing those most in need of transportation services in the community—the elderly poor.

The aging of the suburbs has several implications for transportation policy and the elderly. The dispersion of older persons over a suburban landscape poses a challenge for community planners who have specialized in providing services to younger, more mobile dwellers. Transportation to and from service providers is a critical need. Institutions that serve the needs of elderly persons, such as hospitals, senior centers, and convenience stores, must be designed with supportive transportation services in mind. In addition, service providers must provide transportation services for their elderly clients. Primary transportation systems, or mass transit, must ensure accessibility from all perimeters of the suburban community to adequately serve the dispersed elderly population. The demand for transportation services should be measured to determine the feasibility of alternative systems, such as dial-a-ride and van pools. Alternative funding mechanisms, such as reduced fares, user fees, and the local tax base, need to be examined for equity and viability. Also, the public should be informed of the transportation services available through a coordinated public information network within the community.

The aging suburb trend will increase in the decades to come. It is clear that to the extent that the elderly are denied access to transportation, they are denied access to social services. If community services are to meet the growing social and economic needs for the older suburban dweller, transportation planning and priorities will demand re-examination.

(D) SAFETY

The automobile remains the primary means of transportation for the entire country, including older persons. More than 80 percent of trips by persons age 65 and over are made in automobiles and that percentage is increasing.

A 1988 study by the Transportation Research Board (TRB) on the mobility and safety of older drivers found that up through age 75, most older drivers have good driving records and appear to perform as well as middle-aged drivers. However, although they are involved in a small number of crashes, after age 75, older drivers are about twice as likely to be involved in a crash per mile driven. In addition, older persons are among the most vulnerable to injury in motor vehicle crashes. Automobile occupants age 65 and older are more than three times as likely to die than a 20-year-old occupant from serious injuries of equal severity. The study emphasizes that because it is not a predictor of performance, age alone should not be the basis for restricting or withholding driver's licenses.

The TRB report does recommend changes in roadway design and operation to improve the safety of not only older, but all drivers. For example, current sign legibility standards assume a level of visual ability that many older persons cannot meet. Safety could be enhanced by larger and brighter road signs.

More recently, the National Institute on Aging reported that the accident rate for older drivers fell during the 1980's. Automobile deaths, however, have increased significantly suggesting that older drivers may be particularly vulnerable when crashes do occur.

With the increasing number of older drivers on the roads, several States are examining ways to improve the automobile-traffic system. In 1990, the California Department of Motor Vehicles (DMV) began planning for new night and peripheral vision tests, video simulation exercises and longer, more complex written examinations. Although couched as the State's effort to assure competence of all drivers, and not just the elderly, aging advocates carefully monitored the proposed changes for signs of illegal age discrimination.

Walking is second in importance to driving as a mode of transportation for older persons. For those older persons without driver licenses, between 20 and 40 percent of all their trips are made by walking. Yet many suburban environments do not provide for safe walking; pedestrian crossings are frequently not available and signals are often set to maintain a high volume of auto traffic. In addition, signal timing assumes a walking speed faster than that of many older pedestrians.

3. Federal and State Responses

(A) Federal

In 1990, there were significant developments in transportation programs affecting the elderly and disabled. The passage of the Americans with Disabilities Act (ADA) in July 1990 placed additional responsibilities on Section 18 agencies, both private, nonprofit, and public. These agencies are now required to accommodate the needs of the disabled. In addition, the regulation includes private for-profit companies under contract to provide Section 18 services. Under the final rule published, however, most Section 18 recipients that are private entities (nonprofit or for-profit) will be exempt from the paratransit requirement unless the private entity has a contractual relationship with a local public body.

The 102nd Congress also enacted a number of significant initiatives pertaining to senior transportation. The reauthorization of the Surface Transportation Act through 1997 (H.R. 2950, P.L. 102–240) provides a number of important changes for the elderly and disabled. The law, which renames UMTA the Federal Transit Administration, includes a substantial increase in funding for programs benefiting elderly and disabled persons. Specifically, the new law authorizes the Section 16 programs at $55 million for FY 1992; $70.1 million for FY 1993; $68.7 million for FY 1994–FY 1996; and $97.2 million for FY 1997. For the Rural Transit Assistance Program, the bill authorizes $5 million for FY 1992; $7.9 million for FY 1993; $7.7 million for FY 1994–FY 1996; and $10.9 million for FY 1997.

Key provisions of P.L. 102–240 include: (1) allows paratransit agencies to apply for Section 3 capital funding for transportation projects that specifically address the needs of elderly and disabled persons; (2) establishes a rural transit set aside of 5.5 percent of Section 3 funds allocated for replacement, rehabilitation, purchase

of buses and related equipment, and the construction of business related facilities; and (3) allows transit service providers receiving assistance under Section 16(b) or Section 18 to use vehicles—under certain restrictions—for meal delivery service for homebound persons.

The Older Americans Act 1992 amendments (H.R. 2967, P.L. 102-375) also propose changes dealing with transportation services. The new law requires area plans under Title III to identify the needs and describe methods to be used to coordinate planning and delivery of transportation services. It also requires State plans to assure that the State will coordinate public services within the State to assist older individuals to obtain transportation services. In addition, P.L. 102-375 includes provisions initiated by Chairman Pryor, which would: (1) provide grants to States for developing comprehensive and coordinated senior transportation systems; and (2) provide grants to area agencies on aging for leveraging additional resources to deliver transportation services and coordinating the resources available for such services.

The transportation appropriations bill for fiscal year 1993 (P.L. 102-388) provides the Federal Transportation Administration with its highest funding level since 1985. The bill appropriates over $650 million for Sections 9, 16(b)(2), and 18 of the Federal Transit Act.

(B) STATES

As an indication of concern about transportation issues, the Council of State Governments created the Center for Transportation in 1986 to function as a State policy research think-tank. A survey by the Center reveals that at least 40 States have responded to the issue of coordination of locally designed services by creating either voluntary or legislatively mandated interagency coordination committees. In addition, 9 States impose mandatory coordination on local providers. It is hoped that provisions in P.L. 102-375 initiated by Senator Pryor will aid State and local efforts toward coordination of services.

Montana, for example, has developed a coordinated interagency approach for purchasing vehicles. As the lead agency, the Department of Commerce works to ensure that vehicles are shared by those agencies that need them at the local level. Local technical advisory committees also review and recommend transportation providers and purchasers of services in the community, including the area agencies on aging. In Florida, the Coordinating Council for the Transportation Disadvantaged oversees and develops transportation policy affecting about 4 million elderly, low-income and handicapped residents who need transportation assistance. Approximately $41 million is being spent for these services in all 67 counties of the State. Each county has designated a single provider to coordinate these services.

More recently, Kansas passed the Kansas Coordinated Transit Act to organize the State's numerous agencies, reducing duplicative service and maximizing vehicle usage.

E. LEGAL SERVICES

1. Background

(a) The Legal Services Corporation

Legislation establishing the Legal Services Corporation (LSC) was enacted in 1974. Previously, legal services had been a program of the Office of Economic Opportunity, added to the Economic Opportunity Act in 1966. Because litigation initiated by legal services attorneys often involves local and State governments or controversial social issues, legal services programs can be subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, the Nixon Administration developed legislation creating a separate, independently housed corporation. The Legal Services Corporation was then established as a private, nonprofit corporation headed by an 11 member board of directors, nominated by the President and confirmed by the Senate. No more than 6 of the 11 board members, as directed in the Corporation's incorporating legislation, may be members of the same political party as the President.

The Corporation does not provide legal services directly. Rather, it funds local legal aid programs which are referred to by LSC as "grantees". Each local legal service program is headed by a board of directors, of whom 60 percent are lawyers admitted to a State bar.

Legal services provided through Corporation funds are available only in civil matters and to any individual with an income no higher than 125 percent of the Office of Management and Budget poverty line. The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. Legal services cases deal with a variety of issues including: family related, such as divorce and separation, child custody and support, and adoption; housing problems, primarily landlord-tenant disputes in nongovernment subsidized housing; problems with welfare or other income maintenance programs, and consumer and finance problems; and individual rights, employment, health, juvenile, and education. Most cases are resolved outside the courtroom. LSC attorneys do their primary representation of the elderly in government benefit programs such as Social Security and Medicare.

The Corporation funds 23 national and State support centers, which provide specialized expertise in various aspects of poverty law. Three of these centers are specifically involved in issues that confront older people: the National Senior Citizens Law Centers, in Los Angeles and Washington, D.C.; and Legal Counsel for the Elderly, in Washington, D.C. In addition, LSC currently is funding 21 law school clinical programs to assist eligible clients during the academic year 1992-93. Some of these programs focus exclusively on the elderly.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several other restrictions have since been added in appropriations measures. These include, among others, limitations on lobbying, class actions, and political activities, and prohibitions on the use of Corporation funds

to provide legal assistance in proceedings that seek nontherapeutic abortions or that relate to school desegregation. In addition, if a recipient of Corporation funds also receives funds from private sources, the latter funds may not be expended for any purpose prohibited by the Act. Funds received from other public sources, however, may be spent "in accordance with the purposes for which they are provided."

The appropriations statute for fiscal year 1992 (P.L. 102-140) provided that "none of the funds appropriated by this Act for the Legal Services Corporation shall be expended for any purpose prohibited or limited by or contrary to any of the provisions of . . ." the appropriations statute for fiscal year 1991 (P.L. 101-515). P.L. 101-515 prohibited the use of Federal funds "to participate in any litigation with respect to abortion." It also limited the use of Federal funds for class actions, lobbying, representing illegal aliens, and other matters.

(B) OLDER AMERICANS ACT

Support for legal services under the Older Americans Act (OAA) was a subject of interest to both the Congress and the Administration on Aging (AoA) for several years preceding the 1973 amendments to the OAA. There was no specific reference to legal services in the initial version of the OAA in 1965, but recommendations concerning legal services were made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973 made legal services eligible for funding under Title III of the OAA. Subsequent reauthorizations of the OAA contained provisions relating to legal services. In 1975, amendments granted legal services priority status. The 1978 Amendments to the OAA established a funding mechanism and a program structure for legal services. The 1981 amendments required that area agencies on aging spend "an adequate proportion" of social service funding for three categories, including legal services, as well as access and in-home services, and that "some funds" be expended for each service. The 1984 amendments to the Act retained the priority, but changed the term to "legal assistance", and required that an "adequate proportion" be spent on "each" priority service. In addition, area agencies were to annually document funds expended for this assistance.

A survey by the Center for Social Gerontology in Michigan conducted prior to the 1987 reauthorization of the Act found that 40 States had no specific policy or definition of "adequate proportion" for each of the priority services. Consequently, the 1987 amendments specified that each State unit on aging must designate a "minimum percentage" of Title III social services funds that area agencies on aging must devote to legal assistance and the other two priority services. If an area agency expends at least the minimum percentage set by the State, it will fulfill the adequate proportion requirement. Congress intended the minimum percentage to be a floor, not a ceiling, and has encouraged area agencies to devote additional funds to each of these service areas to meet local needs.

The OAA also requires area agencies to contract with legal services providers experienced in delivering legal assistance and to involve the private bar in their efforts. If the legal assistance grant

recipient is not a LSC grantee, coordination with LSC-funded programs is required.

Another mandate under the OAA requires State agencies on aging to establish and operate a long-term care ombudsman program to investigate and resolve complaints made by or on behalf of residents of long-term care facilities. The 1981 amendments to the OAA expanded the scope of the ombudsman program to include board and care facilities. The 1987 amendments require States to ensure ombudsmen protection from liability, willful interference, and retaliation in the good faith performance of their duties. In many States and localities, there is a close and mutually supportive relationship between State and local ombudsman programs and legal services programs.

The AoA has stressed the importance of such a relationship and has provided grants to States designed to further ombudsman, legal, and protective services activities for older people and to assure coordination of these activities. State ombudsman reports and a survey by the American Association of Retired Persons conducted in 1987 indicate that through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to the records of residents and facilities; provide consultation to ombudsmen on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs, and work with ombudsmen and others to change policies, laws, and regulations that benefit older persons in institutions.

In other initiatives under the OAA, the Administration on Aging began in 1976 to fund State legal services developer positions—attorneys, paralegals, or lay advocates—through each State unit on aging. These specialists work in each State to identify interested participants, locate funding, initiate training programs, and assist in designing projects. They work with legal services offices, bar associations, private attorneys, paralegals, elderly organizations, law firms, attorney generals, and law schools.

In addition, the 1984 amendments also mandated that AoA fund national legal support centers. In fiscal year 1992, AoA awarded funds for legal services to support the following organizations: the National Senior Citizens Law Center; Legal Counsel for the Elderly (sponsored by the American Association of Retired Persons); the ABA's Commission on Legal Problems of the Elderly; the Center for Social Gerontology; the Pension Rights Center; the National Clearinghouse for Legal Services, Inc.; the Mental Health Law Project; and the National Bar Association.

Today, OAA funds support over 600 legal programs for the elderly in greatest social and economic need. The 1987 amendments to OAA required that beginning in fiscal year 1989, the Commissioner collect data on the funds expended on each type of service, the number of persons who receive such services, and the number of units of services provided. For fiscal year 1991, AoA data show that $18.9 million of Title III funds were expended on legal services, serving 323,482 persons.

In 1990, the Special Committee on Aging surveyed all State offices on aging regarding Title III funded legal assistance. Key findings of the survey include: (1) 18 percent of States contract with law school programs to provide legal assistance under Title III–B of

the Act and 35 percent contract with nonattorney advocacy programs to provide counseling services; (2) a majority of States polled (34) designate less than 3 percent of their Title III-B funds to legal assistance; (3) minimum percentage of Title III-B funds allocated by area agencies on aging to legal assistance ranged from 11 percent down to 1 percent; and (4) only 65 percent of legal services developers are employed on a full time basis and only 38 percent hold a law degree.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, either provide services directly or contract with public and nonprofit social service agencies to provide social services to individuals and families. In general, States determine the type of social services to provide and for whom they shall be provided. Services may include legal aid. Because the Omnibus Budget Reconciliation Act of 1981 eliminated much of the reporting requirements previously included in the Title XX program, little information is available on how States have responded to both funding reductions and changes in the legislation. As a result, little data is available on the number and ages of persons being served. Advocates of legal services, however, believe that Social Service Block Grant funding for legal services is limited.

2. ISSUES

(A) NEED AND AVAILABILITY OF LEGAL SERVICES

The need for civil legal services for the elderly, especially the poor elderly, is undeniable. This is partially due to the complex nature of the programs upon which the elderly are dependent. After retirement, most older Americans rely on government-administered benefits and services for their entire income and livelihood. For example, many elderly persons rely on the Social Security program for income security and on the Medicare and Medicaid programs to meet their health care needs. These benefit programs are extremely complicated and often difficult to understand.

In addition to problems with government benefits, older persons' legal problems typically include consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to institutions, nursing home and probate matters. Legal representation is often necessary to help the elderly obtain basic necessities and to assure that they receive benefits and services to which they are entitled.

Due to the increasing victimization of seniors by consumer fraud artists, on September 24, 1992, the Special Committee on Aging convened a hearing entitled "Consumer Fraud and the Elderly: Easy Prey?" The Committee sought to determine whether senior citizens are easy prey for persons that seek to take their money. The evidence suggests that seniors are often the target of unscrupulous people that will sell just about anything to make a dollar. It matters little that the services or products that these individuals sell are of little value, unnecessary, or at times nonexistent.

The purpose of the hearing was to provide a forum for discussion of what various States are doing in combating consumer fraud that targets the elderly, and to examine what the Federal Government might do to support these efforts. The hearing focused not only on the broad issue of consumer fraud that targets older Americans, but more specifically, the areas of living trusts, home repair fraud, mail order fraud, and guaranteed giveaway scams.

The living trust scams involve individuals who tout the living trust as a better alternative to a will. Invariably, the scam artists do not follow the applicable State laws relating to trusts, do not give the full story about the differences between a will and a living trust, do not have estate planning attorneys involved in the process, and charge excessively high fees for drafting phony documents.

