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DEVELOPMENTS IN AGING: 1988
VOLUME 1

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 381, SEC. 19, FEBRUARY 26, 1988

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

FEBRUARY 28 (legislative day, JANUARY 3), 1989.—Ordered to be printed

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC, February 28, 1989.

Hon. J. DANFORTH QUAYLE,
President, U.S. Senate,
Washington, DC.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 381, Section 19, agreed to February 26, 1988, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1988, volume 1.

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

This report describes actions during 1988 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, their families, and for those who hope to become older Americans in the future.

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 381, SECTION 19, 100TH CONGRESS, 2D 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, 1988, through February 28, 1989, 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 $1,094,591, 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 26, 1988.

PREFACE

A number of developments in aging emerged as particularly noteworthy in 1988. Without question, however, the passage of the Medicare Catastrophic Coverage Act of 1988, must top any list. After 18 months of debate, the President signed this measure into law on July 1, 1988.

Beyond the catastrophic health care legislation, 1988 was notable for the fact that all 13 appropriations bills were signed into law and an omnibus reconciliation measure emerged from the Congress. This development was largely the result of the 1987 "Budget Summit" agreement, which followed the October 1987 stock market crash, and was generally perceived to be a positive occurrence as there were relatively few budget surprises that caught beneficiaries and health care and other providers off guard.

The issue with the greatest continuing impact on the elderly in 1988 was the need to strike an acceptable balance between the desire to reduce the Federal deficit and the desire to address the unmet needs of the Nation. As has become the practice, most new initiatives required financing which was either budget neutral or which would actually reduce the deficit. As a result, there was limited progress made toward resolving the many major challenges facing the elderly including: The lack of protection against the devastating costs of long-term illness, the difficulties of assuring health care in rural areas, and the continuing prevalence of poverty among the elderly.

Operating within these forces, the Special Committee on Aging contributed to an impressive record of accomplishments during the second session of the 100th Congress. Following up on a series of hearings on the catastrophic health care needs of Americans of all ages in 1987, the Committee further contributed to the development of legislation by holding a hearing in early 1988 on the serious problems and costs associated with adverse drug reactions. This hearing contributed to assuring that the Medicare Catastrophic Protection Act of 1988 included a drug utilization review provision, which should contribute to reducing inappropriate, excessive and expensive drug prescribing patterns. This provision adds to a wide range of other Medicare benefit improvements including capping the amount a beneficiary must pay out-of-pocket for Medicare-covered services, extending the number of days covered under Medicare's home health and skilled nursing facility benefit, and expanding the Medicare program to cover the costs of prescription drugs once a deductible is met.

The Committee was particularly active in holding a number of hearings on a broad range of subjects and its production and release of information prints. Three hearings, and a staff report focusing on the challenges rural communities face in assuring access to health care, significantly contributed to the Congress' under-

standing of this issue. By the end of 1988, the report, "The Rural Health Care Challenge," was being used as a basis for the development of legislation to be introduced in 1989. In addition, the Committee's hearing on age discrimination led to a greater awareness of the Equal Employment Opportunity Commission's shortcomings in its efforts to enforce the Age Discrimination in Employment Act. In addition, information prints on important issues, such as home care, health insurance for the uninsured, Medicare physician payment reform, were released and received widespread praise.

Where do we now stand on issues of importance to our Nation's seniors? Having taken steps toward expanding coverage and improving access to needed health care, what problems remain on the Congressional agenda? Despite the gains in the second session of the 100th Congress, much remains to be done.

The staggering problem of access to health care for the aged and non-aged alike has been thrust onto the legislative agenda during the past year. Over thirty-seven million Americans lack health insurance. One-third of the U.S. population with incomes below the poverty level are uninsured. These statistics highlight gaps in protection for even the most needy Americans. Likewise, while nearly 98 percent of older Americans are enrolled in Medicare, more than one-quarter of their health costs must be paid out-of-pocket.

Although the passage of the Medicare Catastrophic Coverage Act of 1988 represents an important first step toward protecting the elderly against the costs of catastrophic illness, it focuses on acute, short-term illness, rather than the chronic, long-term illnesses that lead to true catastrophic expenditures. While there are provisions in the new law that will provide information on the need for and availability of long-term care coverage and on ways to finance it, there are more than 2 million older Americans facing catastrophic long-term care expenditures who will remain unprotected from these costs.

Solving their problems requires a major commitment on the part of the Federal Government, as well as renewed efforts by the private sector. Private long-term care insurance has modestly grown in popularity and availability. However, recent analyses by the Brookings Institution indicate that even under generous assumptions, private insurance will cover no more than 20 percent of the Nation's long-term care bill by the year 2020. If this is true, the remainder must come from either the pockets of older Americans and their families or the public sector—either through an expansion of Medicaid, a redesign of Medicare, or a new Federal program.

Part of any comprehensive long-term care initiative must include an acknowledgment of the importance of assuring housing to the growing number of chronically ill Americans of ages. Without shelter, the availability of services traditionally designated as long-term care are of little use to chronically ill persons.

In recent years, cost containment initiatives aimed at controlling health care costs have contributed to an increased demand on community-based human services and housing. This fact, combined with a 75 percent cut in Federal support of housing programs during the last eight years and an ever-increasing aged population, practically guarantees that this demand will continue to grow. In

response to the overwhelming housing needs of the Nation, it now appears very likely that a major housing reform initiative will be given serious consideration during the 101st Congress. However, during the process of any housing reform, it is important to recognize the importance of medical and non-medical long-term care services to the elderly who reside in assisted housing.

Beyond the issue of long-term care, expenditures by older Americans and the Medicare Program on physician services and other services reimbursed under Part B of Medicare continue to increase. As this trend continues, so too will pressures to find an alternative physician reimbursement approach. Should this pressure prove to be overwhelming, developing and implementing a new reimbursement method that is fair to both the elderly and physicians, as well as cost-effective to the Medicare Program, will be a great challenge to the 101st Congress.

Eliminating poverty persists as one of the thorniest policy issues facing the Nation. Among the elderly, this problem is especially difficult. The overall poverty rate among the elderly declined markedly during the past two decades, largely because of improvements in Social Security benefits. Nonetheless, poverty among the aged is more widespread and long-term than among any other adult age group. In 1985, the poverty rate for the elderly as a group was 12.6 percent. Subgroups of the elderly are even worse off—for example, 31.5 percent of the black elderly live in poverty; among Hispanics, 23.9 percent. For black women living alone, 54.5 percent fall below the official poverty line.

Poverty numbers, like statistics in general, often mask the human suffering they represent. To understand what it means to be old and poor, imagine living on about $100 per week (the official elderly poverty line in 1986 was $5,393 for singles, $6,802 for couples). The old are more than twice as likely as the remainder of the population to be stuck in long-term poverty, which means being poor for 8 out of 10 years. Health care costs consume more than three times as much of their disposable income as the nonelderly. Faced with virtually no opportunities to increase their income, the spector of poverty and illness among the aged is frightening indeed.

The above record demonstrates a productive year for the committee measured in legislative accomplishments. The committee's work, however, extends beyond making legislative recommendations. In the past year we have continued to investigate a wide range of problems affecting the elderly, informing the public through committee prints, newsletters, and public hearings.

The report that follows discusses developments of importance to older Americans in 1988. In line with changes implemented in 1984, the report surveys only Federal policies and programs and focuses exclusively on the major policy issues facing Congress and the legislative activity on these issues that transpired in 1988.

In a break from recent practice, comprehensive demographic and statistical information is not included in this year's report. Updated data can be found in a soon to be released information paper entitled "Aging America: Trends and Projections."

We are proud to acknowledge the dedicated work of the authors of this report, the staff of the Special Committee on Aging. This

report is a synthesis of the extensive working knowledge they bring to the committee.

The graying of America presents us with significant challenges and opportunities. Providing for the health, income, and housing needs of this ever-growing older population are only a few of the challenges. We must also seek better ways to enable older Americans to remain productive and independent. Our greatest challenge then is to expand opportunities, to put to use the full talents of this vast resource so that the promise of long life is worth living.

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SUPPLEMENTAL MATERIAL

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DEVELOPMENTS IN AGING: 1988 VOLUME 1

FEBRUARY 28 (legislative day, JANUARY 3), 1989.—Ordered to be printed

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

REPORT

Chapter 1

SOCIAL SECURITY—RETIREMENT AND DISABILITY

OVERVIEW

In 1988, like any other recent Presidential and Congressional campaign year, candidates for elected office stressed their commitment to protecting Social Security from budget cuts. As a consequence, election-year cycle pressures assured that their would be no controversial measures that affected the Social Security program. In the preceding year, with one eye on the upcoming Presidential campaign and the other on the political firestorm that had enveloped the Senate in response to an earlier Republican proposal to cut the 1986 Social Security COLA, the Reagan Administration had negotiated with Congressional leaders a fiscal year 1989 deficit reduction package that steered clear of any proposed cuts in Social Security. On January 1, 1989, Social Security beneficiaries quietly received a 4-percent increase to offset inflation.

Political figures who chose to pursue a contrary agenda did so at their own risk. In mid-1988, for example, when the Co-chairman of the National Economic Commission, Robert S. Strauss, publicly announced that Social Security benefit cuts should be included in a deficit reduction package, his recommendation was quickly denounced by both Presidential candidates and a number of Members of Congress.

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All the while, however, a movement outside of political circles was growing to build tolerance, if not eventual support, for reducing Social Security outgo—either through a COLA cut or a tax increase on benefits—as a means of deficit reduction. This campaign was waged in the popular press, often portraying Social Security as unfairly benefitting well-off elderly at the expense of working Americans. In a related tack, proponents of Social Security reductions claimed that were it not for the disproportionate share of resources diverted to finance Social Security benefits, a better job could be done in assisting the Nation's large numbers of impoverished children. Such anti-elderly epitaphs as "greedy-geezer" were a product of this strategy of pitting one generation against the other.

Aside from these attacks on the merits of Social Security, the engine driving the debate over the program is concern on Wall Street and elsewhere over the financial impact of the Nation's mounting budget deficit. Although Social Security is a self-financing program that has not contributed to the deficit in general revenues, it nevertheless plays an enormous role in determining the appearance of the deficit. Under Gramm-Rudman-Hollings, Social Security trust funds are factored into the deficit totals applicable under that law. Because of the reserves Social Security is accumulating, this accounting method shows a deficit that is offset by the Social Security reserves. Other self-financing trust funds have the same effect, but not to the extent of Social Security. In 1988 alone, the inclusion of Social Security offset $40 billion in the general revenue deficits. Thus, the larger the Social Security trust funds, the smaller the apparent size of the deficit.

At the same time, larger Social Security trust funds mean that the Federal Government needs to borrow less from the public, keeping interest rates lower. Under law, any Social Security reserves are invested in interest-paying Treasury securities, thereby making these assets available to finance other Federal programs. In this way, the Government does not crowd out those in the private sector seeking financing.

During the 1988 Presidential campaign, the two opposite currents moving in political circles and the popular press regarding Social Security did not cross. Contenders for the White House, as well as Members in the House and Senate who were up for re-election, were fully aware of the immense support for Social Security and that proposals to cut program benefits were political taboo. With the budget deficit continuing to climb, however, 1988 marked the setting of the stage for debate over this issue in coming years.

In 1988, Congress was faced with a number of issues involving the Social Security program's administration and the benefit computation for so-called "notch" babies and the cost-of-living adjustment.

During this same period, the implementation of the Social Security Disability Benefits Reform Act of 1984 continued to be a concern related to the Disability Insurance (DI) program. Attention was paid to the manner in which the law was carried out, particularly with respect to beneficiaries' rights to appeal negative decisions.

A. SOCIAL SECURITY—OLD AGE AND SURVIVORS INSURANCE

1. Background

Under title II of the Social Security Act, the old age and survivors insurance (OASI) and disability insurance (DI) program—together, the OASDI program—was 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 under title II are based on a worker's earnings. In October 1988, close to $18 billion in monthly benefits were paid to Social Security beneficiaries, with payments to retired workers averaging $515 and those to disabled workers $509. Administrative expenses were $2.5 billion or 1 percent of total benefit payment during that period, showing next to no change over the preceding fiscal year.

It is fair to say that the Social Security program touches the lives of nearly every American. In 1988, there were over 38 million Social Security beneficiaries. Under the OA portion of Social Security, retired workers numbered nearly 24 million, accounting for 63 percent of all beneficiaries. Disabled workers and dependent family members numbered over 4 million comprising about 10 percent of the total, while surviving family members of deceased workers totalled over 7 million or 18 percent of all beneficiaries. During the same year, about 130 million workers were in Social Security-covered employment, representing approximately 94 percent of the total American workforce.

In 1988, Social Security contributions were paid on up to $45,000 of earnings, the wage cap that is annually indexed to keep pace with inflation. Workers and employees alike pay a 7.51 percent of earnings (of which 1.45 percent represents contributions to the Hospital Insurance portion of Medicare). For the self-employed, the payroll tax is doubled, or 15.02 percent of earnings.

No discussion of Social Security finances would be complete without mention of the accumulating reserves of the Social Security trust funds. As a result of increases in the Social Security payroll tax to build assets sufficient to cover the retirement needs of the so-called baby boom generation in the 21st century, the influx of funds into Social Security is increasingly exceeding the outflow in benefit payments. In 1988, the Social Security reserves totalled an estimated $40 billion, compared with $24 billion in 1987.

(a) History and purpose

Created during the Great Depression by the Social Security Act of 1935, the Social Security Program was heralded by proponents as an unprecedented social advance. Like a jolt, the Wall Street Crash and the havoc resulting from that event had awakened Americans to the fact that the Nation was by no means immune from sudden and uncontrollable economic forces with the power to generate massive unemployment, hunger, and widespread despondency. With no time to lose, the Roosevelt Administration had worked to develop and implement strategies to alleviate rampant individual misfortune, as well as to help protect Americans against

a recurrence of such misfortune. Social Security was among the boldest and most enduring results of this effort.

Although Social Security is a uniquely American program, 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 from the loss of income due to old-age, disability, or death that was similarly government-sponsored, compulsory, and independently financed.

While Social Security is generally regarded as a program primarily for 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 also gain a new measure of income security for themselves or their family in the event of retirement, disability, or death.

President Roosevelt viewed the new and experimental Social Security Program as the centerpiece "for the kind of protection America wants." In the more than half a century since the program's establishment, Social Security has been expanded and changed substantially over this time. 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 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 service credits.

In assessing the value of Social Security, there are a number of multiple features of the program that should be taken into account. First, Social Security goes a long way way toward freeing workers from the unpredictable and random costs of supporting their aged parents and relatives. By spreading these costs across the working population, they become on the average smaller and more manageable. At the same time universal coverage limits the degree to which the burden of supporting aged or disabled persons falls inadvertently to society.

Second, Social Security provides 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 pension benefit upon retirement. Significantly, because Social Security is an earned right, based on contributions over the years from the retired or disabled worker's earnings, Social Security ensures a financial foundation in accordance with a beneficiary's self-respect.

The essential social functions and multiple purposes of Social Security defy comparison with other financial or insurance vehicles. No single instrument could perform the unique combination of functions without approximating Social Security in its features. Most criticisms of Social Security, therefore, readily translate into criticisms of its mix of functions. For example, some critics believe Social Security ought to be only a pension plan, leaving the insurance and intergenerational support functions to specially tailored alternative programs. Others 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 IRA's. Though the use of separate programs would eliminate the compromises entailed in Social Security, it would also raise tremendously the total cost of performing all of Social Security's multifaceted functions, and most likely would jeopardize the widespread political support that has developed for these functions of the program.

The Social Security Program is only now coming of age. The decade of the 1980's marks the first generation of lifelong contributors retiring and beginning to draw benefits. Also during this decade, it is expected that payroll tax rates, eligibility requirements, and the relative value of monthly benefits will finally stabilize at the levels planned for the system.

(B) FINANCING

(1) Financing in the 1970's

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

The experience of the 1970's was considerably less favorable than forecasted however. 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 retirees, and thereby created an additional drain on trust fund reserves.

In 1977, recognizing that the financial status of the Social Security trust funds was rapidly deteriorating, 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 forecasts had 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, and 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 imposed by the work of the National Commission deferred the legislative solution to Social Security's financing problems to the 98th Congress. But 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.

(2) 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 improved financing by $166 billion between 1983 and 1989, and eliminated a deficit which had been expected to average 2.1 percent of payroll 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 for 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 in turn 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.

(3) 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 four different sets of assumptions. Alternative I is designated as the most optimistic, followed by intermediate assumptions II-A and II-B, and finally the more pessimis-

tic alternative III. 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 reserves ratios hit a low of 11 percent at the beginning of 1983, but increased to approximately 41 percent by 1988. Based on intermediate assumptions, the contingency fund ratio is projected to increase gradually to 71 percent by the beginning of 1990. Even under pessimistic assumptions, assets are projected to reach 64 percent by the beginning of the next decade.

(a) OASDI Near Term Financing

Social Security trust fund assets are expected to increase over the next 5 years. Indeed, according to the 1988 OASDI Trustees Report, OASDI assets will be sufficient to meet the required benefit payments throughout and far beyond the upcoming 5-year period. Under all but the most pessimistic assumptions, both the OASI and DI programs will remain solvent on their own for many years. However, should conditions deteriorate drastically during the coming 10 years, DI Trust Fund assets could decline to dangerously low levels.

The projected expansion in the OASDI reserves will be aided by a scheduled payroll tax increase—from 7.51 percent (with an upper limit of $45,000) in 1988 to 7.65 percent in 1990. Under all sets of assumptions in the 1988 Social Security trustees report, the OASDI contingency funds were expected to remain between 41 and 76 percent of projected outgo until 1990. Beginning in 1988, the OASDI reserves are expected to begin a steady buildup as a result both of the scheduled 1990 tax increase and an anticipated leveling off in the growth rate of new retirees.

(b) OASDI Long-Term Financing

In the long run, the Social Security trust fund appears to be in close actuarial balance, meaning that over the next 75 years, it is projected that the taxes collected for Social Security will fall within plus or minus 5 percent of the amount needed to pay benefits. Under current projections based on intermediate assumptions, the trustees predict that the trust funds will remain solvent throughout the next 75 years.