Generally, the home repair fraud scam involves an individual who approaches the victim at home and offers to make home repairs. A fee is agreed upon and some sort of work will be done, although in most instances it is less than quality work. At this point one of several things might happen: The scam artist can take the money and leave, explain the job was more involved than originally estimated and the final cost will be more, or indicate that they can make additional repairs for an additional fee.

Guaranteed giveaway scams involve companies that notify individuals that they have won a prize. However, the victim is conned into sending in money to claim the prize. The victim does receive a prize, but it is usually worth less than advertised and certainly worth less than the victim pays to receive the prize. The mail fraud involves situations where elderly women did not receive the shoes they ordered through the mail.

Clearly the increase in consumer fraud directed at the elderly demonstrates the need for continued efforts in this area. The States have generally taken the lead in addressing this kind of fraud through law enforcement and prosecution. As the hearing illustrated, however, the Federal Government needs to do more. The Legal Services Corporation is one of the weapons in the Federal arsenal to combat senior fraud by providing legal services to aid in prevention of consumer fraud.

Legal Services Corporation programs do not necessarily specialize in serving older clients but attempt to meet the legal needs of the poor, many of whom are elderly. Legal services are provided to people based on financial need. Eligibility is based on incomes up to 125 percent of the established poverty level. It is estimated that approximately 9 million persons over 60 are LSC-eligible.

There is no precise way of determining eligibility for legal services under the Older Americans Act because eligibility is based on economic and social need, but means testing for eligibility is prohibited. Nevertheless, a paper developed by several legal support centers in 1987 concluded that, in spite of advances in the previous 10 years, the need for legal assistance among older persons is much greater than available Older Americans Act resources can meet.

The availability of legal representation for low-income older persons is determined, in part, by the availability of funding for legal services programs. In recent years, there has been a trend to cut Federal dollars to local programs that provide legal services to the elderly. There is no doubt that older persons are finding it more

difficult to obtain legal assistance. When the Legal Services Corporation was established in 1975, its foremost goal was to provide all low-income people with at least "minimum access" to legal services. This was defined as the equivalent of two legal services attorneys for every 10,000 poor people. The goal of minimum access was achieved in fiscal year 1980 with an appropriation of $300 million, and in fiscal year 1981, with $321 million. This level of funding met only an estimated 20 percent of the poor's legal needs. Currently, the LSC is not even funded to provide minimum access. In most States, there is only 1 attorney for every 10,000 poor persons. In contrast, there are approximately 28 lawyers for every 10,000 person above the Federal poverty line.

The Private Attorney Involvement (PAI) project under LSC requires each LSC grantee to spend at least 12.5 percent of its basic field grant to promote the direct delivery of legal services by private attorneys, as opposed to LSC staff attorneys. The funds have been primarily used to develop pro bono panels, with joint sponsorship between a local bar association and a LSC grantee. Over 350 programs currently exist throughout the country. Data indicates that the PAI requirement is an effective means of leveraging funds. A higher percentage of cases were closed per $10,000 of PAI dollars than with dollars spent supporting staff attorneys.

It should be noted, however, that these programs have been criticized by Legal Services staff attorneys. They claim that they have been unjustifiably cited to support less LSC funding and to the diversion of cases from LSC field offices.

Cuts in funding have decreased the LSC's ability to meet clients' legal needs. Legal services field offices report have had to scale down their operations and narrow their priorities to focus attention on emergency cases, such as evictions or loss of means of support. Legal services offices must now make hard choices about who they serve.

The private bar is an essential component of the legal services delivery system for the elderly. The expertise of the private bar is considered especially important in areas such as wills and estates as well as real estate and tax planning. Many elderly persons, however, cannot obtain legal services because they cannot afford to pay customary legal fees. In addition, a substantial portion of the legal problems of the elderly stem from their dependence on public benefit programs. The private bar generally is unable to undertake representation in these matters because it requires familiarity with a complex body of law and regulations, and there is little chance of collecting a fee for services provided. Although many have cited the capacity of the private bar to meet some of the legal needs of the elderly on a full-fee, low-fee, or no-fee basis, the potential of the private bar has yet to be fully realized.

(B) LEGAL SERVICES CORPORATION

(1) Board Appointments

The Legal Services Corporation Act provides that "[t]he Corporation shall have a Board of Directors consisting of 11 voting members appointed by the President, by and with the advice and consent of the Senate, no more than 6 of whom shall be of the same

political party." Presidents Reagan and Bush regularly made recess appointments to the Board, avoiding the requirement of Senate approval. In January 1992, with Congress out of session, President Bush renamed 10 Board members whose previous recess appointments had expired; the 11th had been appointed during a summer recess.

(2) Status of Legal Services Corporation

Few people disagree that provision of legal services to the elderly is important and necessary. However, people continue to debate how to best provide these services. President Reagan repeatedly proposed termination of the federally funded Legal Services Corporation and the inclusion of legal services activities in a social services block grant. Funds then provided to the Corporation, however, were not included. This block grant approach was consistent with the Reagan Administration's goal of consolidating categorical grant programs and transferring decisionmaking authority to the States. Inclusion of legal services as an eligible activity in block grants, it was argued, would give States greater flexibility to target funds where the need is greatest and allowing States to make funding decisions regarding legal services would make the program accountable to elected officials.

The Reagan Administration also revived earlier charges that legal services attorneys are more devoted to social activism and to seeking collective solutions and reform than to routine legal assistance for low-income individuals. These charges resparked a controversy surrounding the program at the time of its inception as to whether Federal legal aid is being misused to promote liberal political causes. The poor often share common interests as a class, and many of their problems are institutional in nature, requiring institutional change. Because legal resources for the poor are a scarce commodity, legal services programs have often taken group-oriented case selection and litigation strategies as the most efficient way to vindicate rights. The use of class action suits against the government and businesses to enforce poor peoples' rights has angered some officials. Others protest the use of class action suits on the basis that the poor can be protected only by procedures that treat each poor person as a unique individual, not by procedures which weigh group impact. As a result of these charges, the ability of legal services attorneys to bring class action suits has been severely restricted.

The Reagan Administration justified proposals to terminate the Legal Services Corporation by stating that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. It was believed that this approach would allow States to choose among a variety of service delivery mechanisms, including reimbursement to private attorneys, rather than almost exclusive use of full-time staff attorneys supported by the Corporation.

Supporters of federally funded legal services programs argue that neither State nor local governments nor the private bar would be able to fill the gap in services that would be created by the abolition of the LSC. They cite the inherent conflict of interest and the

State's traditional nonrole in civil legal services which, they say, makes it unlikely that States will provide effective legal services to the poor. Many feel that the voluntary efforts of private attorneys cannot be relied on, especially when more lucrative work beckons. They believe that private lawyers have limited desire and ability to do volunteer work. Some feel that, in contrast to the LSC lawyers who have expertise in poverty law, private lawyers are less likely to have this experience or the interest in dealing with the types of problems that poor people encounter.

Defenders of LSC believe that the need among low-income people for civil legal assistance exceeds the level of services currently provided by both the Corporation and the private bar. Elimination of the Corporation and its funding could further impair the need and the right of poor people to have access to their government and the justice system. They also contend that it is inconsistent to assure low-income people representation in criminal matters, but not in civil cases.

The Bush Administration made few public statements regarding the LSC. The President did, however, include $317 million for the LSC in his fiscal year 1991 budget request, and for FY 1992 he included $327 million.

3. Federal and Private Sector Response

(A) LEGISLATION

(1) The Legal Services Corporation

The 1974 LSC Act was reauthorized for the first and only time in 1977 for an additional 3 years. Although the Reagan Administration requested no funding for the Legal Services Corporation for fiscal years 1981–88, and the legislation authorizing the LSC expired at the end of fiscal year 1980, the agency has operated under a series of continuing resolutions and appropriations bills, which have served both as authorizing and funding legislation. The Corporation is allowed to submit its own funding requests to Congress. In fiscal year 1985, Congress began to earmark the funding levels for certain activities to ensure that congressional recommendations were carried out. In addition to original restrictions, the legislation for fiscal year 1987 included language that provided that the legislative and administrative advocacy provisions in previous appropriations bills and the Legal Services Corporation Act of 1974, as amended, shall be the only valid law governing lobbying and shall be enforced without regulations. This language was included because the Corporation published proposed regulations that were believed to go far beyond the restrictions on lobbying which are contained in the LSC statute.

For fiscal year 1988, Congress appropriated $305.5 million for the LSC. Congress also directed the Corporation to submit plans and proposals for the use of funding at the same time it submits its budget request to Congress. This was deemed necessary because the appropriations committees had encountered great difficulty in tracing the funding activities of the Corporation and received very little detail from the Corporation about its proposed use of the funding request, despite repeated requests for this information.

The fiscal year 1988 appropriations bill also included a legislative formula governing the allocation of funds for grants and contracts among the basic field programs. In addition, the Corporation is prohibited from imposing requirements on the governing bodies of recipients of LSC grants that are additional to, or more restrictive than, provisions already in the LSC statute. This provision applies to the procedures of appointment, including the political affiliation and length of terms of office, and the size, quorum requirements, and committee operations of the governing bodies.

Congress appropriated $327 million for LSC in fiscal year 1991, earmarking over $280 million for basic field programs and $7.4 million for national support centers. Provisions effective in fiscal year 1991 that were continued from previous years' appropriations include restrictions on lobbying, class action suits, representation of aliens, language requiring prior notification of the Congress when regulations are to be promulgated. Restrictions concerning governing bodies of recipient programs and LSC enforcement of legislative and administrative advocacy containment will expire upon confirmation by the Senate of a Board of Directors who are nominated by President Bush.

During the 102d Congress, for the first time since 1981, the House and Senate considered legislation to reauthorize the Legal Services Corporation, S. 2870 and H.R. 2039 respectively. The House proposed amendments to the Act to further restrict the use of Corporation and private funds for lobbying and class actions, and to prohibit the use of such funds to represent illegal aliens, tenants facing eviction from a public housing project because of a drug conviction, or any party to a case involving Federal or State redistricting. The Senate bill differed from the House bill by not restricting program use of private, public, or lawyers' trust account funds. Both bills also contained provisions requiring LSC to conduct a study to determine the extent and effectiveness of legal assistance provided to older Americans by recipients and other grantees and contractors under the LSC Act. Although reauthorization legislation was considered by both the House and Senate, no legislation was enacted. Congress did, however, fund the LSC for FY 1993 at a level which exceeds its highest level of $350 million (FY 1992) by $7 million.

(2) Older Americans Act

In response to prior conflict between legal assistance providers and area agency staff over confidentiality and reporting, the 1987 amendments to the Older Americans Act (OAA) (P.L. 100-175) specifically provided that State and area agencies may not require Title III legal providers to reveal information that is protected by the attorney-client privilege.

The OAA 1987 amendments also required the State agency to establish a minimum percentage of Title III-B funds that each area agency must spend on legal services. In addition, prior to granting a waiver of this requirement, the State agency must provide a 30-day notice period during which individuals or providers may request a hearing, and must offer the opportunity for a hearing to any individual or provider who makes such a request. The confer-

ence report on the Act's amendments states that the minimum percentage is intended to be a floor, not a ceiling. Area agencies on aging are encouraged to devote additional funds to legal services, as well as access and in-home services, to meet local needs.

The OAA was up for reauthorization in 1991. In preparation for the reauthorization, the Special Committee on Aging convened a series of workshops, one of which focused on legal assistance. Based on the findings from an Aging Committee workshop series, Chairman Pryor introduced legislation (S. 974) which included provisions to strengthen legal assistance services authorized by the Act. Key provisions which were incorporated into the final reauthorization package (H.R. 2967, P.L. 102-375) include: (1) would require AoA to develop guidelines for area agencies to follow in choosing and evaluating legal assistance providers, and (2) would require area agencies to develop a model job description for the legal services developer position in order to clearly establish the appropriate role of the legal services developer.

(B) ACTIVITIES OF THE PRIVATE BAR

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

A relatively recent development in the delivery of legal services by the private bar has been the introduction of the Interest on Lawyers' Trust Accounts (IOLTA) program. This program allows attorneys to pool client trust deposits in interest bearing accounts. The interest generated from these accounts is then channeled to federally funded, bar affiliated, and private and nonprofit legal services providers. IOLTA programs have grown rapidly. There was one operational program in 1983. Today 47 States and the District of Columbia have adopted IOLTA programs that are bringing in funds at a rate of $42 million per year. An American Bar Association study group estimated that if the plan was adopted on a nationwide basis, it could produce up to $100 million a year. The California IOLTA program specifically allocates funds to those programs servicing the elderly. Although many of the IOLTA programs are voluntary, the ABA passed a resolution at its February 1988 meeting suggesting that IOLTA programs be mandatory to raise funds for charitable purposes.

Supporters of the IOLTA concept believe that there is no cost to anyone with the exception of banks, which participate voluntarily. Critics of the plan contend that it is an unconstitutional misuse of the money of a paying client who is not ordinarily apprised of how

the money is spent. Supporters point out that attorneys and law firms have traditionally pooled their client trust funds, and it is difficult to attribute interest to any given client. Prior to IOLTA, the banks have been the primary beneficiaries of the income. While there is no unanimity at this time among lawyers regarding IOLTA, the program appears to have value as a funding alternative.

In 1977, the president of the American Bar Association (ABA) was determined to add the concerns of senior citizens to the ABA's roster of public service priorities. He designated a task force to examine the status of legal problems and the needs confronting the elderly and to determine what role the ABA could play. Based on a recommendation of the task force, an interdisciplinary Commission on Legal Problems of the Elderly was established by the ABA in 1979. The Commission is charged with examining six priority areas: the delivery of legal services to the elderly; age discrimination; simplification of administrative procedures affecting the elderly; long-term care; Social Security; and housing. In addition, since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

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

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

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

A few corporate law departments also have begun to provide legal assistance to the elderly. For example, Aetna Life and Casualty developed a pro bono, legal assistance to the elderly program in 1981 through which its attorneys are granted up to 4 hours a week of time to provide legal help for eligible older persons. The Ford

Motor Company Office of the General Counsel also began a project in 1986 to provide pro bono representation to clients referred by the Detroit Senior Citizens Legal Aid Project.

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

F. PROGNOSIS

Despite Federal funding cutbacks, States will continue to spend as much of their block grant funds on social services for older persons as feasible. However, these expenditures will focus increasingly on emergency services rather than on coordinated long-term services. States will find it increasingly necessary to utilize multiple funding sources to support their programs for the elderly. The lack of data on how the funds are used may require reinstituting a reporting system.

The Stewart B. McKinney Homeless Assistance Act of 1987 marks the first major piece of legislation that has addressed the homelessness issue. It is hoped that the many programs initiated under various departments will begin to provide some relief to those who suffer from one of the more serious social issues in the country. Preliminary attempts to reach the homeless elderly have found that many of them are depressed, have problems with interpersonal relationships, and have difficulty with transitional housing. Strategies to reach the homeless elderly must be developed to go beyond the provision of temporary shelter.

A greater Federal effort might be made to define adult illiteracy and collect the data to determine the actual size and scope of the problem. Additional funding could be used to encourage research into programs that work and provide seed money for promising techniques. The complexity of the issue—and its relation to national productivity, security, and welfare—suggests the need for a Federal concern beyond program funding or public awareness campaigns.

The Older Americans Volunteer Programs and VISTA will continue to receive broad bipartisan support because these programs have proven to be cost-effective, with measurable human benefits as well.

In view of increasingly limited Federal participation in transportation services, the role of State and local governments in the transportation area will become of major significance to needy elderly and handicapped persons. States will need to reassess priorities and focus attention on replacing Federal funding through increased State or local taxes or simply eliminating certain services. Although private sector contributions have played a significant role in social service delivery, it is unlikely that this revenue

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source will be adequate to close the gaps opened by Federal budget cuts in the area of specialized transportation services. Another resource—volunteer activities—has always been important in providing transportation services to older Americans. A report for the Administration on Aging on the transportation problems of older Americans indicated that many agencies servicing the elderly already extensively use volunteers in their programs. Given the limited resources which may be anticipated over the next decade, efforts to increase the role of volunteers are likely to become increasingly important.