Although forecasted to remain healthy for the long term, it should be emphasized that the OASDI trust fund experience in each of the three 25-year periods between 1988 and 2062 varies considerably. In the first 25-year period—1988 to 2012—the trust funds are expected to accumulate rapidly, and maintain an annual surplus of revenues equal to 2.15 percent of taxable payroll. As a result of these surpluses, contingency fund ratios are expected to build to approximately 285 percent by the year 2000.

In the second 25-year period—2013 to 2037—the financial condition of OASDI is expected to continue improving in the early years,

but begin deteriorating toward the end of the period. Trust fund reserves are expected to grow to approximately 531 percent of annual expenditures by 2015, and then decline to 251 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 3.12 percent of taxable payroll. This combination of surpluses and deficits will result in an average deficit of 1.45 percent of taxable payroll over this 25-year period.

The third 25-year period—2038 to 2062—is expected to be one of continuous deficits. Program costs will continue to grow until 2035 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 2048. If considered separately, depletion of DI reserves is expected by 2027, while OASI Trust Fund exhaustion is projected for the year 2050. Annual OASDI deficits over the 25-year period are expected to average 3.32 percent of taxable payroll.

(c) Midterm surpluses

In the years between 1990 and 2015, it is projected that Social Security will receive far more in income than it must distribute in benefits. Under current law, these surpluses 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 2062. 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 surplus funds, and the political and economic implications they entail.

During the period in which Social Security trust fund surpluses are accumulating, the surplus funds can be used, indirectly, to finance other Government expenditures or reduce the public debt. 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 surplus revenues in the 1990's and cut back on underfunded benefits after 2020. The growing trust fund surpluses 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.

(d) Long-term deficits

The longrun 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 30 years. The eroding tax base in future years is forecast as a result of falling fertility rates.

The relative increase in the number of beneficiaries per worker will not necessarily threaten the solvency of Social Security if productivity gains in the future compare to the experience of the past 30 years. If such gains continue, even though the ratio of workers to beneficiaries will in all likelihood decline, this could be offset by economic growth and increased real wages. However, many are highly skeptical about such a scenario.

In addition, this relative increase in the number of beneficiaries will be a problem despite productivity increases if the Social Security tax base is allowed to erode. If current trends continue and nontaxable fringe benefits grow, less and less compensation will be subject to the Social Security payroll tax. In 1950, fringe benefits accounted for only 5 percent of total compensation, and FICA taxes were levied on 95 percent of compensation. By 1980, fringe benefits had grown to account for 16 percent of compensation. Continuation in this rate of growth in fringe benefits, as projected by the Social Security actuaries, might eventually exempt over one-third of payroll from Social Security taxes. This would be a substantial erosion of the Social Security tax base and 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 4.7 percent of the GNP. Under intermediate assumptions—with 1.4 percent real wage growth—Social Security is expected to rise to 6.61 percent of the GNP by 2035, declining to 6.51 percent by 2060.

Currently, neither short-term nor long-term deficits are projected for the OASDI trust funds. Although there is no question that surpluses 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 revise 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 to use the trust funds to offset the Federal budget deficit may overshadow the attention paid to maintaining Social Security's solvency.

2. ISSUES

(A) 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 surpluses that have accumulated in recent years have served to mask its true magnitude. In fact, many contend that the inclusion of the surpluses has disguised the enormity of the Nation's fiscal problems and vented the pressures for true deficit reduction. For these same reasons, there has been increasing concern over the temptation cuts in Social Security benefits pose to those seeking ways to further reduce the apparent size of the budget deficit.

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 budget process by fiscal year 1993, and the subsequent Gramm-Rudman-Hollings law accelerated this removal to fiscal year 1986. As further protections, under rules binding both chambers, Social Security was excluded from any budget documents, budget resolutions, and reconciliation measures and barred from any Gramm-Rudman-Hollings across-the-board cut or sequester. Only in the event that each chamber casted separate votes to modify or suspend the rules could Social Security be considered within the context of a budget resolution or reconciliation bill. However, administrative funds for SSA were not placed off-limits from a budget sequester.

Despite these changes, the removal of the Social Security trust funds from the budget process has been far from complete. While the official budget does not count Social Security, the program's trust funds, which have been running a surplus and will continue to do so, are factored into the deficit reduction targets under Gramm-Rudman-Hollings. Were it not for this inclusion, much deeper budget cuts in Federal spending would be required to reach the law's deficit reduction targets. Indeed, some estimates have shown that in the absence of Social Security, additional cuts of up to $60 billion would be required to meet the Gramm-Rudman-Hollings target of a balanced budget by fiscal year 1991.

As long as Social Security is included in the Gramm-Rudman-Hollings deficit reduction targets, Social Security will remain a potent target for deficit reduction efforts. Further, given sufficient political pressure to cut Social Security benefits or otherwise increase the size of the trust fund, the safeguards contained in the Gramm-Rudman-Hollings law amount to little more than procedural hurdles.

(B) ADMINISTRATIVE ISSUES IN SOCIAL SECURITY

Over time, Congress has monitored the performance of the Social Security Administration (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 an elite agency, marked by high employee

morale and excellent management. In the past 15 years, however, many have contended that the agency has lost its esprit de corps, and the quality of service has declined. Factors cited as causing this decline include new agency responsibilities (for example, the creation of SSI in 1972), multiple administrative reorganization efforts, budget cuts, and the fact that the SSA has had 10 different Commissioners in the last 14 years. Many claim that the agency has sacrificed the quality of service to the public in an effort to cut costs, and that public confidence in the agency consequently has declined.

These criticisms have resulted in numerous Congressional requests for investigations of SSA problems. The outcome has been an ongoing review of the agency by the General Accounting Office (GAO). During the past several years, GAO has released a series of reports on SSA staff reductions and resulting quality of service provided to the public, payment accuracy to beneficiaries, accessibility to the agency by telephone, and problems of fragmented leadership.

(1) Staff Reductions

Efforts by SSA over recent years to reduce its number of field offices and employees have continued to raise concerns about a possible deterioration in the agency's quality of 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.

Indeed, in 1984, SSA was asked to provide OMB with an estimate of the staff-year savings which could result from an agency computer modernization plan. The agency was fraught with disagreement regarding staff-reduction potentials and key persons were not involved in formulating the recommendation which eventually went forward. According to GAO, "it appears that SSA's inability to reach agreement and respond to requests . . . for staff-year savings and the resulting estimate . . . contributed to SSA's being in an essentially reactive position to OMB's call for a 17,000 staff reduction."

While most critics recognize that SSA must monitor its operating costs closely and that some staff reductions and office closings may be necessary, they nonetheless believe that SSA has been pursuing cost cuts without regard to the quality of service being provided. During a recent hearing of the House Ways and Means Subcommittee on Social Security, several parties testified that increasing workloads and the resulting deterioration of overall job effectiveness in some areas is contributing to severe stress among SSA employees. Critics cited the consequential loss of confidence in the system among younger workers, few 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 em-

ployees fast approaching retirement age, along with the SSA's increasing difficulty in retaining a hiring 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 workforce. 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.

In response to congressional concern in this area, the GAO has issued a number of reports in recent years on the effect of staff cutbacks. In 1988, SSA personnel totalled 68,000, a 3-percent reduction over the previous year's level and 12,000 less than the staffing level in the early 1980's. In view of continued congressional attention on any damaging consequences of this planned cutbacks in agency personnel, this issue will remain a focus of concern.

(2) 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 to involve an effort 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 to involve software improvement.

While the SMP was originally designed as a 5-year modernization effort (1982–87), the project will probably not reach completion for several more years. While SSA originally estimated completion of the functional requirements of its redesigned computer by 1985, as of mid-1987 the agency estimated finalization in early 1988. Once those requirements are met, the design, testing, and implementation of the system will not be completed until sometime in the 1990's. According to GAO, this will result in delaying much 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 at best.

The core of 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 to improve and modernize as efficiently as possible.

In 1988, one of a series of reports in recent years on SSA's computer modernization efforts, the GAO released a report in September 1988 which indicated mixed success in this area. Entitled "ADP Systems, Status of SSA's Modernization Efforts," the GAO report credited the agency for scaling back the implementation of a number of projects to a more realistic time frame and for developing a long-range planning process to guide its operations in this area. In the short range, however, GAO noted that the interim operation plan the agency has drawn up has been found deficient in several areas. Until the agency effectively addresses the flaws in the interim plan, the agency's efforts over the next 2 years could be significantly hampered.

(3) SSA as an Independent Agency

Social Security's inclusion in the Federal budget beginning in the early 1970's magnified the visibility of its impact on national fiscal policy. The creation of the unified Federal budget sparked proposals for Social Security cutbacks by the Nixon, Ford, and Carter administrations. These propositions served as an incubator for a movement to create an independent Social Security agency. Calls for agency independence increased when, during the mid 1980's, Social Security funds were repeatedly mentioned as a means toward balancing the Federal budget.

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 (DHHS). 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.

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 DHHS and establishing SSA as an independent agency, with its own administrative structure and responsibilities.

The panel's recommendations to Congress included the establishing an independent SSA to be headed by a single administrator, appointed by the President with the advice and consent of the Senate, to a statutory 4-year term; providing the agency with responsibility

for the OASDI and SSI Programs, exclusive of Medicare and Medicaid; and, 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.