It is a basic tenet in our society that those who live under the law should also have an opportunity to use the law. Access to the legal system for all persons is basic to our democratic system of government and the fundamental purpose of the Legal Services Corporation Act. The federally funded legal services program represents a significant improvement in the system of dispensing justice in this country and has gone a long way to alleviate the harsh consequences of being poor and unable to afford legal services. If we are to continue to make progress in the goal of equal justice and access for all, adequate funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

While all of the Nation's social services programs provide a vital role in linking persons to needed services, there remains the difficulty of effectively tying the programs together. Despite the current trend toward coordinating various funding sources for programs, separate reporting requirements and other administrative obstacles continued to hinder these efforts in 1992. Advocates, however, are hopeful that the new administration and an invigorated economy will provide the support necessary to stimulate further efforts in this direction.

Chapter 11

SPECIAL POPULATIONS—WOMEN'S ISSUES

OVERVIEW

The Senate Special Committee on Aging continues to be committed to addressing the unique needs of special populations. While the four major ethnic minority groups—African Americans, Asian/Pacific Islanders, Native Americans, and Hispanics—have begun to receive greater attention, the Aging Committee has attempted to define "special populations" in a more inclusive sense—citing any group within the elderly community whose needs, concerns, and circumstances are not adequately addressed by generalized policies and services. Included in this group are women, ethnic minorities, the developmentally disabled, and the physically challenged.

1992 was touted as the "Year of the Woman," and there has been increased scrutiny given to the special needs of older women. During a 1992 International Day for the Elderly conference, convened at the United Nations, representatives from around the world agreed that the problems elderly women face are compounded by the fact that women outlive men throughout the world. Women's longevity impacts upon many issues of interest to Federal policymakers including caregiving concerns, health care issues, and financial security.

A. CAREGIVERS

Universally, women are the primary caregivers within families. Even in countries such as China where custom "dictates" that the oldest son will have caregiving responsibilities for the parents, inevitably the day-to-day chores of this task will be handled by the son's wife or daughter(s). Caregiving responsibilities fall on women in America as well—in their roles as wives and mothers, and frequently as care providers for older parents. Multiple caregiving roles leave many middle-aged women strapped for time, energy, and support. Research has shown that the most frequent problem encountered by caregivers is depression. More needs to be done to provide respite for overburdened caregivers. Unfortunately, after years of caregiving for others, some are left without support during their old-old years (80 and over), often forgotten in nursing homes. *Aging America: Trends and Projections* reports that 78 percent of older women lived alone in 1989, whereas men were five times more likely to live with a spouse or someone else.

Current demographic trends and projections show that caregiving concerns are going to be paramount in the future. Trends such as having fewer or no children, high divorce rates or adults who have never been married will have a tremendous impact on the

natural caregiver resource pool. This will undoubtedly increase the need for caregiver support systems.

B. WOMEN'S HEALTH ISSUES

Health care and disease prevention are priorities for all Americans. However, very little is known about diseases that are unique to women. Women are often omitted from clinical trials for new medicines and procedures—as are ethnic minorities, the elderly, and the young. Most often, the results of clinical studies reflect medical outcomes manifest in middle-aged white males.

In an effort to redress this bias in research, attempts have been made to correct omission of women as subjects of medical research. The National Institutes of Health (NIH) announced the Women's Health Initiative which will be the largest community-based clinical trial ever conducted. This project will involve 5 of the 12 institutes of NIH and take place over a 14-year span. The trial will study diet, dietary supplements, exercise, hormone therapy, and smoking cessation as prevention for cardiovascular disease, cancer, and osteoporosis in as many as 140,000 postmenopausal women.

Bernadine Healy, M.D., Director of the NIH, along with women's groups, and from Congress have been instrumental in making women's health a priority in the research community and bringing this issue to the attention of the public.

Three areas of research that will have a tremendous impact on the lives of older women are: breast cancer, ovarian cancer, and osteoporosis.

1. Breast Cancer

Cancer is a large group of diseases characterized by uncontrolled growth and spread of abnormal cells. For women, breast cancer is the second leading cause of cancer mortality behind lung cancer. The National Cancer Institute (NCI) estimates that approximately 46,000 women will die of breast cancer this year. In fact, one woman in nine will contract breast cancer during her lifetime. Researchers have asserted that breast cancer is most common in women of upper socioeconomic class; those who have never been married, those who live in urban areas; and women who reside in the northern region of the country.

A Congressional Research Service issue brief on breast cancer states that:

> "Women who have their first child before the age of 30 reduce their risk of breast cancer. Women with multiple pregnancies may decrease their risk of postmenopausal breast cancer; however, additional studies suggest an increase in cases of premenopausal breast cancer among such women. Lactation seems to decrease the risk, and the longer a woman breast feeds, the lower the risk of premenopausal breast cancer. The younger a woman is at the time of the first menstrual period, the higher the risk of breast cancer. Also, the later a woman experiences menopause, the more likely she is to develop breast cancer." There is also an increased risk associated with moderate alcohol consumption, especially in women who consumed alcohol in early adulthood.

During the 102nd Congress, the Mammography Quality Standards Act was enacted to ensure that all mammographies meet the same high quality standards for the early detection of breast cancer. Treatment for breast cancer depends on the type of cancer and whether or not it has spread to other parts of the body. Lumpectomy and radiation treatment are as effective as mastectomy in treating early-stage breast cancer. However, only 20 percent of women eligible for lumpectomy have this newer procedure. Women and their surgeons need to be more aware of this alternative. The 5-year survival rate in patients with localized breast cancer is 90 percent; if the cancer has spread, the survival rate is 60 percent.

2. Ovarian Cancer

Ovarian cancer is the fourth leading cause of cancer mortality in women. According to the NCI, 1 woman in 70 will contract ovarian cancer in her lifetime and 1 in 100 will die from this disease. Eighty percent of diagnosed cases occur in women over the age of 50. One in four tumors removed from the ovaries is malignant; however, this ratio increases with the age of the patient.

Ovarian cancer is difficult to diagnose because it often imitates other diseases. Because of the lack of distinguishable symptoms during the early stages of ovarian cancer, a majority of cases are not discovered until the disease has reached advanced stages. The NCI is supporting research to evaluate the usefulness of a protein called CA125 in the early detection of ovarian cancer. According to the Congressional Research Service, "preliminary results indicate that CA125 may be able to predict ovarian cancer in postmenopausal women. CA125 is currently in use as a marker in blood tests for monitoring women being treated for ovarian cancer; when the blood levels of CA125 rise, the cancer is probably recurring."

The drug taxol, which is made from Pacific yew trees, has been found to be effective in ovarian cancer patients whose tumors have recurred or are resistant to chemotherapy. The NCI is working to develop a synthetic version of taxol.

3. Osteoporosis

Osteoporosis is the principle bone disease found in postmenopausal women and the elderly. Osteoporosis causes bone mass decrease, which increases the risk that bones will fracture. Approximately 24 million Americans are affected by osteoporosis, and 80 to 90 percent of these are women. 1986 figures estimate that osteoporosis costs between $7 billion to $10 billion. Since the percentage of the population over the age of 65 is expected to rise, the prevalence of osteoporosis and related fractures is expected to increase and the cost is sure to skyrocket.

The cause of osteoporosis is unknown. However, several well-documented risk factors have been identified including: early menopause, female gender, Caucasian or Asian ethnicity, small body frame, prolonged periods of inactivity, excessive alcohol and caffeine consumption, smoking, and family history.

Current research indicates that the principal causes of osteoporosis are deficiencies of estrogen and calcium. Many noninvasive methods are being used to determine bone density in an effort to

diagnose the disease before bone fractures occur. Absorptiometry is a technique which measures bone density by measuring the number of photons that pass through the bone. The denser an individual's bones are, the more photons will be absorbed. At this time, there is no single standard form of measurement to indicate normal or abnormal results. Measurement results are dependent on numerous variables such as sex, age, race, site of measurement, and method of measurement.

Estrogen and calcium replacement are the principle prevention and treatment strategies to date. Estrogen Replacement Therapy (ERT) is currently the only postmenopausal therapy that has proven to be effective in preventing the bone loss that occurs during this time. However, ERT is associated with a number of serious side effects, including an increased risk of endometrial cancer and a possible increase in the risk of breast cancer. Longitudinal studies will be needed to determine the long-term risks and benefits of all potential osteoporosis preventions and treatments.

C. FINANCIAL SECURITY

As previously mentioned, women on average live longer than men and are more likely to live alone in their older years. Women are also more likely to live their final years in poverty. While most older (65 and older) men are married, most older women are either widowed or divorced. Half of all older women who live alone are poor or near poor.

Despite the attention received by a few women who have succeeded in high-paying male-dominated careers, most women continue to work in low paying positions in the three sectors which are traditionally dominated by females—sales, service, and clerical fields.

According to the Southport Institute for Policy Analysis, women of all ages continue to earn only 70 percent of what men earn. Part of the earnings gap for older women may be attributable to discriminatory employment practices on the basis of both sex and age. In order to meet the demands of family care, women often seek part-time employment. Part-time employment is often poorly paid and rarely offers health or retirement benefits, giving credence to the saying, "A paycheck away from poverty".

More needs to be done with respect to the inadequate retirement benefits women receive. The average Social Security benefits for women are low for three reasons:

1. Women do not earn Social Security credits for family care work.
2. Women's lower earning result in lower benefits.
3. Taking time out of the paid work force to provide family care are counted as "zero" years which in turn lowers benefits.

All too often there is a direct correlation between the quality of life and economic security. Balancing the benefits scales will pose both challenges and opportunities for law makers.

D. PROGNOSIS

The aging of the population presents challenges and opportunities for everyone. However, since women have a longer life expect-

ancy than men, a closer look at the impact aging has on women as a special population will undoubtedly benefit older Americans as a whole. Caregiving concerns, health care, and financial security are issues that face everyone. Due to societal norms, omission of women from clinical trials, and economic discrimination, elderly women have been forced to live out their final years alone, unhealthy, and in poverty.

The 102nd Congress ushered in a new-found respect and concern for women's health and income security issues. As the 103rd Congress gets underway, both Houses of Congress will focus continued attention on the special needs of women.

Chapter 12

FEDERAL BUDGET

OVERVIEW

A. BUDGET ACTION IN 1992

Action on the Federal budget in 1992 occurred under the spotlight of a Presidential campaign, the ongoing procedural constraints imposed by the 1990 budget agreement, and the strain of rapid changes in domestic and international conditions. These circumstances, along with the weakened economy and worsening deficit projections, led to confrontation between the President and Congress over budgetary matters in 1992.

Early in the year, with the economy in recession, Congress and the President faced increasing pressure to enact economic stimulus legislation. However, the deficit outlook had worsened considerably. Both OMB and CBO projected at the time that the fiscal year 1992 deficit would approach $400 billion, about $100 billion more than the record $269 billion deficit set in fiscal year 1991 (the actual fiscal year 1992 deficit was $290 billion). Though the deficit outlook was projected to improve appreciably by mid-decade, baseline deficits were projected to return to the $400 billion level by the end of the decade and steadily increase thereafter.

The weak economy combined with high deficits created a dilemma for lawmakers seeking to address economic problems. Any sizable economic stimulus package increasing spending or cutting revenues also would have to include spending or revenue offsets to avoid pushing the deficit higher, but including such offsets as part of the package likely would dampen the sought-after boost to the economy. Further, most of the major budgetary proposals high on the legislative agenda at the beginning of 1992, including those to create a national health care system, improve education, expand programs benefiting children, and increase funding for public works, would have added substantially to the deficit unless offset.

Lawmakers also were faced with procedural constraints under the Budget Enforcement Act of 1990 (BEA). In 1992, discretionary spending provided in annual appropriations acts could not exceed limits for separate categories of spending—defense, domestic, and international—established for fiscal year 1992 (in the case of supplemental appropriations acts) and fiscal year 1993 (in the case of regular or continuing appropriations acts). Mandatory spending and revenue legislation, under the "pay-as-you-go" (PAYGO) process established by the BEA, could not increase the combined net deficits for fiscal years 1992 and 1993. Legislation causing the discretionary spending limits to be exceeded or increasing the deficit

in violation of the PAYGO requirement would trigger automatic spending reductions, or sequestration, to offset any excess. Sequestration reductions, like deficit offsets enacted into law, would counter the intended effects of any major economic stimulus legislation or other major budgetary enactments. Only if both Congress and the President declared such legislation to be an emergency requirement would sequestration be avoided.

Though the President and a growing consensus within Congress agreed upon the need for legislative action to stimulate the economy and address other pressing problems, there was less agreement on the proper approach. Many were hopeful that the collapse of the Soviet Union in 1991 would lead to dramatic reductions in defense spending, the so-called peace dividend, which could then be used to stimulate the economy and boost domestic spending without increasing the deficit. Others felt that domestic economic conditions warranted broader use of the emergency exemption under the BEA, so that legislative initiatives for stimulating the economy could be enacted without offsetting deficit reductions.

1. Breaking Down the "Firewalls"

Since late 1991, efforts had been underway to merge the separate discretionary categories for fiscal years 1992 and 1993 set by the BEA (1993 is the last year for which separate categories are established) to take advantage of the change in defense spending requirements caused by the decline and fall of the Soviet Union. By eliminating the so-called "firewalls" between the discretionary spending categories, lawmakers could shift savings in defense spending to domestic programs without the threat of sequestration as long as total discretionary spending remained under the combined caps for all discretionary spending.

Support for eliminating the firewalls accelerated in 1992. Early in the year, CBO estimated that leaving the separate discretionary categories and accompanying spending limits in place would mean that total domestic discretionary spending for fiscal year 1993 would have to be frozen at fiscal year 1992 levels to remain within the domestic discretionary spending limits.

Both the President, in his fiscal year 1993 budget, and Congress, in its fiscal year 1993 budget resolution, set defense spending for fiscal year 1993 at levels billions of dollars below the BEA limits (see following discussion). However, the President and Congress differed over both the appropriate amounts of defense spending reductions and the purposes to which savings from such reductions should be applied.

Legislation was introduced in both the House and Senate to eliminate the separate discretionary categories. However, the House and Senate considered and rejected these measures in March, before final action on the congressional budget resolution. In the House, H.R. 3732 was rejected on March 31 by a vote of 187–238. In the Senate, S. 2399 was rejected on March 26 by virtue of the Senate's failure to invoke cloture (by a vote of 50–48) on the motion to proceed to its consideration.

2. The President's Fiscal Year 1993 Budget

On January 29, the President submitted his fiscal year 1993 budget. The President indicated his willingness to use defense savings to offset his other budget proposals (principally his proposed increase in the personal income tax exemption) and to amend the BEA to accommodate such offsets as long as Congress agreed to extend the discretionary spending caps into future years and make other changes in BEA procedures.

The President also proposed a series of changes in the tax code to stimulate the economy, including a capital gains tax cut, tax credits for research and development and for first-time home buyers, an investment tax credit, and other changes. He proposed a freeze on domestic discretionary spending and an overall cap on entitlement and other mandatory spending programs similar to the discretionary spending limits established in the BEA.

During his State of the Union address on January 28, the day before submitting his fiscal year 1993 budget, President Bush challenged Congress to act on his tax proposals for short-term economic stimulus by March 20 or, if not, to understand that "from the day after that, if it must be: the battle is joined."

3. The Congressional Budget Resolution

The budget resolution for fiscal year 1993, H. Con. Res. 287, was adopted by the House on March 5 and by the Senate on April 10, 1992 (the Senate first considered S. Con. Res. 106). On May 21, both Houses adopted the conference report (H. Rept. 102–529, May 20, 1992), thereby completing action on the budget resolution.

To provide for the possibility that legislation merging the separate discretionary categories would be enacted in 1992, the House, in its version of H. Con. Res. 287, approved two separate sets of budget aggregates and functional spending categories—one referred to as Plan A, the other as Plan B. Plan A (embodied in Section 2 of the resolution) was based on the assumption that the three separate categories of discretionary spending in fiscal year 1993 would be merged. Plan B (embodied in Section 3) was based on the assumption that the separate discretionary categories would not be merged or modified. Section 3(a) of the resolution stated that if legislation merging the separate categories "is not enacted into law before conferees on this resolution are appointed by the Speaker, it is the sense of the House" that Plan B would become the position of the House for purposes of conference committee action.

Both plans would have reduced defense spending in fiscal year 1993 by about $15 billion in budget authority and $10 billion in outlays below the applicable spending limits (about twice the reduction recommended by the President). Under Plan A, the defense savings would have been used mostly to "pay for" increased spending in domestic programs (above the BEA limits), but several billion would have been applied to deficit reduction. Under Plan B, almost all of the defense savings would have been applied to deficit reduction, and domestic spending would have been held at the limits.

The Senate's version of the budget resolution recommended fiscal year 1993 defense savings about half the size of those recommended

by the House and proposed that budget authority for domestic programs be set at a level nearly $4 billion below the limit.

In final form, the budget resolution split the difference between the House and Senate on defense spending (setting the budget authority amount at about $11 billion below the fiscal year 1993 limit) and set spending for international and domestic programs at about the capped levels.

The final budget resolution, like the original House and Senate resolutions, also met the PAYGO requirement, recommending about $2 billion in unspecified reductions for mandatory spending in fiscal year 1993 and no changes in revenues from baseline levels.

4. Annual Appropriations for Fiscal Year 1993

The House and Senate completed action on the 13 regular appropriations acts for fiscal year 1993 on October 5, 1992, shortly before the close of the second session of the 102nd Congress. One short-term continuing appropriations measure for the fiscal year (P.L. 102–376) was enacted. By October 6, President Bush had signed all of the regular appropriations acts into law.

Discretionary appropriations in the regular appropriations acts for fiscal year 1993 generally were consistent with the budget resolution and complied with the discretionary spending limits for the fiscal year. The end-of-session sequestration report for fiscal year 1993 issued by OMB on October 23 indicated that total discretionary appropriations for the fiscal year amounted to $514.8 billion in budget authority, about $16.8 billion below the aggregate discretionary spending limits. Enacted budget authority and outlay levels were under the limits for each separate discretionary category, except for domestic outlays (but the $315 million excess was covered by the special outlay allowance). Consequently, no sequesters were necessary.

During action on regular appropriations measures for fiscal year 1993, the House and Senate considered floor amendments shifting spending among the discretionary spending categories. Despite House and Senate rejection in March of legislation to eliminate the firewalls between the categories, some Members remained hopeful that similar legislation would be revived later in the year, or that particular proposals to shift spending between the categories might meet with the approval of the President and Congress on a case-by-case basis.

Ultimately, none of the fund-shifting amendments were approved by Congress largely because the President made it clear that he would not support appropriations bills exceeding the domestic discretionary limits. In a statement of administration policy issued in September, OMB Director Richard Darman made it clear that "if the President were presented a bill that violates the firewalls, his senior advisors would recommend a veto." As Senator Robert C. Byrd, Chairman of the Senate Appropriations Committee, lamented during Senate consideration of one of the amendments to shift funds:

> While we debate and spin our wheels here on the Senate floor, the President is sharpening his veto pencil * * *. Even if the House were to agree to this amendment, even if the House

were to agree to take down the wall, the President is going to veto this bill, and we cannot override his veto. [*Congressional Record*, September 16, 1992, page S13603]

5. Annual Appropriations for Fiscal Year 1992

During the year, Congress enacted four measures affecting fiscal year 1992—a continuing resolution, a rescission bill, and two emergency supplemental appropriations bills. The budget enforcement procedures under the BEA were not violated by action on any of these fiscal year 1992 appropriations measures.

Fiscal year 1992 foreign assistance appropriations were provided under a continuing resolution (P.L. 102–145) through March 31, 1992. Upon the expiration of P.L. 102–145, the House and Senate completed action on a further continuing resolution (H.J. Res. 456) providing appropriations through the end of the year. President Bush signed the measure into law on April 1 as Public Law 102–266.

Congress enacted two supplemental appropriations measures for fiscal year 1992. The first, H.R. 5132 (which was signed into law on June 22 as P.L. 102–302), provided funds (designated as emergency requirements for purposes of the BEA) needed to deal with the riot damage in Los Angeles, flooding in Chicago, and other matters. The second, H.R. 5620 (which was signed into law on September 23 as P.L. 102–368), provided funds principally to meet urgent needs caused by Hurricanes Andrew and Iniki and Typhoon Omar.

Congress also approved a bill, H.R. 4990 (which was signed into law on June 4 as P.L. 102–298), rescinding budget authority for fiscal year 1992. The measure was unusual both because of its size—it rescinded $8.2 billion in budget authority—and the circumstances of its consideration.

It is unusual for Congress to act on omnibus rescission legislation, preferring instead to include rescissions in annual appropriations acts. However, early in 1992, Congress was confronted with a large number of rescission proposals from the President, totalling about $7.9 billion, and was challenged by the President and some Members to act on the proposals or face an effort by the President's supporters to discharge the Appropriations Committees of his proposals.

At the end of April, the House and Senate Appropriations Committees reported differing omnibus rescission bills, each accepting some rescissions proposed by the President, rejecting others, and providing alternative spending cuts. By reporting these measures, the committees were able to preempt efforts to discharge the President's specific proposals. The $8.2 billion package agreed upon by Congress and signed into law approved less than $2.1 billion of the rescissions proposed by the President, but added more than $6 billion in congressionally initiated reductions.

6. Mandatory Spending and Revenue Legislation

In 1992, as in the year previous, action on mandatory (entitlement) spending and revenue legislation was covered under the PAYGO process. Thus, proposals to promote economic recovery and other domestic needs that required legislation increasing mandato-

ry spending or reducing revenues also would require offsetting spending cuts or tax increases to avoid a PAYGO sequester of certain entitlement programs in the fall. If agreement could not be reached on appropriate offsets, Congress and the President had the option to declare such legislation an emergency and thereby exempt from PAYGO enforcement procedures.

Mandatory spending and revenue legislation enacted in 1991 was estimated to reduce the combined deficits for fiscal years 1992 and 1993 by about $2.2 billion. Under the PAYGO process, this so-called "PAYGO carryover balance" could be used as a credit for legislation enacted in 1992 that affected the deficits for these fiscal years.

However, the PAYGO carryover balance from 1991 was consumed early in the year when Congress and the President agreed to an extension of unemployment compensation benefits on February 7 (P.L. 102-244). Additional legislation covered by the PAYGO process in 1992 had to be deficit-neutral in the net for fiscal years 1992 and 1993 (or be declared an emergency). This posed particular difficulties for the enactment of short-term economic stimulus legislation, as such measures typically increase current deficits in the hope of promoting economic growth.

In the early part of 1992, attention focused mainly on House and Senate action on revenue legislation for economic recovery. On March 20, the House and Senate approved H.R. 4210, the Tax Fairness and Economic Growth Act of 1992. CBO estimated that the measure would increase the net deficit in fiscal years 1992 and 1993 by about $1 billion, and would increase the deficit through fiscal year 1995 by about $9.3 billion. The measure incorporated some of the tax proposals for economic stimulus proposed in the President's budget, but also included certain tax increases that the President did not support. The President vetoed H.R. 4210 the same day it was approved by Congress, which also was the deadline for action on his economic stimulus package that he had set in his State of the Union address, on the grounds that it "would increase taxes and harm the economy." The House sustained the President's veto on March 25 by a vote of 211-215 (a two-thirds vote of those present and voting being necessary to override a Presidential veto).

Despite the President's veto of H.R. 4210, support for congressional action on economic stimulus legislation remained high. Urban riots and unrest during April, in the wake of the jury verdict in the Rodney King police brutality case in Los Angeles, significantly increased support for urban assistance legislation. Some of the proposals for urban assistance involved the enactment of new tax legislation, such as urban enterprise zones, and the enactment of legislation to expand entitlement programs.

On July 2, the House passed H.R. 11, the Revenue Act of 1992. The measure included tax incentives, including the creation of enterprise zones, for urban and rural assistance and for economic growth. CBO estimated that the House-passed version would increase the fiscal year 1992 and 1993 deficits by about $2.4 billion. The Senate passed H.R. 11, as amended, on September 29. CBO estimates of the Senate-passed version showed that the measure would affect the fiscal year 1992 and 1993 deficits only negligibly, indicating that the measure was essentially deficit-neutral for these years. The House and Senate reached agreement on the legis-

lation on October 8, just before the October 9 adjournment of the 102nd Congress.

President Bush, having earlier in the year renewed his pledge to reject any tax increase legislation, vetoed H.R. 11 on November 4—the day after he was defeated in the election. The President vetoed the measure "because it includes numerous tax increases, violates fiscal discipline, and would destroy jobs and undermine small business." Congressional proponents of the legislation claimed that it included revenue increases proposed by the President earlier in the year, and disputed the President's characterization of some of the provisions of the bill as tax increases.

7. Budget Process Legislation

In 1992, the House and the Senate considered proposals to amend the Constitution to require a balanced budget and to amend the Impoundment Control Act of 1974 to expand the President's rescission authority. In the case of the balanced budget amendment, the requisite two-thirds majority was not achieved in the House or Senate. In the case of legislation to expand the President's rescission authority, the House approved a measure late in the year, but in the Senate proposals to expand the President's rescission authority were ruled out of order under the Congressional Budget Act of 1974.

Backers of a constitutional amendment to require a balanced budget had vowed to force congressional consideration of the proposal again in 1992. In 1990, the House narrowly rejected a balanced budget amendment (H.J. Res. 268) by a vote of 276–152, missing by 9 votes the necessary two-thirds majority of those present and voting that is required for approval of constitutional amendments.

Representative Charles Stenholm led the 1992 balanced budget amendment drive in the House as he had in 1990, and his proposal, H.J. Res. 290, became the focus of House action. During May, the House Budget Committee held a series of hearings on the balanced budget amendment in anticipation of House action sometime in June. On June 11, the House considered H.J. Res. 290 and a series of proposed substitutes. After agreeing to a relatively minor modification of H.J. Res. 290 proposed by Representative Stenholm, the House rejected the resolution by a vote of 280–153, again missing the required two-thirds majority by 9 votes.

After the House rejected H.J. Res. 290, Senator Paul Simon, the principal sponsor of the major Senate alternative (S.J. Res. 18), announced that he would defer seeking Senate action on a balanced budget amendment until the next Congress. However, on June 24, Senator John Seymour offered a balanced budget amendment in the form of a floor amendment during Senate consideration of an unrelated measure (S. 2733, a measure to provide for the regulation of government-sponsored enterprises). After rejecting several attempts to amend the proposal, the Senate on June 30 and July 1 failed by identical votes of 56–39 to invoke cloture and prevent a threatened filibuster. Senator Seymour withdrew the amendment on July 1, and the Senate agreed by unanimous consent to put

aside consideration of the balanced budget amendment for the remainder of the 102nd Congress.

Proposals to expand the President's rescission authority under the Impoundment Control Act of 1974 had been proposed by both Presidents Reagan and Bush, and have been acted on in different forms by the House and Senate several times in recent years. In 1992, expanded rescission proposals again garnered substantial support in Congress. President Bush reiterated his request for expanded rescission authority in his fiscal year 1993 budget and made the case for it throughout the year in the Presidential campaign. Supporters of the proposal focused on its potential utility in controlling mounting deficits. Opponents worried that expanding the President's rescission authority would shift significant budgetary power to the President.

Proposals for expanded rescission authority generally fell into two broad categories: (1) enhanced rescission, in which the President would be granted authority to rescind appropriations without congressional approval, but which could be overturned through the enactment of a law, and (2) expedited rescission, in which expedited procedures would be established to ensure a vote in Congress on the President's rescission proposals.

In the Senate, Senator McCain attempted twice during 1992 to offer his enhanced rescission proposal as a floor amendment to pending legislation. In both instances, the amendments were ruled out of order in violation of Section 306 of the Congressional Budget Act, which prohibits Senate consideration of budget process legislation not reported by the Senate Budget Committee. Supporters of the amendments failed to gather the 60 votes necessary to waive the prohibition under Section 306.

In the House, Representative Gerald Solomon attempted three times during the summer to convince the House to make his enhanced rescission proposal (which was similar to Senator McCain's proposal) in order as a floor amendment to annual appropriations bills. Though he was unsuccessful in his efforts, the House leadership agreed to hold hearings on the issue later in the year. On September 18 and 25, the House Rules Subcommittee on the Legislative Process held hearings on expended rescission, item veto, and other budget process proposals. During the hearings, Representative Solomon announced his intention to attempt again to bring the proposal, or a similar one, to the House floor, perhaps during consideration of a short-term continuing appropriations measure that would be needed as Congress finished action on fiscal year 1993 appropriations.

An alternative to the enhanced rescission proposals offered by Representative Solomon and Senator McCain, and one which had gathered substantial support in the House by the time the House Rules Subcommittee held hearings in September, had been proposed by Representative Tom Carper. Mr. Carper's proposal, H.R. 2164, provided for expedited rescission authority, establishing a timetable and special procedures for consideration of the President's rescission proposals. On October 3, the House approved H.R. 2164 by a vote of 312–97. The Senate did not consider the measure. The 102nd Congress adjourned on October 9.

B. PROSPECTS FOR 1993

In 1993, the 103rd Congress faces an array of difficult budgetary choices. The economy is showing signs of recovery, but the level of unemployment is not substantially diminished. President Clinton, in his economic address to a joint session of Congress on February 17, proposed legislation to promote both short-term economic stimulus and long-term economic growth. However, because the baseline estimates of the deficit remain high, at or above $300 billion for the foreseeable future, a major part of his program calls for spending cuts and revenue increases to reduce the deficit. Some have questioned whether the economic stimulus legislation proposed by the President now is necessary, or whether such legislation, because it increases the deficit, would dampen the current recovery.

The President will submit to Congress his formal fiscal year 1994 budget sometime in late March. It is likely that the President's major spending and revenue proposals for economic growth then will be considered in two major legislative vehicles: (1) an omnibus supplemental appropriations measure for the short-term stimulus package, and (2) omnibus reconciliation legislation for deficit reduction and long-term investment proposals.

A supplemental appropriations measure is likely to be considered early in the year, perhaps even before the President submits his formal budget in late March. Because the separate discretionary categories remain in effect for fiscal year 1993, substantial new domestic discretionary spending in any supplemental appropriations measure would have to be declared an emergency requirement to avoid a sequester in 1993.

On the other hand, the discretionary spending caps merge into a single set of caps on all discretionary spending for fiscal year 1994. Fiscal year 1994 regular appropriations measures benefit from greater flexibility in shifting funds between defense, domestic, and international affairs accounts. Domestic discretionary initiatives funded in fiscal year 1994 appropriations acts would benefit from this flexibility. Yet because of certain required adjustments in the discretionary caps for fiscal year 1994, total discretionary appropriations may have to be held at or slightly below 1993 levels to comply with the legal limits. Thus, even the greater flexibility afforded by a single set of caps may not yield sufficient resources to fund all domestic discretionary priorities.

Reconciliation legislation would spring from the congressional budget resolution. The Congressional Budget Act of 1974 establishes a deadline of April 15 for adoption of the budget resolution, though this deadline often has slipped. Reconciliation legislation ordered under a budget resolution typically must be developed by the instructed committees within a month or so of the resolution's final adoption, with the committees submitting their recommendations to the Budget Committees for packaging into an omnibus measure (the deadline for submitting reconciliation legislation to the Budget Committees usually is set in the budget resolution itself). However, because of the sheer magnitude and complexity of such legislation and the number of committees involved, conference

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agreements and final House and Senate action may carry late into the year.

In addition, several factors point to possible changes in budget enforcement procedures in 1993. President Clinton was not a party to the 1990 budget agreement and he has questioned the effectiveness of current budget enforcement procedures. The President's announced policy proposals seem unlikely to fit within the budget enforcement framework established under the BEA. For example, his proposals to increase public and private investment might breach the discretionary spending limits and violate the PAYGO requirement for mandatory spending and revenue legislation.