The rationale for excluding Medicare from an independent SSA is that the agency would be able to focus solely on ensuring that benefits were provided, and thus able to do a better job. Incorporating Medicare, which involves third-party intermediaries and an entirely different set of administrative tasks, would greatly complicate the mission of an independent SSA. At the same time, it should seem to make most administrative sense to keep Medicare and Medicaid together, due to the overlap between the programs in clientele, structure, and purpose as public health care financing programs. If both Medicare and Medicaid were to be brought under SSA, it would leave DHHS with little responsibility. Some argue that SSA would then be an enormously complex, multiprogram agency, with all the problems presently attendant upon DHHS. Despite these objections, others contend that Medicare should be retained within the independent SSA for purposes of continuity.

Not surprisingly, in 1988 legislative proposals to establish SSA as an independent agency have reflected both sides of the debate over whether Medicare should be included. In the House, H.R. 1036, sponsored by the Chairman of the Ways and Means Subcommittee on Social Security, Representative Andy Jacobs, would have excluded Medicare from an independent agency. On the Senate side, however, S. 34, authored by his counterpart, Senator Daniel Moynihan, would have kept Medicare within the agency's walls. No final action was taken on these bills.

Sponsors of independent agency proposals often point out that since 1971, SSA has had nine different Commissioners and DHHS has had six different 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. Further, advocates point to major policy debacles that have plagued Social Security in the past 5 years, including the crisis in the DI 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.

Many opponents of an independent SSA believe, however, that conflicts could arise between board members that could impair the agency's efficiency. They further point out that most agency problems do not result from SSA's location as a part of DHHS, but are rather the result of poor planning and policymaking. Organizational structure may be less to blame than bad leadership, low morale, and ill-considered and voluminous Congressional legislation. 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, and considering the potential administrative and statutory ramifications of their

contributions. 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 DHHS, the Office of Personnel Management, the General Services Administration, and the Office of Management and Budget, but rather that those agencies provide valuable oversight contributions, without which problems could be much worse. Arguments are also made that independence, in and of itself, would not ensure elimination of the frequent turnover of SSA Commissioners.

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.

According to the General Accounting Office (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 Congress and the public. 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 identified in our report. Independence is not the panacea."

(C) BENEFIT 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. At present, there are a

number of specific issues related to the benefit structure that drew the attention of Congress in 1988. Among these were the Social Security "Notch," a revised consumer price index for the elderly, the Social Security earnings sharing, and the Social Security earnings limitation.

(1) The Social Security "Notch"

The Social Security "notch" refers to the difference in monthly Social Security benefits between those born in or prior to 1916, and those born in 1917 or later. The difference, which resulted from changes made by the 1977 Social Security amendments, is substantial only 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 over a decade ago. In 1972, the Congress first mandated automatic annual indexing of both the formula to compute initial benefits at retirement, and of benefit amounts after retirement. The intent was to eliminate the need for ad hoc benefit increases, and to fix benefit levels in relation to the economy. 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 over-indexing of benefits would have entailed doubling the Social Security tax rate. This later scenario 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 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-indexation 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. In fact, although those born from 1917 to 1921—the so-called notch babies—have been the most vocal supporters of a "correction," these beneficiaries fare much better than those born

later. Individual Members of Congress have responded to the notch babies' complaints by introducing a series of proposals, most of which would give benefit increases to those born after 1916.

The two major notch bills introduced in the 100th Congress included H.R. 1917, introduced by Representative Roybal, and S. 1830, introduced by Senator Sanford. To examine concerns over this issue, the Senate Special Committee on Aging held a hearing entitled "The Social Security Notch: Justice of Injustice?" on February 22, 1988. The lead witness was Senator Sanford, who advanced the view that the notch problem called for compensatory action on the part of Congress to beneficiaries born in the notch years. In addition, the committee heard from a number of notch babies themselves and from James Roosevelt, the founder of the National Committee to Preserve Social Security and Medicare, who shared this view. Testimony from Arthur Flemming, Co-Chairman of Save our Security, focused on the origin of the notch, pointing out that it was the result of over-indexing of those born prior to the notch years. In addition, he urged that, should the Congress nevertheless decide to increase the benefits of the notch beneficiaries, that offsetting revenues to the Social Security trust funds be provided to ensure that future viability of the system.

A severe blow was dealt to the notch movement with the release of a March 1988 GAO report entitled "Social Security: The Notch Issue." The report carefully traces the background of the notch, portraying the problem as the result of the over-indexing of the benefits for those born in the period preceding the notch years. Although no position is taken with respect to pending legislative proposals to compensate notch beneficiaries, the report characterizes them 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 for future retirees would be jeopardized.

Reiteration of these same findings was a November 1988 study by the National Academy of Social Insurance, a nonprofit, nonpartisan organization focusing on Social Security and related issues. At a January 1989 hearing of the Senate Finance Subcommittee on Social Security, Robert Meyers, former chief actuary of the SSA and current chair of the study panel, summarized the study's conclusion with "the real problem with regard to this matter is that those persons born before 1917 who worked well 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 recommended that no legislative action be taken on the notch benefit issue.

Drawing on these reports, the Chairmen of the Social Security subcommittee in both the House and the Senate, Representative Jacobs and Senator Moynihan, respectively, have gone on record as opposing notch legislation. 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 in this area can be expected to extend into the 101st Congress.

(2) A Consumer Price Index for the Elderly

The first Federal Consumer Price Index (CPI) was developed by the Shipbuilding Labor Adjustment Board during World War I as a tool to resolve labor disputes over wage levels fairly and quickly, thereby leaving national defense production uninterrupted. Since that time, the CPI has undergone numerous modifications, resulting in the inflation index which is currently in place.

The CPI, which measures the average U.S. inflation rate, is computed using hundreds of components. The CPI's importance to older Americans stems from its use in determining cost-of-living adjustments (COLA's) for Social Security and other Federal retirement programs. In 1972, Congress amended the Social Security Act to provide for automatic cost-of-living adjustments and to link them to changes in the CPI. It was believed that automatic increases would more effectively maintain the value of the retirement income of American retirees.

When automatic COLA's were first mandated, a single CPI was in existence. That index represented the prices of goods and services purchased by urban wage earners and clerical workers, and did not (and does not) survey retirees. In 1978 however, a new CPIu was created. The new index measured the goods and services purchased by all urban consumers, including white/blue collar workers, the unemployed, and retirees. Whereas the old CPI, redesignated as the CPIw, is representative of approximately 32 percent of the population, the CPIu is representative of about 80 percent.

While the CPIu includes a measure of the inflation experienced by the elderly, the CPIw does not. This has led many to argue that the CPIu, not the CPIw, should be tied to Social Security cost-of-living adjustments. The idea of an entirely separate index for the elderly did not appear until 1982. In March of that year, the National Commission on Social Security released its final report in which it discussed the need for a separate index. The Commission recommended that the Congress "authorize the necessary funds and personnel for the Bureau of Labor Statistics to undertake the field surveys and analyses needed to determine how a special index for the elderly might be calculated and whether and to what extent it would be appropriate for adjusting the level of Social Security benefits for price increases for all Social Security beneficiaries."

In 1982, the General Accounting Office released a report on the subject. In its report, the GAO recommended that COLA's be tied to the CPIu rather than the CPIw and, rather than use a CPIe (CPI for the elderly) for COLA's, BLS should publish a "hybrid retirees index" to "assure detection of major divergences in the cost-of-living for retirees." The Office of Management and Budget, however, opposed these recommendations due to cost and other considerations and they were never implemented.

A 1982 study by Hageman found that food at home, fuel oil, natural gas, electricity, medical care services, hospital care, and insurance are of greater relative importance to retirees than for younger persons. The persistent rise in medical care costs appears to ac-

count for slightly higher inflation experienced by the elderly than by the general population, a trend that may be expected to continue. For example, while the general inflation rate from August 1987 to August 1988 was 4 percent, the medical inflation rate was 6.6 percent, a difference of over 60 percent.

At a June 1987 hearing of the Senate Special Committee on Aging, witnesses from a variety of organizations expressed their views regarding the importance of an accurate inflation measure with which to determine cost-of-living changes for older Americans. Supporters of a separate CPIe testified that they believed the impact of high medical inflation, as well as the cost of prescription drugs and other items heavily relied upon by older Americans, is not adequately reflected in the current CPI. They noted that the CPIw, currently used to determine COLA increases, does not cover a single retiree, but is primarily an index of middle and younger age groups. Further, they contended that even if a separate CPIe would result in only modest differences in COLA increases, such increases could be extremely important to older persons living on fixed incomes.

Legislation mandating the Bureau of Labor Statistics (BLS) to create a CPIe was added by unanimous vote to the Older Americans Act Amendments of 1987, signed into law on November 1987 as Public Law 100–175. In July 1988, BLS issued the results of its efforts. Although preliminary, the experimental index showed that Americans 65 or older appear to have experienced higher inflation than has the rest of the Nation. According to study, the inflation rate for the elderly they surveyed rose a total of 19.5 percent over the last 5 years, compared with 16.5 percent for the consumer price index that is used as a basis for the Social Security COLA and other Federal retirement programs, the CPIw. BLS concluded that it appeared that higher medical and housing costs were the primary factors for the difference.