It is possible to accommodate these proposals within the BEA framework by declaring them emergency requirements exempt from budget enforcement procedures. However, the President's focus on deficit reduction in his February 17 economic address also may indicate his reluctance to abandon the BEA discipline in the absence of an alternative framework. As "A Vision of Change for America," the background document prepared by the White House to elaborate on the President's proposals, states:

> A strong, workable enforcement mechanism is essential to the credibility of any deficit reduction package. As part of the process of implementing the President's economic program, the Administration will propose specific measures to ensure that the deficit reduction contained in the plan, once enacted, is maintained.

The document goes on to state that the President will propose in his fiscal year 1994 budget that the discretionary spending limits be extended through 1998, though the levels are not specified, and that the PAYGO requirement be extended through 2003. It states further that the budget will recommend legislation to expand the President's rescission authority "similar to H.R. 2164 as passed by the House last year."

Under current budget enforcement procedures, further deficit reduction legislation beyond that called for under the 1990 budget agreement is not necessary. However, political pressure caused by higher deficits has fueled support for new deficit reduction procedures to restore a procedural discipline requiring a declining deficit path.

Early in 1993 (probably in March) Congress will have to enact legislation to increase the statutory limit on the public debt. Debt-limit measures historically have become legislative vehicles for budget process reform and other unrelated initiatives. They were the vehicles for enactment of the GRH Act in 1985, for its revision in 1987, and a debt-limit extension was incorporated in the 1990 reconciliation legislation that included the BEA.

Many are speculating that a range of budget process reforms will be offered as amendments to debt-limit legislation in 1993, and that such reforms may include major modifications to the budget enforcement process. At the very least, it seems plausible that any measure extending the debt limit will be short-term in nature, for a few months or so, until an acceptable timetable for consideration of budget process reform legislation is settled upon.

SUPPLEMENT 1

Brief Synopsis of Hearings and Workshops Held in 1992:

The Aging Committee convened five hearings during the 2nd Session of the 102nd Congress in Washington, DC:

March 3, 1992—Elderly Left Out in the Cold? The Effects of Housing and Fuel Assistance Cuts on Senior Citizens.

April 7, 1992—Medicare Balance Billing Limits: Has the Promise Been Fulfilled?

June 18, 1992—Aging Artfully: Health Benefits of Art and Dance.

July 29, 1992—Grandparents as Parents: Raising a Second Generation.

September 24, 1992—Consumer Fraud and the Elderly: Easy Prey?

The Aging Committee held five field hearings during the 2nd Session of the 102nd Congress:

February 10, 1992—Long-Term Care and Prescription Drug Costs, Fort Smith, Arkansas

February 10, 1992—Continuing Long-Term Care Services, Lauderhill, Florida

February 11, 1992—Skyrocketing Health Care Costs and the Impact on Individuals and Businesses, Jonesboro, Arkansas

February 12, 1992—Answers to the Health Care Dilemma, El Dorado, Arkansas

April 15, 1992—Skyrocketing Prescription Drug Costs: Effects on Senior Citizens, Lewiston, Maine

April 22, 1992—The Effects of Escalating Drug Costs on the Elderly, Macon and Atlanta, Georgia

The Aging Committee held two roundtable discussions during the 2nd Session of the 102nd Congress:

June 2, 1992—Roundtable Discussion on Guardianship

November 12, 1992—Roundtable Discussion on Intergenerational Mentoring

Health Care Reform: The Time Has Come—Part 1: Long-Term Care and Prescription Drug Costs, Fort Smith, AR, February 10, 1992, Hon. David Pryor, Presiding

WITNESSES

Millie Brewbaker, Caregiver, Charleston, AR

Hilda Poe, Caregiver, Fort Smith, AR

David Banks, Chairman and Chief Executive Officer, Beverly Enterprises, Fort Smith, AR

Sister Donald Mary Lynch, Administrator, Mercy Hospital of Scott County, Pinewood Nursing Home, Waldron, AR

Linda Short, President, Arkansas Association of Residential Care Facilities, Fort Smith, AR

Ron Coker, R.Ph., Pharmacist, Coker Drugs, Van Buren, AR

Becky Johnson, Independent Case Management, Little Rock, AR

Harry Mason, Jr., Long Term Care Campaign, DeValls Bluff, AR

Janet Stevens, Parents for Children Who are Deaf, Blind, and Multi-Handicapped, Little Rock, AR

ISSUES RAISED AND TESTIMONY SUMMARY

Senator Pryor chaired a series of three field hearings in Arkansas on the issue of health care reform. The first hearing focused on long-term care and prescription drug costs.

Between 9 and 11 million Americans of all ages need some type of long-term care. Senior citizens comprise two-thirds of this group, and most of these individuals are living at home being cared for by families and friends. Access to affordable home and community-based long-term care is almost nonexistent. During the course of the hearing, caregivers, as well as aging advocates, testified about the importance of long-term care assistance in the realm of health care reform measures. Mrs. Brewbaker discussed her own personal caregiving responsibilities, including the need for caregiver support and relief. Mr. Mason, representing the Arkansas Long Term Care Campaign, explained the Medicaid Elder Choices program which offers a wider range of home and community-based services to people who normally would not be eligible for Medicaid. This program provides personal care to help people stay out of nursing homes and protects spouses from impoverishment.

Another vital issue that was raised at this forum was the high cost of prescription drugs. Prescription drug costs represent the highest out-of-pocket expense for three out of four elderly. Over 5 million Americans age 55 and over now say that they have to make choices between buying food and paying for needed medications. Prescription drug manufacturers have been increasing their prices an astounding 142 percent, more than triple the general inflation rate. The group heard from Ron Coker, a practicing pharmacist, who stated:

> The worst part of all this is that when I, the independent pharmacist, have to charge a client $105.95 for 30 Prilosec, he is sure that I have "taken him to the cleaners." My fee of $5.95 affords me less than 5 percent profit. Where are all of the high paid executives of the major pharmaceutical companies at this time?

The group also heard testimony from Mrs. Poe which truly sums up the real problem associated with affordability and accessibility of prescription drugs—she detailed that the prescription drug bill for her daughter and husband in 1991 totaled $5,600, and these bills were not covered by any type of insurance.

HEALTH CARE REFORM: THE TIME HAS COME—PART 2: SKYROCKETING HEALTH CARE COSTS AND THE IMPACT ON INDIVIDUALS AND BUSINESSES, JONESBORO, AR, FEBRUARY 11, 1992, HON. DAVID PRYOR, PRESIDING

WITNESSES

Mike Ellis, Hot Springs, AR (testimony via videotape)
Charles E. Wilcox, Jr., Mountian Home, AR
Peggy Caldwell, Travel Service of Jonesboro, Jonesboro, AR
William H. Kimbrough, Director of Group Insurance Programs, Tyson Foods, Inc. Springdale, AR
Lee Douglas, Commissioner, Arkansas Insurance Department, Little Rock, AR
Kenny Whitlock, Director, Division of Economic and Medical Services, Arkansas Department of Human Services, Little Rock, AR
Roger Busfield, Ph.D., President, Arkansas Hospital Association, Little Rock, AR
Mike Moody, M.D., President, Arkansas Academy of Family Physicians, Salem, AR

ISSUES RAISED AND TESTIMONY SUMMARY

This second session in the series of Arkansas field hearings focused on skyrocketing health care costs and insurance companies' reactions to these costs, as well as how these costs affect real people—the individuals and small business owners. The following facts were a few statistics that were outlined:

The United States will spend $817 billion for health care by the close of 1992.

Presently, we are spending $2,566 for each man, woman, and child in this Nation. If these costs are not controlled, we will be spending $5,712 for each citizen by the turn of the century.

There are 33 to 37 million Americans who have no health insurance.

The U.S. health care system is indeed in a crisis situation. The panel heard from Dr. Roger Busfield of the Arkansas Hospital Association who stated, "When we point an accusing finger at what providers charge patients, we need to look deeper to find what suppliers are charging hospitals for those things the hospitals must have to treat their patients."

In turn, insurance companies, responding to these costs and attempting to limit their liability, have turned more and more to underwriting and marketing practices that discriminate against small businesses and individuals. As a result, the audience heard from many witnesses who were seeking insurance coverage and were priced out of the market or excluded at any price. The testimony of Peggy Caldwell, a small business owner in Jonesboro, provided extremely insightful information as to the problems associated with affording insurance coverage not only for herself, but for her employees. As a result of her minor health problems, insurance coverage is completely unaffordable and Ms. Caldwell must pay for all her expenses out-of-pocket. Problems like the ones discussed during

this forum must be solved in order for our Nation's citizens to have access to quality and affordable health care.

HEALTH CARE REFORM: THE TIME HAS COME—PART 3: ANSWERS TO THE HEALTH CARE DILEMMA, EL DORADO, AR, FEBRUARY 12, 1992, HON. DAVID PRYOR, PRESIDING

WITNESSES

Robert Herzfeld, Health Insurance Agent, Benton, AR, Representing the Arkansas Chamber of Commerce Small Business Council

Alan White, Sr., Arkansas National Liaison for the National Federation of Independent Businesses, Stamps, AR

Orlo L. Dietrich, Jr., President and Chief Executive Officer, Burgett & Dietrich, Little Rock, AR

George Mitchell, Ph.D., Chief Executive Officer. Accompanied by Robert L. Shoptaw, Jr., Executive Vice President and Chief Operating Officer Representing Arkansas Blue Cross and Blue Shield

Herb Bingaman, President, Arkansas Seniors Organized for Progress, Little Rock, AR

Phyllis Kordsmeier, Executive Director, CABUN Rural Health Services, Inc., Hampton, AR

Peter J. Carroll, M.D., Director, AHEC South Arkansas, El Dorado, AR

ISSUES RAISED AND TESTIMONY SUMMARY

The final session in the series of Arkansas field hearings focused on possible answers to the many problems that face our present health care system. There is no doubt that the United States has the best health care money can buy. The problem facing us is the fact that fewer and fewer Americans can afford access to needed medical care. It is safe to assess that health care costs are the driving force behind the current health care debate.

This forum provided an opportunity to hear from many individuals "outside the beltway" regarding their ideas on ways to solve this crisis situation. Included among the many strategies suggested for health care reform were:

Tax fairness.—Importance of offering 100 percent tax incentives to employers to provide coverage for their employees.

Health care reform.—Changes in our current health care system must be comprehensive in nature. Many individuals support a national health care proposal.

Safety net coverage.—The public and private sectors must cooperate to meet the needs of the uninsured; Medicaid must be a last-resort means to finance health care.

Medical malpractice liability.—Necessary to reduce the need for defensive medicine and the cost of the liability insurance premiums.

Community health centers.—The need for expansion of primary medical care in rural areas has been growing at a rapid pace, and the provision of such centers will increase the accessibility and affordability of medical care to many people who otherwise could not have access to these services.

Managed care.—This program was structured to localize care as much as was medically practical, thus, benefiting the local hospital specialist from the reduction of medical care to outside communities.

Testimony given by health insurance agents, directors of rural community health centers, hospital administrators, physicians, and employers provided an extremely well-rounded and insightful view of ways to comprehensively reform our health care system. All three hearings outlined valuable recommendations that will help the Aging Committee members and other members of Congress develop approaches to provide affordable, accessible health care for all Americans.

Elderly Left Out in the Cold? The Effects of Housing and Fuel Assistance Cuts on the Elderly, Washington, D.C., March 3, 1992, Honorable William Cohen, Presiding

WITNESSES

Ms. Mary Moore, Des Moines, IA

Ms. Lois Day, Blanchard, ME

Honorable Arthur J. Hill, Assistant Secretary for Housing, Federal Housing Commissioner, U.S. Department of Housing and Urban Development

Ms. Donna Neal Givens, Principal Deputy Assistant Secretary, Administration for Children and Families, U.S. Department of Health and Human Services

Mr. La Verne Ausman, Administrator, Farmers Home Administration, U.S. Department of Agriculture

Mr. Robert Odom, Executive Director, Social Development Commission, Milwaukee, WI

Ms. Margaret Dixon, American Association for Retired Persons

Ms. Diane De Vaul, Director of Policy, Northeast-Midwest Institute

Michael Rodgers, Senior Vice President, American Association of Homes for the Aging

Mr. Moises Loza, Executive Director, Housing Assistance Council, Inc.

Ms. Diana Huot, York-Cumberland Housing Development Corporation

ISSUES RAISED AND TESTIMONY SUMMARY

The Bush Administration's proposed FY 1993 budget called for drastic reductions to several energy assistance and housing programs. These programs have played an important and vital role in helping thousands of America's financially needy meet basic energy and housing needs. The Senate Special Committee on Aging, concerned about the proposed budget cuts, convened this hearing to examine the impact of the Administration's proposals on the livelihood and survival of the elderly.

The Administration proposed a 29-percent cut to the Low Income Home Energy Assistance Program, (LIHEAP); a 90-percent reduction in the number of units financed under the Section 202 Elderly Housing; the elimination of the Congregate Housing Services Pro-

gram (CHSP) and to rescind $16.7 million of the $17.7 million appropriated in FY 1992; and cuts to two Farmers Home Administration rural housing programs—a 40-percent reduction to Section 515 programs which provides multifamily rural housing for low-income families, rural elderly, and rural disabled persons; and a funding reduction from $12.5 million appropriated in FY 1992 to $5 million for FY 1993 in Section 504 program, which provides grants for rural elderly citizens for essential home safety repairs, modernization, and improvements. Undoubtedly, deep cuts could have a devastating impact on the livelihood and survival for many elderly persons, and others who have come to depend on rental assistance programs for decent and affordable housing.

Witnesses described that a combination of program cuts and increased demand for these services will wreak havoc on older Americans. Elderly and rural housing, support and congregate service make the difference in allowing senior citizens to remain independent longer. Without such programs, seniors would literally be "out in the cold" and forced to enter boarding homes or nursing homes not because they need that level of care but because there is simply no safe place to live. A situation the Acting Chairman described as "penny wise and pound-foolish from a budgetary standpoint."

The task of adequately funding desperately needed human assistance programs is a difficult one, especially given the extraordinarily challenging budget constraints faced by the President and the Congress. However, many households simply cannot afford or absorb these cuts.

MEDICARE BALANCE BILLING LIMITS: HAS THE PROMISE BEEN FULFILLED?, WASHINGTON, D.C., APRIL 7, 1992, HONORABLE WILLIAM COHEN, PRESIDING

WITNESSES

David Lee, Medicare Beneficiary, Sag Harbor, NY

Stanley Lipson, Medicare Beneficiary, Bayside, NY

Susan Stayn, Program Director, Medicare Beneficiaries Defense Fund

Carol Walton, Deputy Director, Bureau of Program Operations, Health Care Financing Administration

Carol Jimenez, Director of Litigation, Medicare Advocacy Project

Jack Guildroy, Board Member, American Association of Retired Persons

Nancy W. Dickey, M.D., Member, Board of Trustees, American Medical Association

ISSUES RAISED AND TESTIMONY SUMMARY

In 1989, Congress enacted legislation to protect Medicare beneficiaries from excessive out-of-pocket costs for physician services. Despite this law, untold numbers of older Americans continue to be subjected to physician overcharges. These overcharges are not only a blatant consumer rip-off, but also a great financial hardship for those beneficiaries living on a fixed income. As part of an ongoing effort to examine the causes of this unacceptable situation, this Aging Committee hearing was held to discuss the importance of

balance billing limits and to address the root cause for continued overcharges.

The legislation enacted in 1989 limits the amount that nonparticipating physicians can charge their Medicare patients over and beyond the Medicare-approved amount. This is generally referred to as the limiting charge. In 1992, doctors can charge no more than 20 percent above the Medicare-approved amount. In 1993, this figure will drop to 15 percent above the Medicare-approved amount.

The Health Care Financing Administration (HCFA), the Federal agency responsible for administering the Medicare program, has neglected to inform all parties involved of this new law. As a result, patients who see nonparticipating physicians continue to be overbilled because doctors are unaware of the billing limits, and patients have not been informed of their rights and obligations.

During the hearing, it was made clear that HCFA has been extremely lax regarding the monitoring and enforcement of the limiting charge law. HCFA must be more responsive and accountable to the needs of beneficiaries and physicians. One witness described his experience as a "wild goose chase for accurate information and useful assistance," after realizing he had been overcharged.