Even a 3-percent difference in the COLA could make a sizeable difference to the many elderly persons relying solely on their Social Security for retirement security. On average, the yearly percentage difference would be a $3.50 to $5 per month shortfall, an amount not insignificant to many retirees. However, BLS noted that the so-called "experimental" index for older Americans was not ready to be utilized as an index for COLA's and that much more extensive research on the special purchasing habits of the elderly, as well as additional sampling population studies, needed to be completed. BLS also found that the CPIu did come much closer to mirroring the inflation rate finding produced by the "experimental" index. Whereas the CPIw produced inflation rate finding that was 3 percent less over 5 years, the CPIu produced an inflation rate measure that was a little over 1 percent off.

To build on the findings of BLS, S. 2831 and S. 2832 were introduced on September 26, 1988 by Senator Melcher to require the use of the CPIu in place of the CPIw for indexing Social Security and other retirement programs and to authorize funding for the BLS to refine the research tools and sampling methods needed to assess whether a separate index for the elderly was warranted. In the last days of the 100th Congress, S. 2831 was incorporated by the Senate into a catch-all tax technical corrections bill, but was later dropped

in conference between the House and Senate on this legislation. Renewed efforts in the 101st Congress in this area are likely.

(3) Earnings Sharing

Social Security currently provides benefits to women either as covered workers or as dependent wives, widows, or ex-wives of covered workers. However, a woman cannot receive both benefits. Therefore, in the case of a one-earner couple, the Social Security benefit provided to a married couple is equal to 1½ times the benefit earned by the employed spouse. In the case of a two-earner couple, the Social Security benefit is based technically on their combined earnings record, but the lower earner's record is subsumed into the dependent spouse benefit, unless and until that record provides a larger benefit than the dependent spouse benefit.

This benefit structure was designed when less than 17 percent of married women worked outside of the home and the predominant family pattern was single-earner couples where the woman was the full-time homemaker and marriages were life long. Since mid-century, however, very different social patterns have emerged. The number of two-earner couples, for example, has risen dramatically, as has the number of marriages ending in divorce. Indeed, many of the presumptions upon which the Social Security system was built have changed.

Three distinct groups of women may be considered disadvantaged by the current Social Security system: (1) Divorcees; (2) two-earner couples; and (3) widows whose husband dies at an early age. First, widows whose husband dies early often have been the recipient of reduced benefits. Their husband's incomplete earnings record often leave them with inadequate benefits. This problem can be exacerbated by many widows' decision to begin drawing actuarially reduced Social Security benefits at younger ages.

Second, divorcees are entitled to dependent's benefits based on their last marriage—of 10 or more years duration—and are disadvantaged in two respects. The working ex-spouse may decide to retire early, without consulting his ex-wife and her benefits as a dependent spouse will be reduced. More importantly, if the marriage does not last 10 years, a divorcee is not entitled to a dependent spouse benefit at all. Where women's work histories have been interrupted by unsuccessful marriages, an insubstantial earnings record and inadequate benefits are the inevitable result.

Finally, two-earner couples are disadvantaged by the current formula for determining benefits. Under present law, a two-earner couple whose combined earnings equal those of a one-earner couple receive benefits substantially lower than a one-earner couple. This is due both to the additional dependent-spouse benefit provided to the one-earner couple and to the fact that the base salary for determining the benefit of the two-earner couple will be the higher earner's salary unless and until the lower earner is entitled, on the basis of the lower earner's earnings record, to a benefit larger than that which the lower earner would be entitled to as a dependent of the higher earner.

Earnings sharing has emerged as the most popular proposal to address these equity and adequacy issues. However, while several

bills have been introduced, none has yet received a great deal of consideration during the 100th Congress.

Under earnings sharing a couple's annual aggregate earnings would be divided equally between them for the purposes of computing a Social Security earnings record. Three notable developments would take place were earnings sharing to be implemented. First, the individual would be entitled to a Social Security benefit in his or her own right, thus removing any stigma of dependency attached to that benefit. Some argue that the change would merely recognize the value of a woman's work in the home. Second, it would allow divorced and widowed spouses to build on the earnings records amassed by their former spouses to improve their Social Security benefits. Finally, earnings sharing would remedy the present inequities between one- and two-earner couples whose identical aggregate income yields unequal Social Security benefits.

Studies by the Social Security Administration and the Congressional Budget Office have shown that while earnings sharing would remedy the current inequities between one-earner and two-earner couples, it is far less effective at improving the adequacy of benefits received by older widowed and divorced women. Since Social Security currently provides a spousal benefit to a divorced spouse after 10 years of marriage—so long as she does not remarry—Social Security benefits based only on the income earned during the marriage might be significantly lower. Earnings sharing itself does nothing to remedy the problems of widows benefits under Social Security, except to encourage younger widows to add to the work record amassed by their spouses. To the extent that they do not, they will continue to receive inadequate benefits. While some earnings sharing proposals address this problem by guaranteeing at least current law benefits—the so-called no-loser bills—this adds tremendously to the implementation costs of earnings sharing.

As an unresolved issue, earnings sharing could receive attention in 1989. However, policy concerns such as the implementation costs, adequacy of benefits to divorced and widowed elderly, and the political impracticality of restructuring Social Security so soon after the 1983 amendments will most likely continue to retard the progress of any such legislation.

(4) Social Security Earnings Test

An issue which promises to receive increasing attention over the coming year involves the elimination of the Social Security earnings test. In 1988, a Social Security recipient between the ages of 65 and 69 had his or her benefits reduced by $1 for every $2 he or she earned above $8,400. For those between age 62 and 65, the earnings limitation was set at $6,120. This benefit reduction is widely viewed as a disincentive to the continued employment of older workers. Indeed, many believe that the earnings test penalizes those aged 62 to 69 who wish to remain in the workforce. Once workers reach age 70, they are not subject to the test.

The earnings test is among the least popular features of Social Security. Proponents of its elimination argue that while the test reduces Federal budget outlays, it also denies to the country valuable potential contributions of older, more experienced workers. Sup-

porters add that no such limit exists when the additional income is from pensions, interest, dividends, or capital gains, and that it is unfair to single out those who wish to continue working.

Critics, however, point out that eliminating the earnings test would be extremely expensive. They find it difficult to justify draining the Federal budget by an additional $16 billion over 5 years in order to finance the test's immediate removal. Proponents, on the other hand, point out that older Americans who remain in the workforce persist in making contributions to the national economy and continue paying Social Security taxes.

Given the higher cost of eliminating the earnings test, it is probable that any legislative resolution of this issue would involve a compromise. These could include proposals to phase the test's elimination over a period of several years, or to modify the earnings test for certain of the population.

One such possible compromise involves farmers and other self-employed persons. It is widely acknowledged that farmers and other self-employed individuals are in positions different from the general population. Under present law, a farmer who loses money over a number of years and subsequently makes more in 1 year than the earnings test allows is penalized. Therefore, if total elimination of the earnings test seems unlikely, some may advocate requiring that SSA take recent years involving economic losses into account when testing the earnings of self-employed persons in a given year. Such a provision could require that SSA average 2 or 3 years of income together when testing the income of the self-employed. In essence, farmers and other self-employed individuals could offset their economic losses in 1 year with gains in another. Some estimates have shown that such an alternative would only cost $250 million over 5 years.

Another possible approach entails a slow phase-out of the test. The resulting total elimination of the earnings test would not only eliminate the inequities experienced by farmers and other self-employed individuals, but would eliminate a major disincentive for the continued employment of all older workers.

In late 1988, the Commissioner of The Social Security Administration, Dorcas Hardy, announced her support for the elimination of the earnings limitation. However, she emphasized that her position was not a reflection of the Administration, which has consistently opposed this proposal. Since that time, no further sign of her support for the elimination has surfaced publicly, but the issue will nevertheless remain a concern among a number of Members of the 101st Congress as well as older workers.

B. SOCIAL SECURITY DISABILITY INSURANCE

1. Background

During 1988, SSA continued the implementation of the extensive changes mandated by the Social Security Disability Reform Act of 1984 (P.L. 98-460). This legislation revised the standards and the process used by the SSA in reviewing the eligibility status of Disability Insurance (DI) beneficiaries.

Since the inception of the DI program, SSA had the responsibility of continuously monitoring the eligibility of beneficiaries on the rolls. In response to the concern that SSA was not adequately reviewing 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 (CDR's) 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 no longer eligible for DI benefits.

Not long after the CDR's 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 CDR's under guidelines that differed from SSA's official policy. By 1984, more than half the States were either not processing CDR's, 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 DI program. The main reform was to require that SSA prove a beneficiary's medical condition had improved from the time of the initial disability determination. Under that mandate, SSA promulgated three major sets of administrative regulations the following year. These rules 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. Congressional committees continue to closely monitor the implementation of the new law, and a full evaluation of the impact of the reform measure is expected to be available by mid-1988.

2. Issues and Legislative Response

In contrast to the sweeping reforms enacted in the 1984 Social Security Disability Reform law and the subsequent flurry of regulatory activity to implement the act, recent congressional legislation has been relatively limited. Instead, the focus has largely been one of oversight, ensuring that the new law is carried out as effectively and fairly as possible.

(A) EXTENSION OF INTERIM BENEFITS

Since 1983, a DI beneficiary who has been determined to be no longer disabled has been able to elect to continue receiving benefits, and thus medical care under Medicare, while appealing his or her case to an administrative law judge (ALJ) of an unfavorable eligibility determination. Each year, SSA reviews the cases of thousands of disabled workers. A significant number of these reviews yield adverse decisions, many of which are appealed and ultimately

reversed. (In cases where the initial decision is upheld, case benefits during the appeal are treated an overpayments and may be subject to recovery.) This provision was enacted in response to the fact that an appeal to an ALJ can take up to several months.

On December 21, 1987, the law authorizing interim payments during the appeals period was to expire. Thus, a decision to terminate benefits at the initial level was to take immediate effect, regardless of whether that decision was later ruled incorrect. Although back payments would be provided in such cases, the absence of benefits in the interim would pose a severe hardship on many disabled workers and their families.

Prior to the 1983 law authorizing interim payments, hundreds of thousands of disabled persons abruptly found themselves without any means of support or medical care as a result of the unprecedented number of DI terminations in the early eighties. Originally mandated for 1 year, in 1984, Congress extended the interim authority through 1987 as part of the reform law. By the end of that period, it was assumed, the abuses that were rampant at that time would be eliminated.

In 1988, over 215,000 cases—8 percent of the total number of DI beneficiaries—are expected to come under review. Based on past termination rates, approximately 51,000 cases will be deemed ineligible. About 41,000 of these decisions will likely be challenged, with about half of those ultimately being reversed. Thus, without an extension of the law, in 1 year alone, benefits could be unfairly denied 20,000 disabled workers and 40,000 of their dependents.

Following notice from the Secretary of the Department of Health and Human Services (DHHS) of the imminent lapse of the law, Congress acted swiftly in the final days of 1987 to extend the interim authority through 1988. This legislation was included in the Omnibus Budget Reconciliation Act of 1987, enacted on December 22, 1987, as Public Law 100-203. The question of any future extensions was postponed in anticipation of a DHHS study on the interim-payment program originally expected to be completed in 1988, but later postponed until 1989. As a result, a further extension was provided as part of the 1988 Miscellaneous Revenue Act of 1988, enacted into law as Public Law 100-647. The law covers all appeals filed prior to January 1990.

(B) ATTORNEY FEES

From the standpoint of the 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. In 1987, approximately 60 percent of cases that were challenged had legal representation.

Payment for the services of an attorney in such cases is taken from the past-due benefits awarded to successful claimants. Under law, compensation is the smaller of 25 percent of the retroactive benefits, the amount agreed upon between the attorney and the client, or the amount set by SSA.

On April 1, 1987, adminstrative law judges temporarily lost the authority to approve fee requests above $1,500 as a result of a new

SSA policy. Previously, the maximum amount such judges could approve was double that amount—$3,000. A fee petition above $1,500 required approval by a regional authority. The basis for this action, according to SSA, was a report of the Inspector General, which concluded that attorney fees were frequently excessive and should be lowered to a set rate.

Following the start of the new policy, many DI attorneys protested that the new policy would deny them adequate compensation, and that payments would be further delayed and complicated as a result of the additional layer of bureaucracy. Moreover, it was argued, disability claimants would be the ultimate losers because fewer and fewer attorneys would be willing to represent them.

Underlying the issue of DI attorney fees is the challenge of ensuring adequate safeguards against overcharges while providing fair compensation for services performed on behalf of the claimant. The only point which disability attorneys and SSA agree upon is that the original payment system is cumbersome, drawn out, and in need of reform.

Opposition to the new SSA policy rapidly intensified, along with concern over the potential adverse impact on beneficiary representation. In late 1987, Congress thus enacted legislation in the reconciliation measure (P.L. 100-203) to rescind the new SSA directive and impose a moratorium until mid-1989 on changes to the original payment policy pending the completion and consideration of studies by SSA and GAO.

The resulting GAO report, entitled "Time Required to Approve Attorney Fees Can Be Reduced" was issued in late 1988 and found that generally fees for attorneys were not unreasonable. According to the report, 93 percent of the fee requests up to $3,000 were approved, as was 94 percent of total amount requested. For the most part, only when fees requested exceeded $3,000 were there significant reductions in the amont provided. However, GAO found that the approval process on average took about 7 months and recommended to SSA a number of ways to streamline the process. Notwithstanding these delays, GAO found that claimants did not have difficulty finding an attorney to represent them. Based on these findings, it is unlikely that SSA would attempt to revive the proposal that initially generated controversy in this area. The report from SSA was not yet available in 1988.

(C) FACE-TO-FACE INTERVIEWS

As part of Congress oversight in 1988 of the implementation of the 1984 Social Security Disability Benefits Reform Act, a report was carried out by the General Accounting Office (GAO) on demonstration projects authorized under the law to test the merits of providing applicants and beneficiaries under the DI program with a face-to-face interview at the initial stage of the determination process. These projects were intended to test whether initial interviews result in a more accurate evaluation of such a person's condition, assure that all relevant information is obtained, and streamline the decision concerning disability benefits. For cases that are not part of the demonstration program, a DI applicant or beneficiary does

not have any face-to-face interview until and unless a final decison is appealed to an administrative law judge.

GAO's report, entitled "Social Security Observations on Demonstration Interviews With Disability Claimants" does not advocate either approach used by SSA. Instead, the report recommends caution in revising the current system, stressing the need for SSA to objectively evaluate the merits of the demonstration projects.

C. PROGNOSIS

The 1983 changes in Social Security financing are widely regarded as having ensured the solvency of the system well into the next century. However, the same law that appears to have restored fiscal health to Social Security also has resulted in rapidly building reserves that are posing an increasing temptation for those seeking ways to reduce the Federal budget deficit.

Although some would argue that provisions in the Gramm-Rudman-Hollings Act excluding Social Security benefits from cuts in the event of automatic spending reductions protects the program, the mounting pressure on the Congress to bring down Federal spending will nevertheless extend to Social Security. Although tax increases would alleviate some of this pressure, the degree to which this approach to deficit reduction was maligned during the 1988 Presidential campaign makes this all but a last resort. At the same time, the depth of the spending cuts that would be required to make significant progress on deficit reduction poses similar political problems for the Congress. In an attempt to avoid tax hikes or funding cuts for already strained program areas, the option of delaying or cancelling some future Social Security COLA's likely will be debated. In such a political climate, the prospects would likely diminish for fully eliminating the Social Security earnings test and other perceived inequities in the Social Security program.

Another source of possible controversy for Social Security in coming years is the payroll tax increases that were scheduled in the 1983 law, the last one to occur in 1990. As covered wokers feel the effects of these tax increases, pressure may mount to defer or reduce them.

Despite these expected challenges to the Social Security system, the program retains the overwhelming support of the general public, the elderly, and many in the Congress. Given this fact and the projected long-term solvency of the trust funds, Social Security may be expected to continue effectively in coming years.

Regarding the DI program, it appears clear that the 1984 reforms brought to a halt the extensive and abusive administrative practices in the continuing disability review process in the early eighties. A more complete and accurate picture will continue to emerge in coming years. In the meantime, the Congress can be expected to continue watching closely the law's impact program on those entitled to benefits under the DI program.

Over the long run, Congressional and administrative actions affecting the DI program will likely continue to take pendulum-like swings. Thus, after moving to assure that the program is not arbitrarily denying benefits to those who meet eligibility requirements and are in desperate need of assistance, the Congress will be more

receptive to critics who inevitably point to abuses of the system. The challenge facing the Congress and the DI program is to strike a balance which addresses fairly and effectively both of these vital concerns.

Chapter 2

EMPLOYEE PENSIONS

OVERVIEW

Many employees receive retirement income from sources other than Social Security. Numerous pension plans are made available to employees from a variety of employees, 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 Congressional interest throughout recent years, which culminated in massive pension reforms during 1986.

Largely because 1986 reforms, the Congress has enacted no new major revisions of the laws affecting pensions since that time. Indeed, most of the major retirement income policy issues that were debated in recent years had been either fully or partially resolved by legislation. However, there were some exceptions.

Among the more notable changes to occur during 1988 was the emergence of a new Federal policy governing the accrual of pension credits for workers beyond the normal retirement age. Concern also continued over overfunded and underfunded pensions from the preceding year. As a result, many organizations and Congressional members fought for new legislation to require that employers who withdraw fund assets from overfunded plans share the spoils with their employees, however, these efforts were unsuccessful.

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. However, 17 percent of all private plan participants are covered by multiemployer plans which provide members of a union with continued benefit accrual while working for any of a number of employers within the same industry and/or region. As of September 1987, 67.1 percent (52.7 million) of all wage and salary workers were covered by an employer-sponsored pension plan in 1984. Employees of larger firms were far more likely to be covered by an employer-sponsored pension plan than were employees of small firms. While business and repair service, retail trade, agricultural and personal service workers received a low rate of pension coverage, more than 70 percent of those employed by public utilities,

professional and related services, and the manufacturing and mining industries were covered by a plan. According to 1985 data, private pension funds totaled $917 billion and accounted for 42 percent of the institutional assets in the economy. In 1986, Federal tax expenditures for public and private employer-sponsored pensions costs the Government $71 billion.

Most private plan participants are covered under a defined-benefit pension plan. The remainder participate in defined-contribution pension plans. Defined-benefit plans specify the benefits that will be paid in retirement, usually as a function of the worker's years of service under the plan or years of service and pay. The employer makes annual contributions to the pension trust based on estimates of the amount of investment needed to pay future benefits.