While HCFA has finally given meaningful instruction to Medicare carriers (insurance companies which administer the Medicare program regionally), Senator Pryor introduced legislation to ensure that the balance billing limits provide the protections that Congress intended. S. 2698, the "Medicare Beneficiary Protection Act of 1992," would clarify that Medicare patients are not liable for overcharges, require HCFA to disseminate information about the billing limits to both patients and doctors, and strengthen monitoring and enforcement of the law.

Skyrocketing Prescription Drug Costs: Effects on Senior Citizens, Lewiston, ME, April 15, 1992, Hon. William Cohen, Presiding

WITNESSES

Al Rawley, Bangor, ME
George A. Roy, Biddeford, ME
Wilfred W. Graham, Portland, ME
Gertrude Zimmerman, Brunswick, ME
Lillian Trumble, Lisbon Falls, ME
Bernard W. Miller, Pharmacist, Bangor, ME
John Desjardins, Pharmacist, Bath, ME
Gregory O'Keefe, M.D., Vinalhaven, ME
Roger B. Hickler, M.D., Cape Elizabeth, ME
Patricia Eye, R.N., Bangor, ME
Eloise L. Moreau, Executive Director, Western Area Agency on Aging, Inc.
Elaine Fuller, Director, Bureau of Medical Services, Maine Department of Human Services

ISSUES RAISED AND TESTIMONY SUMMARY

Conducted by the Ranking Republican Member of the Aging Committee, this field hearing centered around the testimony of a number of Maine senior citizens, outlining the daily hardships many of them experience as it relates to the high cost of prescription drugs.

A question that is posed time and time again is why?—why are drug costs rising at three times the general rate of inflation? Although many dollars must be spent on the research and development of new drugs, a great deal of expenses are directly related to excessive marketing and promotional campaigns. Figures for 1991 indicate that the pharmaceutical industry spent $10 billion on marketing, which was actually $1 billion more than the industry spent on research.

The audience heard heart-wrenching stories from individuals who have high prescription drug bills, while living on very limited incomes. One witness testified that he and his wife have spent over $48,000 out of pocket for their prescription drugs since 1986. Another witness outlined for the panel the outrageous out-of-pocket amount she pays for her daily medications, while only receiving $314 a month. Mr. Miller, a member of the pharmacy profession, summarized the problem in one statement: "There is no question that today's prescription is a bargain. However, when the prescription price takes food off the table * * * we need alternatives to these high prices."

The good news is that modern technology and research advancement provide our society with the ability to save lives with remarkable drugs. The bad news, however, is that many Americans are finding that they cannot afford these life-saving medications. For this reason, Senator David Pryor, Chairman of the Special Committee on Aging, introduced legislation during the 102nd Congress which attempts to curb prescription drug price increases. Senator Pryor has been on the forefront of this issue since 1989, when he assumed the Chairmanship of the Aging Committee.

THE EFFECTS OF ESCALATING DRUG COSTS ON THE ELDERLY, MACON AND ATLANTA, GA, APRIL 22, 1992, HON. WYCHE FOWLER, JR., AND HON. DAVID PRYOR, PRESIDING

WITNESSES

Morning Session in Macon, GA

Tommy Olmstead, Mayor, Macon, GA

Richard Jackson, Ph.D., Professor and Chairman, Department of Pharmacy Administration, Mercer University School of Pharmacy

Danny Toth, President, Georgia Pharmaceutical Association

Andrew Galloway, Vice President for Legislative Affairs, Medical Center of Central Georgia

Louise Lentz, Older Americans Council, Macon, GA

Nancy Hill, Ombudsman, Middle Georgia Community Action Agency, Warner Robins, GA

Earline Ham, President, Emergency Fund for the Medically Indigent, Baldwin County, GA

Accompanied by Carolyn Thomas, Board Member

WITNESSES

Afternoon Session in Atlanta, GA

Ron Dubberly, Fulton County Library
Sue Ellen Crosslea, Representing Mayor Maynard Jackson, Atlanta, GA
Russ Toal, Commissioner, Georgia Department of Medical Assistance
James W. Cooper, Jr., Ph.D., Professor and Head, Department of Pharmacy Practice, University of Georgia College of Pharmacy
Larry L. Braden, R.Ph., Executive Vice President, Georgia Pharmaceutical Association
Vita Ostrander, Volunteer, American Association of Retired Persons
Betsy Styles, Program Director for Aging Services, Catholic Social Services, on behalf of Jean Kaple, senior witness
Elaine Burge, Administrator, Budd Terrace Intermediate Care Facility
Frank Marxer, M.D., Director, Outpatient Services and Geriatric Evaluation and Management Services, Wesley Woods Geriatric Hospital
Donald F. Snell, Deputy Executive Director, Grady Memorial Hospital

Issues Raised and Testimony Summary

The Special Committee on Aging and many other Congressional offices have been flooded with letters from elderly citizens around the Nation expressing their frustration with the increasing cost of prescription drugs. These two field hearings addressed these concerns raised by a number of witnesses which included members of the pharmacy profession, various medical groups, and consumers.

Over 5 million senior citizens must choose between buying their life-saving medication and purchasing food. Year after year, the drug industry consistently raised prices three times the rate of general inflation in the United States. As a result, Americans are forced to pay the highest prices for prescription drugs—the average consumer pays 54 percent more than the average European citizen and 62 percent more than the average Canadian citizen. One member of the pharmacy profession testified to the willingness of the Nation's pharmacists to contribute to reducing health care and prescription drug costs for the elderly. One such example was the forced change in pharmacy law which now allows generic drugs to be dispensed more readily, which in turn, has saved consumers hundreds of millions of dollars each year.

Legislative efforts to control the escalating price of drugs have been headed by Chairman Pryor through his introduction of S. 2000, "The Prescription Drug Cost Containment Act of 1991." Although this bill was not passed during the 102nd Congress, strong cost containment efforts in this area will continue in the upcoming session of Congress.

ROUNDTABLE DISCUSSION ON GUARDIANSHIP, WASHINGTON, D.C., JUNE 2, 1992, MRS. ANNA KINDERMANN, MODERATOR

PRESENTERS

A. Frank Johns, Attorney, Greensboro, NC
John Regan, Professor of Health Care Law, Hofstra University
Ingo Keilitz, National Center of State Courts
Martha Miller, Attorney, Little Rock, AR
Patrick Murphy, Public Guardian, Cook County, IL

ISSUES RAISED AND PRESENTATION SUMMARY

The purpose of the guardianship forum was to educate the Committee about what role the Federal Government might play in guardianship law, an area that's been traditionally left to the States. Although the majority of States now have laws in place which would appear to protect the interest of the potential ward, these laws still fail to provide adequate safeguards against unwarranted and overly restrictive guardianship orders, appointment of unfit guardians, and abusive practices by appointed guardians.

The participants in the roundtable discussed several aspects of this issue, including the need for sufficient data to document the extent of abuse within State guardianship systems and to make informed policy decisions regarding the manner in which guardians should be appointed and monitored. After documenting several of the problems, the advisability and feasibility of Federal intervention was outlined. And finally, States' resistance to Federal intervention (on an issue traditionally within exclusive State jurisdiction) was an understandable concern raised by the States about increasing utilization of unfunded Federal mandates.

This broad study on the problems surrounding the guardianship issue provided a perfect forum for identifying major issues of concern. It is hoped that additional workshops may be held in the future to explore these areas in a more detailed fashion.

AGING ARTFULLY: HEALTH BENEFITS OF ART AND DANCE, WASHINGTON, D.C., JUNE 18, 1992, HONORABLE DAVID PRYOR, PRESIDING

WITNESSES

Jack Palance, Tehachapi, CA
Elizabeth "Grandma" Layton, Wellsville, KS
Robert E. Ault, Registered Art Therapist, American Art Therapy Association
Howard "Sandman" Sims, New York, NY
Barrie Bailey, Las Vegas, NV
Marie J. Seymour, Dance/Movement Therapy Consumer, Bethesda, MD
Judith R. Bunney, Past President, American Dance Therapy Association

ISSUES RAISED AND TESTIMONY SUMMARY

The health benefits of art and dance to help the Nation's elderly was explored by the Senate Special Committee on Aging. Art and dance therapy show great promise as innovative approaches to im-

proving the health of senior citizens. Although the fields are relatively new, initial research presented at the hearing showcased that artistic endeavors of all types can create an important sense of satisfaction for older persons, or people of any age.

Testimonials were given, beautiful art pieces displayed, and dances performed. Evidence was also presented that these disciplines have significant health benefits which science is only beginning to measure. But perhaps, most importantly, the hearing helped Congress gain an understanding and appreciation of the need to expand the use of these innovative approaches in health facilities that serve older Americans.

Jack Palance, artist and Academy Award winner famous for his one-armed push-ups, testified that painting has helped him maintain a youthful outlook. He stated, "I'm just gonna get right down to it and say that painting is a fantastic way to awaken or reawaken your creative sensitivities * * * I think it's time to evaluate a radical painter like Jackson Pollack and drip 65 million gallons of paint over Washington and call it—THE DECORATION OF AGING INDEPENDENCE."

Likewise, 76-year-old Barrie Bailey, a dancer and stuntwoman, testified that dance and physical activity are important to keeping the mind and body young. Howard "Sandman" Sims, says he knows what dance can do for people—old people in particular—because he is a "living testimony." (Mr. Sims has been dancing for 71 years.) Sandman Sims concluded by saying that one is never too old to dance. "Most people's hearts are manufactured to dance, not everyone does it, but it's never too late to dance your dance."

Encouragement to awaken the creative spirit is sorely needed in our nursing homes, hospitals, and other care-giving settings. People often lose a sense of excitement as they lose abilities due to the aging process. Art, dance and music can give individuals a sense of accomplishment that can be revitalizing physically, emotionally, and mentally.

Congress approved legislation authorizing art, dance and music therapy to be funded under the Older Americans Act. In addition to direct services, the legislation authorized research and demonstration programs to study these therapies.

Grandparents as Parents: Raising a Second Generation, Washington, D.C., July 29, 1992, Honorable David Pryor, Presiding

WITNESSES

The Honorable Thomas Downey (D-NY), Chairman, Select Committee on Aging, Subcommittee on Human Services, U.S. House of Representatives

Evelyn M. Davis, M.D., Assistant Clinical Professor of Medicine, Behavioral/Developmental Pediatrics, Harlem Hospital/Columbia College of Physicians and Surgeons, New York, NY

Mrs. Joan McMillin, Bellflower, CA

Mrs. Mary Shaheen, resident Yarmouth, ME, accompanied by Master Nathaniel Shaheen, grandson

Ms. Janet Sainer, Special Consultant, The Brookdale Foundation Group, New York, NY

Mrs. Ethel Dunn, Executive Director, Grandparents United for Childrens' Rights, Madison, WI

Ms. Edith Owen, Outreach Worker, Tacoma-Pierce County Health Department, Child Guidance Clinic, Tacoma, WA

ISSUES RAISED AND TESTIMONY SUMMARY

The Senate Special Committee on Aging brought attention to a subject that is frequently overlooked in most discussions of "family unit"—the vital role grandparents play in raising their grandchildren. Over 3.2 million American children live with their grandparents—a phenomenon which appears to be growing and cuts across all social economic, ethnic, and racial lines. Despite this trend, grandparents have found little support in our legal and child service systems. Accordingly, this hearing provided a forum to discuss the challenges and hardships faced by these "unsung heroes" and ways our Nation's family policies and support systems can better serve the interests of these grandparents and the children they are raising.

The issues confronting grandparents who have assumed responsibility for their grandchildren are many and varied. (The most common reasons for grandparents to be raising their grandchildren include the widespread use of drugs and alcohol; the HIV infected child; parental neglect, abuse and/or abandonment; and physical illness or incarceration.) In addition to coping with the emotional and psychological challenges of "reparenting", many grandparents often have difficulty obtaining legal custody, financial and/entitlements and other child health benefits.

One witness, Mrs. Joan McMillan testified that it took 3½ years to gain custody of her grandchildren who lived with them all their lives. Furthermore, there has been no financial resources to help her in the "struggle to provide some security" for their grandchildren.

Witnesses testified that benefits and services to grandparents-caregivers must be expanded. Specifically, recommendations were made by Ms. Ethel Dunn that would provide for "kin mandate" or kin-care laws in all 50 States; the proper administration of entitlement funds, such as AFDC benefits; the authorization of appropriate funding to qualified agencies to examine the issue of "grandparents as reparents"; and a new system for Federal review of State child welfare programs.

CONSUMER FRAUD AND THE ELDERLY: EASY PREY?, WASHINGTON, D.C., SEPTEMBER 24, 1992, HONORABLE DAVID PRYOR, PRESIDING

WITNESSES

Archie Wilcox, victim of scam artists, Duluth, MN

Mrs. Marcella Patrick, victim of scam artists, Springfield, IL

Honorable Patricia J. Gorence, Deputy Attorney General, State of Wisconsin

Honorable Roland W. Burris, Attorney General, State of Illinois

Honorable Winston Bryant, Attorney General, State of Arkansas, accompanied by Ms. Kay DeWitt, Deputy Attorney General and Head of Consumer Protection Division

Honorable Hubert H. Humphrey III, Attorney General, State of Minnesota
Ms. Joan King, member, National Legislative Council, American Association of Retired Persons
Ms. Susan Giesberg, President, National Association of Consumer Agency Administrators
Ms. Kathy Finucane, Director of Arbitration, Better Business Bureau of Western Virginia
Kenneth M. Hearst, Assistant Chief Postal Inspector, Criminal Investigations, U.S. Postal Inspection Service, accompanied by George C. Davis, Assistant General Counsel for Enforcement

ISSUES RAISED AND TESTIMONY SUMMARY

Scams directed toward the elderly have increased in frequency, magnitude, and sophistication. Everyday there are new examples of outrageous tactics that swindlers use to rob senior citizens of their savings, independence, and dignity. This hearing focused on four major schemes, involving living trusts, which as marketed by some individuals are sham estate planning devices; guaranteed give-aways; home repair fraud; and mail order fraud, which have victimized thousands of senior citizens nationwide. Likewise, it provided an opportunity to determine how to better address this problem on State and Federal levels.

Mr. Archie Wilcox, victim of mail order fraud scam, testified an "element of hypnotism" is involved in any scam. "They treat you like a long lost friend" and "capture your mind." Mr. Wilcox lost over $5,000 in a series of mail order scams. Also, several State attorney generals highlighted what their individual States were doing to both prevent and combat crimes against consumers.

Arkansas Attorney General Winston Bryant testified that State and Federal authorities should coordinate efforts and resources in fighting consumer fraud and abuse. Chairman Pryor urged seniors to be wary of con artists and offered this practical advice: "Be suspicious of any mail solicitation that contains only a P.O. Box number. Be suspicious of anyone who urges you to act now. Check out the company with the Better Business Bureau. And never give personal financial information to a stranger—your savings or checking account balance or credit card number."

Senator Pryor introduced legislation that strengthens the investigatory and enforcement powers of the Postal Service and that prohibits "government look-alike mail."

DISCUSSION

Roundtable on Intergenerational Mentoring, Washington, D.C., November 12, 1992, Ms. Ann Fishman, Moderator

PRESENTERS

Joyce Berry, Ph.D., Commissioner, Administration on Aging, Washington, D.C.
Richard Danzig, Partner, Latham & Watkins, Washington, D.C.
Susan Edgar, Executive Director, New York City School Volunteer Program, Inc., New York, NY

Marc Freedman, Director of Special Projects, Public/Private Ventures, San Francisco, CA

Patricia Gilbert, National Coordinator, Intergenerational Tutoring Program, OASIS, St. Louis, MO

Nancy Henkin, Executive Director, Center for Intergenerational Learning, Temple University, Philadelphia, PA

Austin Heyman, Executive Director, Interages, Kensington, MD

Susan Jenkins, Director of Planning and Evaluation, Gulf Coast Jewish Family and Mental Health Services, Clearwater, FL

Linda Macgregor, Associated Director, Boston Partners in Education, Inc., Boston, MA

Ronald Manheimer, Executive Director, North Carolina Center for Creative Retirement, University of North Carolina at Asheville, Asheville, NC

Daniel Merenda, President and CEO, National Association of Partners in Education (NAPE), Alexandria, VA

Sally Newman, Executive Director, Generations Together, University of Pittsburgh, Pittsburgh, PA

Portia Porter Mittelman, Staff Director, U.S. Senate Special Committee on Aging, Washington, D.C.