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. Fewer than a third of all participants in medium and large size private plans receive benefits based on a fixed dollar amount for each year of service. Most fixed dollar plans cover union or hourly employees and are collectively bargained between the union and employer. The majority of pension plan participants are in salary-related plans that base the benefit on a fixed percentage of career average pay or final 3 or 5 years pay.

Workers in private-sector defined-benefit plans are typically in large primary pension plans funded entirely by the employer. More than three-quarters of the participants in defined-benefit plans are in plans with more than 1,000 participants. The largest employers generally supplement their defined-benefit plan with one or more defined-contribution plans. Where supplemental plans occur, 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 the contributions to defined-benefit plans come from employees. Most of those contributing to their pension plans are government employees.

Defined-contribution plans, on the other hand, specify only 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. Defined-contribution schemes are not strictly "pension plans," in that they are not all intended solely to provide retirement income. However, they are all included in ERISA and Internal Revenue Code definitions of plans subject to tax qualifications and fiduciary requirements.

Private pensions are provided voluntarily by employees. 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 deduct their current contributions even though they do not provide immediate compensation for employees; (2) income earned by the trust fund is tax-free; and (3) employer contributions and trust earnings are not taxable to the employee until received as a benefit. The major tax

advantage, however, is the tax-free accumulation of trust interest (inside build-up) and the fact that the benefits are usually taxed at a lower rate than contributions.

In the last decade, the Congress has increasingly used special tax treatment as leverage to enforce widespread coverage and benefit receipt. In the Employee Retirement Income Security Act (ERISA) of 1974, Congress first established minimum standards for pension plans to ensure broad distribution of benefits and limited 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 the fact of discrimination in small corporations by requiring so-called "top heavy" plans—namely, plans in which the majority of plan assets benefit key employees—to accelerate vesting and provide a minimum benefit for short-service workers.

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: (1) Limitations on tax-favored voluntary savings; (2) reform of coverage, vesting, and nondiscrimination rules; (3) changes in the rules governing distribution of benefits; and (4) modifications of 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' preretirement earnings with sufficient benefits 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 preretirement earnings. The Commission also recommended that "replacement ratios" for low-wage earners should be higher than for high-wage earners.

Because Social Security provides a higher replacement ratio to low earnings workers (25 percent), pensions often tilt their benefits the other way—providing a higher replacement to the higher paid. For example, a plan for a minimum wage worker receiving 54 percent of preretirement earnings from Social Security would only need to replace 20 to 35 percent of that person's preretirement earnings to meet a goal of 75 percent replacement. On the other hand, a worker paying the maximum Social Security tax (with 25 percent replacement from Social Security) would need to replace an additional 50 percent of preretirement earnings to meet that same ratio.

According to the Bureau of the Census, of all retirees receiving pension benefits in 1984, 66.4 percent were men. While the mean monthly pension income of male retirees was approximately $670, pension income for women was about $370 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 be receiving Social Security benefits concurrently with their pensions.

Career patterns have the greatest effect on the amount of benefits paid by pension plans. Workers who enter plans late in life or work short periods under a plan earn substantially lower benefits than those who enter early and work a full career. The 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 preretirement income while the median benefit of those with 35 years of service replaced 37 percent of preretirement 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 1984, 67 percent of all wage and salary workers were covered by an employer-sponsored pension plan. While the coverage rate for workers with monthly earnings below $500 was only 37.8 percent, those earning $2,000 or more each month were covered by a pension 84 percent of the time.

Employers who offer pension plans do not have to cover each of their employees. The law governing pensions—ERISA—permits employers to exclude part-time, newly hired, and very young workers from the pension plan. In addition, the law has required employers to cover, at most, only 70 percent of the remaining workers (only 56 percent if employees must contribute to participate in the plan); and an even smaller percentage of workers if the classification of workers the plan excludes does not result in the plan discriminating in favor of the highly paid.

The 1986 Tax Reform Act increased the minimum requirements for the proportion of an employer's work force that must be covered under company pension plans. 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 straight forward percentage test found substantial latitude under the classification test to exclude large percentages 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 having to meet this test if it could show that it benefited a classification of employees that did not discriminate in favor of highly compensated employees. 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 a much tougher and more specific alternative test: A "ratio test" and an "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, at least 70 percent of the average benefit of highly compensated employees (counting noncovered employees as having zero benefits). Plans are required to meet these new coverage requirements by January 1, 1989.

Most noncovered workers, however, work for employers who do not sponsor a pension plan. Nearly three-quarters of the noncovered employees work for small employers. Small firms tend not to provide pensions because a penson plan 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 been slowing steadily over the last few decades. The most rapid growth in coverage occurred in the 1940's and 1950's when the largest employers adopted pension plans. In recent years, coverage has actually declined slightly due to recession, job loss in the well-covered manufacturing sector and job expansion in the poorly covered service sector. It is unlikely that pension coverage will grow much 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 therefore 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.

Most workers today do not stay with the same employer the number of years required to vest in their pension plans. ERISA standards have required that plans which vest no benefits during the first 10 years of employment fully vest those benefits after 10 years of employees service. Due to declining job tenure, today's workers are having more difficulty earning pensions than did their predecessors. The average job tenure for a male aged 40–44, for ex-

ample, has dropped from 9.5 years in 1966 to 8 years in 1981. Women's average job tenures are declining less rapidly—but already tend to be much shorter than those of men. Job tenure for women aged 40–44 dropped from 4.1 years in 1966 to 3.9 years in 1981.

To enable more employees to either partially or fully vest in a pension plan, the 1986 Tax Reform Act required more repaid vesting than in the past. The new provisions, which apply to all employees working as of January 1, 1989, will require that if no part of a benefit is vested prior to 5 years of employee service, then benefits must be fully vested at the end of 5 years. If a plan provides for vesting of 20 percent of the benefit after 3 years, 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 usually 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 in that 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 mandatory 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 (permitting the tax payment to be calculated as though the individual had no other income). 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, appear to have been largely ineffective. To the extent that workers receive lump-sum distributions, they 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.

How and when a plan distributes benefits to employees is a key factor in that plan's ability to deliver adequate retirement benefits. Even if a worker is vested, he or she may lose pension benefits under some plans upon changing jobs. This benefit loss results from differences in how some plans accrue benefits.

Final-pay formulas have been popular with employees because they relate the pension benefit to the worker's earnings immediately preceding retirement. However, final-pay plans penalize workers who leave the plan before retirement by freezing benefits at the last pay level under the plan. Workers who are years from retirement will often be entitled to pension benefits of little value.

Therefore, a mobile worker earning benefits under several final-pay plans will receive much lower benefits than a steady worker who spends a full career under a single plan.

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. Current tax law provides special tax treatment for lump-sum distributions—both under the IRA rollover rules if they are saved in a retirement account and under the 10-year forward averaging and capital gains rules without regard to how they are used.

Current policy regarding distributions is often criticized for encouraging the consumption of preretirement distributions and the loss of retirement savings. While not all employer plans are designed solely to provide retirement income, many of those that are provide lump sum distributions for many circumstances other than retirement.

The Tax Reform Act of 1986 established substantial disincentives to use pension or deferred compensation plan accruals for any purpose other than providing a stream of retirement income. It imposes an excise tax of 10 percent on distributions from a qualified plan before age 59½, other than those: Taken as a life annuity, taken upon the death of the employee, taken upon early retirement at or after age 55, or used to pay medical expenses.

(4) Pension Integration

Current rules permitting employers to reduce pension benefits to account for Social Security benefits can result in an excessive reduction or even elimination of lower paid workers' 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 adjustment a plan can make to pension benefits before the plan is considered discriminatory.

In general, two types of integration 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; current rules permit plans to make no contributions below the integration level. In offset integration, plans reduce the pension benefit by a percentage of the Social Security benefit, which can result in the elimination of an individual's entire pension.

In the past, pension integration could be used unfairly, thus depriving workers of legitimate benefits. Internal Revenue Service rulings permitted a defined-contribution plan to provide contributions on pay above the Social Security wage base ($45,000 in 1988) at a rate 5.7 percent higher than those provided on pay below the wage base. Plans could provide no contributions on pay below the

wage base if the contribution rate above the wage base was 5.7 percent or less. The rulings permitted a defined-benefit plan to meet either an excess plan or an offset plan rule. In the excess plan, the difference in benefits as a percentage of final earnings paid above and below the average Social Security wage base could not exceed 37.5 percent. In the offset plan, the final pension benefit could be reduced by an amount equal to 83.3 percent of the Social Security benefit. In practice, pension benefits were often eliminated for workers with low wages.

Tax Reform modified the amount of integration permissable under the revenue rulings to prevent the elimination of pension benefits. Under the new integration rules, 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 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 times 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. The new integration rules apply to contributions or benefits that became effective January 1, 1989.

(B) TAX EQUITY

Private pensions are encouraged through tax benefits, estimated by the Treasury to equal $53 billion in 1986. In return, Congress regulates private plans to prevent over-accumulation of benefits by the highly paid. Efforts to prevent discriminatory provisions of benefits have focused on the potential for discrimination in voluntary savings plans and on the effectiveness of current coverage and discrimination rules.