Anita Rogers, Project Director for Linking Lifetimes, Center for Intergenerational Learning, Temple University, Philadelphia, PA

Shayne Schneider, President, Mentors, Inc., Washington, D.C.

Sylvia Stern, Sylvia A. Stern & Associates, Austin, TX

Carol Tice, Director, T-LC Mentors, Ann Arbor Public Schools, Ann Arbor, MI

Remmel Dudley, Retiree, Falls Church, VA

ISSUES RAISED AND PRESENTATION SUMMARY

This forum was convened to outline the importance of intergenerational mentoring, which is defined as the guidance or "helping hand" that an older generation extends to a younger generation to assist in bringing a child into a healthy adulthood. The lack of sufficient mentoring may take place in any type of home; however, the responsibility to guide our children into maturity is still an important, if not essential, task.

The feature speaker during this workshop was Marc Freedman, author of two books entitled, *The Kindness of Strangers: Reflections on the Mentoring Movement* and *Partners in Growth: Elder Mentors and At-Risk Youth.* After Mr. Freedman presented the key elements of his works, the floor was open to all participants for discussion.

The main purpose of this roundtable was to assess the possibility of future legislation which would develop a National Mentor Corps, a public-private partnership that would provide a mentor-rich environment in our public school system from Kindergarten through college. This program could match the needs of the young with the skills of elders while strengthening our public schools in the process.

SUPPLEMENT 2

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Supplement 3

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(202) 783-3238

REPORTS

Developments in Aging, 1959 to 1963, Report No. 8, February 1963.*
Developments in Aging, 1963 and 1964, Report No. 124, March 1965.*
Developments in Aging, 1965, Report No. 1073, March 1966.*
Developments in Aging, 1966, Report No. 169, April 1967.*
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Developments in Aging, 1968, Report No. 91-119, April 1969.*
Developments in Aging, 1969, Report No. 91-875, May 1970.*
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Developments in Aging: 1971 and January-March 1972, Report No. 92-784, May 1972.*
Developments in Aging: 1972 and January-March 1973, Report No. 93-147, May 1973.*
Developments in Aging: 1973 and January-March 1974, Report No. 93-846, May 1974.*
Developments in Aging: 1974 and January-April 1975, Report No. 94-250, June 1975.*
Developments in Aging: 1975 and January-May 1976—Part 1, Report No. 94-998, June 1976.*
Developments in Aging: 1975 and January-May 1976—Part 2, Report No. 94-998, June 1976.*
Developments in Aging: 1976—Part 1, Report No. 95-88, April 1977.*
Developments in Aging: 1976—Part 2, Report No. 95-88, April 1977.*
Developments in Aging: 1977—Part 1, Report No. 95-771, April 1978.*
Developments in Aging: 1977—Part 2, Report No. 95-771, April 1978.*
Developments in Aging: 1978—Part 1, Report No. 96-55, March 1979.*
Developments in Aging: 1978—Part 2, Report No. 96-55, March 1979.*
Developments in Aging: 1979—Part 1, Report No. 96-613, February 1980.*
Developments in Aging: 1979—Part 2, Report No. 96-613, February 1980.*
Developments in Aging: 1980—Part 1, Report No. 97-62, May 1981.*
Developments in Aging: 1980—Part 2, Report No. 97-62, May 1981.*

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Developments in Aging: 1981—Volume 1, Report No. 97-314, March 1982.*
Developments in Aging: 1981—Volume 2, Report No. 97-314, March 1982.*
Developments in Aging: 1982—Volume 1, Report No. 98-13, February 1983.*
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Developments in Aging: 1983—Volume 1, Report No. 98-360, February 1984—$13.*
Developments in Aging: 1983—Volume 2, Report No. 98-360, February 1984—$8.*
Developments in Aging: 1984—Volume 1, Report No. 99-5, February 1985.—$9.*
Developments in Aging: 1984—Volume 2, Report No. 99-5, February 1985—$8.*
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Developments in Aging: 1985—Volume 3—America in Transition: An Aging Society.*
Developments in Aging: 1986—Volume 1, Report No. 100-9, February 1987.*
Developments in Aging: 1986—Volume 2, Appendixes, Report No. 100-9, February 1987.*
Developments in Aging: 1986—Volume 3—America in Transition: An Aging Society, Report No. 100-9, February 1987.*
Developments in Aging: 1987—Volume 1, Report No. 100-291, February 1988.
Developments in Aging: 1987—Volume 2—Appendixes, Report No. 100-291, February 1988.*
Developments in Aging: 1987—Volume 3—The Long-Term Care Challenge, Report No. 100-291, February 1988.*
Developments in Aging: 1988—Volume 1—Report No. 101-4, February 1989.*
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Developments in Aging: 1990—Volume 2—Appendixes, Report No. 102-28, February 1991.*
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COMMITTEE PRINTS

1961

Comparison of Health Insurance Proposals for Older Persons, 1961, committee print, April 1961.*
The 1961 White House Conference on Aging, basic policy statements and recommendations, committee print, May 1961.*
New Population Facts on Older Americans, 1960, committee print, May 1961.*
Basic Facts on the Health and Economic Status of Older Americans, staff report, committee print, June 1961.*
Health and Economic Conditions of the American Aged, committee print, June 1961.*
State Action To Implement Medical Programs for the Aged, committee print, June 1961.*
A Constant Purchasing Power Bond: A Proposal for Protecting Retirement Income, committee print, August 1961.*
Mental Illness Among Older Americans, committee print, September 1961.*

1962

Comparison of Health Insurance Proposals for Older Persons, 1961–62, committee print, May 1962.*
Background Facts on the Financing of the Health Care of the Aged, committee print, excerpts from the report of the Division of Program Research, Social Security Administration, Department of Health, Education, and Welfare, May 1962.*
Statistics on Older People: Some Current Facts About the Nation's Older People, June 1962.*
Performance of the States: 18 Months of Experience With the Medical Assistance for the Aged (Kerr-Mills) Program, committee print, June 1962.*
Housing for the Elderly, committee print, August 1962.*
Some Current Facts About the Nation's Older People, October 1962.*

1963

A Compilation of Materials Relevant to the Message of the President of the United States on Our Nation's Senior Citizens, committee print, June 1963.*
Medical Assistance for the Aged: The Kerr-Mills Program, 1960–63, committee print, October 1963.*

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1964

Blue Cross and Private Health Insurance Coverage of Older Americans, committee print, July 1964.*
Increasing Employment Opportunities for the Elderly—Recommendations and Comment, committee print, August 1964.*
Services for Senior Citizens—Recommendations and Comment, Report No. 1542, September 1964.*
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1963–64, committee print, October 1964.*

1965

Frauds and Deceptions Affecting the Elderly—Investigations, Findings, and Recommendations: 1964, committee print, January 1965.*
Extending Private Pension Coverage, committee print, June 1965.*
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Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, committee print, November 1965.*

1966

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The War on Poverty As It Affects Older Americans, Report No. 1287, June 1966.*
Needs for Services Revealed by Operation Medicare Alert, committee print, October 1966.*
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1967

Reduction of Retirement Benefits Due to Social Security Increases, committee print, August 1967.*

1969

Economics of Aging: Toward a Full Share in Abundance, committee print, March 1969.* [1]
Homeownership Aspects of the Economics of Aging, working paper, factsheet, July 1969.* [1]
Health Aspects of the Economics of Aging, committee print, July 1969 (revised).* [1]
Social Security for the Aged: International Perspectives, committee print, August 1969.* [1]

[1] Working paper incorporated as an appendix to the hearing.

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Employment Aspects of the Economics of Aging, committee print, December 1969.* [1]

1970

Pension Aspects of the Economics of Aging: Present and Future Roles of Private Pensions, committee print, January 1970.* [1]
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Older Americans and Transportation: A Crisis in Mobility, Report No. 91-1520, December 1970.*
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1971

Medicare, Medicaid Cutbacks in California, working paper, factsheet, May 10, 1971.*
The Nation's Stake in the Employment of Middle-Aged and Older Persons, committee print, July 1971.*
The Administration on Aging—Or a Successor?, committee print, October 1971.*
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Elderly Cubans in Exile, committee print, November 1971.*
A Pre-White House Conference on Aging: Summary of Developments and Data, Report No. 92-505, November 1971.*
Research and Training in Gerontology, committee print, November 1971.*
Making Services for the Elderly Work: Some Lessons From the British Experience, committee print, November 1971.*
1971 White House Conference on Aging, a report to the delegates from the conference sections and special concerns sessions, Document No. 92-53, December 1971.*

1972

Home Health Services in the United States, committee print, April 1972.*
Proposals To Eliminate Legal Barriers Affecting Elderly Mexican-Americans, committee print, May 1972.*

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Cancelled Careers: The Impact of Reduction-in-Force Policies on Middle-Aged Federal Employees, committee print, May 1972.*

Action on Aging Legislation in 92d Congress, committee print, October 1972.*

Legislative History of the Older Americans Comprehensive Services Amendments of 1972, joint committee print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging, December 1972.*

1973

The Rise and Threatened Fall of Service Programs for the Elderly, committee print, March 1973.*

Housing for the Elderly: A Status Report, committee print, April 1973.*

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Home Health Services in the United States: A Working Paper on Current Status, committee print, July 1973.*

Economics of Aging: Toward a Full Share in Abundance, index to hearings and report, committee print, July 1973.*

Research on Aging Act, 1973, Report No. 93-299, committee print, July 1973.*

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Improving the Age Discrimination Law, committee print, September 1973.*

1974

The Proposed Fiscal 1975 Budget: What It Means for Older Americans, committee print, February 1974.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, February 1974.*

Developments and Trends in State Programs and Services for the Elderly, committee print, November 1974.*

Nursing Home Care in the United States: Failure in Public Policy:*

- Introductory Report, Report No. 93-1420, November 1974.
- Supporting Paper No. 1, "The Litany of Nursing Home Abuses and an Examination of the Roots of Controversy," committee print, December 1974.
- Supporting Paper No. 2, "Drugs in Nursing Homes: Misuse, High Costs, and Kickbacks," committee print, January 1975.
- Supporting Paper No. 3, "Doctors in Nursing Homes: The Shunned Responsibility," committee print, February 1975.
- Supporting Paper No. 4, "Nurses in Nursing Homes: The Heavy Burden (the Reliance on Untrained and Unlicensed Personnel)," committee print, April 1975.
- Supporting Paper No. 5, "The Continuing Chronicle of Nursing Home Fires," committee print, August 1975.

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Supporting Paper No. 6, "What Can Be Done in Nursing Homes: Positive Aspects in Long-Term Care," committee print, September 1975.

Supporting Paper No. 7, "The Role of Nursing Homes in Caring for Discharged Mental Patients (and the Birth of a For-Profit Boarding Home Industry)," committee print, March 1976.

Private Health Insurance Supplementary to Medicare, committee print, December 1974.*

1975

Protecting Older Americans Against Overpayment of Income Taxes, committee print, January 1975.*

Senior Opportunities and Services (Directory of Programs), committee print, February 1975.*

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The Proposed Fiscal 1976 Budget: What It Means for Older Americans, committee print, February 1975.*

Future Directions in Social Security, Unresolved Issues: An Interim Staff Report, committee print, March 1975.*

Women and Social Security: Adapting to a New Era, working paper, committee print, October 1975.*

Congregate Housing for Older Adults, Report No. 94-478, November 1975.*

1976

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Fraud and Abuse Among Clinical Laboratories, Report No. 94-944, June 1976.*

Recession's Continuing Victim: The Older Worker, committee print, July 1976.*

Fraud and Abuse Among Practitioners Participating in the Medicaid Program, committee print, August 1976.*

Adult Day Facilities for Treatment, Health Care, and Related Services, committee print, September 1976.*

Termination of Social Security Coverage: The Impact on State and Local Government Employees, committee print, September 1976.*

Witness Index and Research Reference, committee print, November 1976.*

Action on Aging Legislation in 94th Congress, committee print, November 1976.*

Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1976.*

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1977

The Proposed Fiscal 1978 Budget: What It Means for Older Americans, committee print, March 1977.*
Kickbacks Among Medicaid Providers, Report No. 95-320, June 1977.*
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1978

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Paperwork and the Older Americans Act: Problems of Implementing Accountability, committee print, June 1978.*
Single Room Occupancy: A Need for National Concern, committee print, June 1978.*
Protecting Older Americans Against Overpayment of Income Taxes, committee print, December 1978.*
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1979

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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

State and Local Government Terminations of Social Security Coverage, committee print, December 1980.*

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The Proposed Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, March 1982.*
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Health Care Expenditures for the Elderly: How Much Protection Does Medicare Provide?, committee print, April 1982.*
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Aging and the Work Force: Human Resource Strategies, committee print, August 1982.*
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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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Prospects for Medicare's Hospital Insurance Trust Fund, committee print, March 1983.*
The Proposed Fiscal Year 1984 Budget: What It Means for Older Americans, committee print, March 1983.*
You and Your Medicines: Guidelines for Older Americans, committee print, June 1983.*
Heat Stress and Older Americans: Problems and Solutions, committee print, July 1983.*
Current Developments in Prospective Reimbursement Systems for Financing Hospital Care, committee print, October 1983.*
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Older Americans and the Federal Budget: Past, Present, and Future, committee print, April 1984.*
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The Supplemental Security Income Program: A 10-Year Overview, committee print, May 1984, Stock No. 052-050-05928-1, $6.50.*
Long-Term Care in Western Europe and Canada: Implications for the United States, committee print, July 1984.*
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Section 202 Housing for the Elderly and Handicapped: A National Survey, committee print, December 1984.*
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Health and Extended Worklife, committee print, February 1985.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Personnel Practices for an Aging Workforce: Private-Sector Examples, committee print, February 1985.*
10th Anniversary of the Employee Retirement Income Security Act of 1974, committee print, April 1985.*
Publications list, committee print, April 1985.*
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How Older Americans Live: An Analysis of Census Data, committee print, Serial No. 99-D, October 1985.*
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1986

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The Cost of Mandating Pension Accruals for Older Workers, committee print, Serial No. 99-G, February 1986.*
The Impact of Gramm-Rudman-Hollings on Programs Serving Older Americans: Fiscal Year 1986, committee print, Serial No. 99-H, February 1986.*
Alternative Budgets for Fiscal Year 1987: Impact on Older Americans, committee print, Serial No. 99-I, May 1986, stock No. 552-070-00760-1, $1.75.
Nursing Home Care: The Unfinished Agenda, committee print, Serial No. 99-J, May 1986, stock No. 052-070-06155-3, $1.50.
Hazards in Reuse of Disposable Dialysis Devices, committee print, Serial No. 99-K, October 1986, stock No. 552-070-01074-2, $14.
The Health Status and Health Care Needs of Older Americans, committee print, Serial No. 99-L, October 1986, stock No. 552-070-01493-4, $1.50.
A Matter of Choice: Planning Ahead for Health Care Decisions, committee print, Serial No. 99-M, December 1986.*
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Publications List, committee print, March 1987, Serial No. 100-B.*
Older Americans Act Amendments of 1987: A Summary of Provisions, committee print, December 1987, Serial No. 100-C.*

1988

Helping Older Americans To Avoid Overpayment of Income Taxes, committee print, January 1988, Serial No. 100-D.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Publications List, committee print, February 1988, Serial No. 100-E.*
Compilation of the Domestic Volunteer Service Act of 1973, April 1988, Serial No. 100-F.*
The President's Fiscal Year 1989 Budget Proposal: How it Would Affect Programs for Older Americans, committee print, April 1988, Serial No. 100-G.*
Home Care at the Crossroads, committee print, April 1988, Serial No. 100-H.*
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Legislative Agenda for an Aging Society: 1988 and Beyond, joint committee print, June 1988, Serial No. 100-J.*
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Medicare's New Prescription Drug Coverage: A Big Step Forward, But Problems Still Exist, committee print, October 1988, Serial No. 100-M.*
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EEOC Headquarters Officials Punish District Director for Exposing Headquarters Mismanagement, committee print, December 1988, Serial No. 100-Q.*

1989

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1990

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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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Understanding Medicare: A Guide for Children of Aging Parents, July 1990, Serial No. 101-O.*
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Lifelong Learning for an Aging Society, December 1991, Serial No. 102-J.* (See 102-R.)

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A Status Report: Accessibility and Affordability of Prescription Drugs for Older Americans, August 1992, Serial No. 102-O.*
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1993

Protecting Older Americans Against Overpayment of Income Taxes, January 1993, Serial No. 103-A.

HEARINGS

Retirement Income of the Aging:*
- Part 1. Washington, D.C., July 12 and 13, 1961.
- Part 2. St. Petersburg, Fla., November 6, 1961.
- Part 3. Port Charlotte, Fla., November 7, 1961.
- Part 4. Sarasota, Fla., November 8, 1961.
- Part 5. Springfield, Mass., November 29, 1961.
- Part 6. St. Joseph, Mo., December 11, 1961.
- Part 7. Hannibal, Mo., December 13, 1961.
- Part 8. Cape Girardeau, Mo., December 15, 1961.
- Part 9. Daytona Beach, Fla., February 14, 1962.
- Part 10. Fort Lauderdale, Fla., February 15, 1962.

Housing Problems of the Elderly:*
- Part 1. Washington, D.C., August 22 and 23, 1961.
- Part 2. Newark, N.J., October 16, 1961.
- Part 3. Philadelphia, Pa., October 18, 1961.
- Part 4. Scranton, Pa., November 14, 1961.
- Part 5. St. Louis, Mo., December 8, 1961.

Problems of the Aging:*
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- Part 2. Trenton, N.J., October 23, 1961.
- Part 3. Los Angeles, Calif., October 24, 1961.
- Part 4. Las Vegas, Nev., October 25, 1961.
- Part 5. Eugene, Oreg., November 8, 1961.
- Part 6. Pocatello, Idaho, November 13, 1961.
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- Part 9. Honolulu, Hawaii, November 27, 1961.
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- Part 13. Kansas City, Mo., December 6, 1961.

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- Part 2. Walla Walla, Wash., November 10, 1961.
- Part 3. Hartford, Conn., November 20, 1961.
- Part 4. Boston, Mass., December 1, 1961.
- Part 5. Minneapolis, Minn., December 4, 1961.
- Part 6. Springfield, Mo., December 12, 1961.

Relocation of Elderly People:*
- Part 1. Washington, D.C., October 22 and 23, 1962.
- Part 2. Newark, N.J., October 26, 1962.
- Part 3. Camden, N.J., October 29, 1962.
- Part 4. Portland, Oreg., December 3, 1962.

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Relocation of Elderly People—Continued
Part 5. Los Angeles, Calif., December 5, 1962.
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Frauds and Quackery Affecting the Older Citizen:*
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Part 2. Los Angeles, Calif., January 9, 1964.
Part 3. San Francisco, Calif., January 11, 1964.
Long-Term Institutional Care for the Aged, Washington, D.C., December 17 and 18, 1963.*
Increasing Employment Opportunities for the Elderly:*
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Services for Senior Citizens:*
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Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.*
Nursing Homes and Related Long-Term Care Services:*
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Part 3. Washington, D.C., May 7, 1964.
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Preneed Burial Service, Washington, D.C., May 19, 1964.*
Conditions and Problems in the Nation's Nursing Homes:*
Part 1. Indianapolis, Ind., February 11, 1965.
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NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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Extending Private Pension Coverage:*
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The War on Poverty As It Affects Older Americans:*
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Services to the Elderly on Public Assistance:*
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Needs for Services Revealed by Operation Medicare Alert, Washington, D.C., June 2, 1966.*
Tax Consequences of Contributions to Needy Older Relatives, Washington, D.C., June 15, 1966.*
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, Washington, D.C., September 20, 21, and 22, 1966.*
Consumer Interests of the Elderly:*
Part 1. Washington, D.C., January 17 and 18, 1967.
Part 2. Tampa, Fla., February 3, 1967.
Reduction of Retirement Benefits Due to Social Security Increases, Washington, D.C., April 24 and 25, 1967.*
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Part 2. Ann Arbor, Mich., July 26, 1967.
Costs and Delivery of Health Services to Older Americans:*
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Part 2. New York, N.Y., October 19, 1967.
Part 3. Los Angeles, Calif., October 16, 1968.
Rent Supplement Assistance to the Elderly, Washington, D.C., July 11, 1967.*
Long-Range Program and Research Needs in Aging and Related Fields, Washington, D.C., December 5 and 6, 1967.*
Hearing Loss, Hearing Aids, and the Elderly, Washington, D.C., July 18 and 19, 1968.*
Usefulness of the Model Cities Program to the Elderly:*
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Part 6. Boston, Mass., July 11, 1969.
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Adequacy of Services for Older Workers, Washington, D.C., July 24, 25, and 29, 1968.*

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Availability and Usefulness of Federal Programs and Services to Elderly Mexican-Americans: *
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Economics of Aging: Toward a Full Share in Abundance:*
Part 1. Washington, D.C., survey hearing, April 29 and 30, 1969.
Part 2. Ann Arbor, Mich., consumer aspects, June 9, 1969.
Part 3. Washington, D.C., health aspects, July 17 and 18, 1969.
Part 4. Washington, D.C., homeownership aspects, July 31 and August 1, 1969.
Part 5. Paramus, N.J., central suburban area, August 14, 1969.
Part 6. Cape May, N.J., retirement community, August 15, 1969.
Part 7. Washington, D.C., international perspectives, August 25, 1969.
Part 8. Washington, D.C., national organizations, October 29, 1969.
Part 9. Washington, D.C., employment aspects, December 18 and 19, 1969.
Part 10A. Washington, D.C., pension aspects, February 17, 1970.
Part 10B. Washington, D.C., pension aspects, February 18, 1970.
Part 11. Washington, D.C., concluding hearing, May 4, 5, and 6, 1970.
The Federal Role in Encouraging Preretirement Counseling and New Work Lifetime Patterns, Washington, D.C., July 25, 1969.*
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Part 2. St. Petersburg, Fla., January 9, 1970.
Part 3. Hartford, Conn., January 15, 1970.
Part 4. Washington, D.C. (Marietta, Ohio, fire), February 9, 1970.
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Older Americans in Rural Areas:*
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Part 2. Majestic-Freeburn, Ky., September 12, 1969.
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Income Tax Overpayments by the Elderly, Washington, D.C., April 15, 1970.*
Sources of Community Support for Federal Programs Serving Older Americans:*
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Part 2. Boston, Mass., April 30, 1971.
Evaluation of Administration on Aging and Conduct of White House Conference on Aging:*
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Adequacy of Federal Response to Housing Needs of Older Americans:*
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Flammable Fabrics and Other Fire Hazards to Older Americans, Washington, D.C., October 12, 1971.*
A Barrier-Free Environment for the Elderly and the Handicapped:*
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Future Directions in Social Security:*
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Fire Safety in Highrise Buildings for the Elderly:*
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Part 2. Washington, D.C., February 28, 1973.
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Part 1. Los Angeles, Calif., June 14, 1974.
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The Impact of Rising Energy Costs on Older Americans—Continued
Part 2. Washington, D.C., September 25, 1974.
Part 3. Washington, D.C., November 7, 1975.
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Part 6. Washington, D.C., June 28, 1977.
Part 7. Missoula, Mont., February 14, 1979.
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Part 9. Washington, D.C., March 9, 1977.
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Part 1. Winterset, Iowa, August 16, 1976.
Part 2. Ottumwa, Iowa, August 16, 1976.
Part 3. Gretna, Nebr., August 17, 1976.
Part 4. Ida Grove, Iowa, August 17, 1976.
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Part 10. Terre Haute, Ind., November 11, 1977.
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Part 12. Roswell, N. Mex., November 18, 1977.
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Part 14. Albuquerque, N. Mex., November 21, 1977.
Part 15. Pensacola, Fla., November 21, 1977.
Part 16. Gainesville, Fla., November 22, 1977.

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Part 17. Champaign, Ill., December 13, 1977.
Medicine and Aging: An Assessment of Opportunities and Neglect, New York, N.Y., October 13, 1976.*
Effectiveness of Food Stamps for Older Americans:*
Part 1. Washington, D.C., April 18, 1977.
Part 2. Washington, D.C., April 19, 1977.
Health Care for Older Americans: The "Alternatives" Issue:*
Part 1. Washington, D.C., May 16, 1977.
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Part 4. Cleveland, Ohio, July 6, 1977.
Part 5. Washington, D.C., September 21, 1977.
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Part 8. Washington, D.C., April 17, 1978.
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Federal Paperwork Burdens, With Emphasis on Medicare (joint hearing with Subcommittee on Federal Spending Practices and

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Open Government of the Senate Committee on Governmental Affairs), St. Petersburg, Fla., August 6, 1979.*
Abuse of the Medicare Home Health Program, Miami, Fla., August 28, 1979.*
Occupational Health Hazards of Older Workers in New Mexico, Grants, N. Mex., August 30, 1979.*
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Part 1. Akron, Ohio, August 30, 1979.
Part 2. Washington, D.C., September 13, 1979.
Part 3. Pennsauken, N.J., May 23, 1980.
Part 4. Washington, D.C., July 25, 1980.
Regulations To Implement the Comprehensive Older Americans Act Amendments of 1978:*
Part 1. Washington, D.C., October 18, 1979.
Part 2. Washington, D.C., March 24, 1980.
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Energy and the Aged: A Challenge to the Quality of Life in a Time of Declining Energy Availability, Washington, D.C., November 26, 1979.*
Adapting Social Security to a Changing Work Force, Washington, D.C., November 28, 1979.*
Aging and Mental Health: Overcoming Barriers to Service:*
Part 1. Little Rock, Ark., April 4, 1980.
Part 2. Washington, D.C., May 22, 1980.
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Part 1. Washington, D.C., April 24, 1980.
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Part 3. Orlando, Fla., July 9, 1980.
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Part 2. St. Petersburg, Fla., October 28, 1980.
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Part 1. Washington, D.C., November 21, 1980.
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Part 1 (Short-Term Financing Issues). Washington, D.C., June 16, 1981.
Part 2 (Early Retirement). Washington, D.C., June 18, 1981.
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Energy and the Aged: The Widening Gap, Erie, Pa., February 19, 1982.*

Hunger, Nutrition, Older Americans: The Impact of the Fiscal Year 1983 Budget, Washington, D.C., February 25, 1982.*

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Quality Assurance Under Prospective Reimbursement Programs, Washington, D.C., February 4, 1983.*
Combating Frauds Against the Elderly, Washington, D.C., March 1, 1983.*
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Social Security Reviews of the Mentally Disabled, Washington, D.C., April 7, 8, 1983.*
The Future of Medicare, Washington, D.C., April 13, 1983.*
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Community Alternatives to Institutional Care, Harrisburg, Pa., July 6, 1983.*
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Endless Night, Endless Mourning: Living With Alzheimer's, New York, N.Y., September 12, 1983.*
Controlling Health Care Costs: State, Local, and Private Sector Initiatives, Washington, D.C., October 26, 1983, stock No. 052-070-05899-4, $3.75.*

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Social Security: How Well Is It Serving the Public? Washington, D.C., November 29, 1983.*
The Crisis in Medicare: Proposals for Reform, Sioux City, Iowa, December 13, 1983.*
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Living Between the Cracks: America's Chronic Homeless, Philadelphia, Pa., December 12, 1984.
Unnecessary Surgery: Double Jeopardy for Older Americans, Washington, DC, March 14, 1985, Serial No. 99–1.
Rural Health Care in Oklahoma, Oklahoma City, OK, April 9, 1985, Serial No. 99–2.*
Prospects for Better Health for Older Women, Toledo, OH, April 15, 1985, Serial No. 99–3.*
Pacemakers Revisited: A Saga of Benign Neglect, Washington, DC, May 10, 1985, Serial No. 99–4, Stock No. 552–070–00035–6, $25.

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The Pension Gamble: Who Wins? Who Loses? Washington, DC, June 14, 1985, Serial No. 99-5.
Americans At Risk: The Case of the Medically Uninsured, Washington, DC, June 27, 1985, Serial No. 99-6.*
The Graying of Nations II, New York, NY, July 12, 1985, Serial No. 99-7, stock No. 052-070-06113-8, $4.75.*
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Challenges for Women: Taking Charge, Taking Care, Cincinnati, OH, November 18, 1985, Serial No. 99-12, stock No. 552-070-00264-2, $2.50.*
The Relationship Between Nutrition, Aging, and Health: A Personal and Social Challenge, Albuquerque, NM, December 14, 1985, Serial No. 99-13, stock No. 552-070-00311-8, $3.25.*
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Employment Opportunities for Women: Today and Tomorrow, Cleveland, OH, April 21, 1986, Serial No. 99-17, stock No. 552-070-00632-0, $3.*
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Nursing Home Care: The Unfinished Agenda, Washington, DC, May 21, 1986, Serial No. 99-19.*
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Working Americans: Equality at Any Age, Washington, DC, June 19, 1986, Serial No. 99-21, stock No. 552-070-00818-7, $4.50.
The Older Americans Act and Its Application to Native Americans, Oklahoma City, OK, June 28, 1986, Serial No. 99-22, stock No. 552-070-00836-5, $6.

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Part 2. Little Rock, AR, August 28, 1986.
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Home Care: The Agony of Indifference, Washington, DC, April 27, 1987, Serial No. 100-5.*
Outpatient Hospital Costs, St. Petersburg, FL, June 27, 1987, Serial No. 100-6.*
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The Social Security Notch: Justice or Injustice? Washington, DC, February 22, 1988, Serial No. 100-17.*
Adverse Drug Reactions: Are Safeguards Adequate for the Elderly? Washington, DC, March 25, 1988, Serial No. 100-18.*
Vanishing Nurses: Diminishing Care, Philadelphia, PA, April 6, 1988, Serial No. 100-19.*
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Advances in Aging Research, Washington, DC, May 11, 1988, Serial No. 100-21.
Kickbacks in Cataract Surgery, Philadelphia, PA, May 23, 1988, Serial No. 100-22.
The Rural Health Care Challenge:
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Part 2—Rural Health Care Personnel, Washington, DC, July 11, 1988, Serial No. 100-23.*
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Prescription Drug Prices: Are We Getting Our Money's Worth? July 18, 1989, Washington, DC, Serial No. 101-6.*
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Long-Term Care in Rural America: A Family and Health Policy, Challenge, August 22, 1989, Little Rock, AR (joint with Pepper Commission), Serial No. 101-8.*
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Medicare Coverage of Catastrophic Health Care Cost: What Do Seniors Need, What Do Seniors Want? Las Vegas, NV October 10, 1989, Serial No. 101-11.*
The Shadow Caregivers: American Families and Long-Term Care, November, 13, 1989, Philadelphia, PA, Serial No. 101-12.
Our Nation's Elderly: Hidden Victims of the Drug War? Washington, DC, November 15, 1989, Serial No. 101-13.
Skyrocketing Prescription Drug Prices: Turning a Bad Deal Into a Fair Deal, November 16, 1989, Washington, DC, Serial No. 101-14.
Medigap Insurance: Cost, Confusion, and Criminality, December 11, 1989, Madison, WI, Serial No. 101-15.*
Rising Medigap Premiums: Symptom of a Failing System? January 8, 1990, Harrisburg, PA, Serial No. 101-16.
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Crimes Against the Elderly: Let's Fight Back, August 21-22, 1990, Reno and Las Vegas, NV, Serial No. 101-26.
Long-Term Care for the Nineties: A Spotlight on Rural America, August 21, 1990, Little Rock, AR, Serial No. 101-27.
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Resident Assessment: The Springboard to Quality of Care and Quality of Life for Nursing Home Residents, October 22, 1990, Washington, DC, Serial No. 101-30.
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