In recent years, there has been a substantial increase in tax-free individual contributions to retirement and savings plans. Prior to 1974, only employees of public or tax-exempt organizations could elect to defer a portion of their salary without paying income taxes on it through a tax-sheltered annuity (TSA) as established under section 403(b) of the Internal Revenue Code. Private sector employees could make only after-tax contributions to a retirement plan. Beginning in 1974, the Congress gradually extended the opportunity to make tax-free elective deferrals to all employees. Legislation was enacted in 1974 permitting workers not covered by a employer-sponsored pension plan to defer up to $2,000 a year to an individual retirement account (IRA). Then, in 1978, cash or deferred arrangements (CODA's) were authorized for private employees under section 401(k). Workers covered under a CODA may make elective tax-free contributions (by agreeing with the employer to reduce their salaries) to an employer plan. The amount that any worker could contribute was limited by the total limit on all pension contributions (25 percent of salary up to $30,000) and by separate non-

discrimination test for 401(k) plans restricting the average percentage of salary deferred by highly paid workers to 150 percent of the average percentage of salary deferred by lower paid workers. Finally, in 1981 Congress opened up the opportunity to defer $2,000 a year in an IRA to all workers.

Concern has grown in recent years that tax-free voluntary savings may offer too great a tax shelter for the highly paid and may be inequitable. The tax benefits of voluntary savings are most attractive to those in the highest tax brackets. While a large portion of the tax benefits goes to those who would probably save for retirement without it, many who need the retirement savings do not benefit from the tax provisions. In addition, there is some concern that the aggregate tax expenditures to encourage savings have become excessive. For example, the majority of those using IRA's in the past were also participating in a corporate pension or 401(k) plan.

Nondiscrimination rules are intended to ensure that employee benefit plans that are tax-favored are of benefit to a broad cross-section of employees and not just the highly paid. Corporate pension and deferred compensation plans are required to meet a number of nondiscrimination tests for coverage and comparability of benefits as set forth in sections 401 and 410 of the Internal Revenue Code (and various revenue rulings) to become tax-qualified. Plans are required to benefit either 70 percent of the employees who meet age and service requirements (56 percent in a contributory plan) or a classification of employees that the Secretary of the Treasury finds not to be discriminatory. Benefits provided in one or a number of plans by the same employer must be reasonably comparable (in relation to pay) at various pay levels.

CODA's, in which participation is optional for the employees, must meet an additional nondiscrimination test based on the use of the plan, to ensure that the highly paid are not benefitting disproportionately from the plan. Under current law, the top one-third of employees, by pay, cannot defer more than 1.5 times the average proportion of salary that the lower paid two-thirds actually defer.

In the last few years, there has been growing concern that the current coverage rules are too loosely structured and have been weakened too much through revenue rulings to ensure broad participation in employer plans by lower paid workers. In addition, there has been some concern that the current CODA discrimination rules permit excessive deferrals by the highly paid in relation to the amounts actually deferred by the lower paid. Tax-sheltered annuities have not been exempt from nondiscrimination requirements for tax qualified plans since these were established under a separate section 403(b).

(1) Limitations on Tax-favored Voluntary Savings

The Tax Reform Act tightened the limits on voluntary tax-favored savings plans in an effort to target limited tax resources where they can be most effective in producing retirement benefits. The Act repeals the deductibility of contributions to an IRA for participants in pension plans with adjusted gross incomes (AGI's) in excess of $35,000 (individual) or $50,000 (joint)—with a phased-

out reduction in the amount deductible for those with AGI's within $10,000 below these levels. It also reduces 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. Additionally, the Act tightens the nondiscrimination test that further limits the elective contributions of highly compensated employees in relation to the actual contributions of lower paid employees. Finally, the Act encourages the small employer adoption of pension plans by permitting employers with fewer than 25 employees to adopt simplified employer pensions (SEP's) with elective employee deferrals.

(2) Limitations on Benefits and Contributions

The amount of additional accumulation an individual can have each year in a tax-favored plan is limited under Section 415 of the Internal Revenue Code. Under prior law, the annual budget payable from a defined-benefit plan could not exceed 100 percent of an individual's compensation (up to a maximum benefit of $90,000). The annual contribution made to a defined-contribution plan could not exceed 25 percent of compensation (up to a maximum of $30,000). If an employee participates in both defined-benefit and defined-contribution plans, their total accumulation is subject to a combined limit. Although the dollar limits are currently frozen, beginning in 1988 they will be indexed for post-1986 cost-of-living increases.

In recent years, the Congress has reduced and frozen the Section 415 limits largely in an effort to raise revenue for the Federal Government in the context of deficit reduction. The Tax Reform Act restores the indexing of the Section 415 limits, modifies the relationship between the benefit and contribution amounts to establish parity, and changes the adjustment in the defined-benefit dollar limit for early retirement. The defined-benefit limit would be indexed for inflation beginning in 1987, while the defined-contribution limit would remain frozen until the defined-benefit limit is four times as great—a ratio of contributions to benefits that is believed to result in roughly equal retirement benefits. Once the four-to-one ratio is reached, both limits would be indexed. Although, the defined-benefit limit remains the same for benefits commencing at age 65, the Tax Reform Act requires full actuarial reduction for benefits paid at earlier ages—so that the maximum annual benefit for someone retiring at age 55 is reduced from the current floor of $75,000 to $40,000.

To reduce the potential for an individual to overaccumulate by using several plans, the Tax Reform Act both retains the current law combined limit and adds 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 is 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 Ameri-

can 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 substantially increase 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 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 created since 1974 must reach full funding within 30 years. Plans predating ERISA are allowed 40 years to develop 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 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 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 $1,858 a month in 1987 (adjusted annually). As of 1986, the single-employer program was funded through annual premiums of $8.50 per participant paid by employers to a nonprofit Government corporation—the Pension Benefit Guaranty Corporation (PBGC). When an employer terminated a plan, the PBGC received any assets in the plan and made a claim against additional assets up to 30 percent of the employer's net worth. A similar termination insurance program was enacted in 1980 for multiemployer defined-benefit plans, using a slightly higher annual premium, but guaranteeing only a portion of the participant's benefits.

During 1988, continued attention was focused on three important pension funding issues: (1) Termination of underfunded plans; (2) reversions of assets from termination of overfunded plans; and (3) investment performance of pension funds.

(1) Termination of Underfunded Plans

The past 5 years have brought increasing concern that the single-employer termination insurance program, operated by the PBGC, is inadequately funded. By the end of fiscal year 1984, PBGC had liabilities of $1.5 billion and assets of only $1.1 billion—leaving a deficit of $462 million. Projections at that time indicated that without a premium increase the fund for single-employer plans would be exhausted by 1990. During 1985 the PBGC assumed $615 million in additional liabilities. By the end of fiscal year 1985, the PBGC reported liabilities of $2.7 billion and assets of only $1.4 billion, leaving a deficit of $1.3 billion.

A major cause of the PBGC's problem was 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 were requesting 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 since they were likely to have little or no net worth.

Terminations of underfunded pension plans have also reduced the benefits paid to participants and beneficiaries. Even though vested benefits are generally insured by the PBGC, the termination insurance program does not protect all benefits vested in underfunded plans. Employees are often in a difficult position when an employer terminates an underfunded plan. On the one hand, termination will result in a loss of benefits. On the other hand, the inability of the company to restructure its debt may force the company to go out of business and the workers to lose their jobs.

While during the past few years, the PBGC has assumed responsibility for several large claims, none was as large as 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 their future profitability.

During 1986, several important events took place with regard to pension underfunding. First, the premium paid to the PBGC by employers was increased from $2.60 to $8.50 per participant. In addition the circumstances under which employers can terminate underfunded pension plans and dump them into the PBGC's lap were tightened up considerably. A distinction is now made between "standard" terminations, where the employer is not in financial

trouble and "distress" terminations, where the employer is unlikely to have adequate assets to meet plan obligations. In a standard termination, employers will have to pay all benefits 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—where a company has filed for bankruptcy, or will clearly go out of business unless the plan was terminated, or where the cost of the pension has become unreasonably burdensome—involves increased employer liability to both the PBGC and plan participants.

While significant accomplishments were made in 1986, however, the new changes did not solve the PBGC's financing problems. The insurance agency's troubles grew subtantially worse with the termination of the pension plans of the bankrupt LTV Corporation at the end of 1986 and beginning of 1987. As a remedy, a provision in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203) calls for an additional PBGC premium increase as of 1989. Beginning in 1989, firms will be required to pay a premium ranging from $16 to $50 per employee. This "variable-rate premium" will penalize those companies with large unfunded liabilities. While the companies sponsoring the 83 percent of all pension plans which are adequately funded will only be required to pay $16 per employee, companies sponsoring the remaining 17 percent will be forced to pay a variable premium, according to their level of underfunding. The new law will require companies to pay an additional $6 per employee for each $1,000 of underfunding. According to the PBGC, roughly 4 percent of all plans will pay the maximum rate of $50 per employee. Companies will also be required to make quarterly payments to the PBGC, rather than annual payments as has been the case. Due to the difficult conditions presently existing in the steel industry, the new provisions gave steel companies a 5-year transition period.

The new variable-rate premium resulted from lengthy debate. The Administration had proposed a variable-rate premium ranging from $8.50 to $100 per employee. Unions bitterly opposed the Administration proposal, stating that it would deepen the crises of companies which are already financially troubled. Therefore, the unions favored a Democratic alternative calling for a $20 flat-rate premium. However, this idea was unacceptable to the business communmity. In the end, the above-mentioned compromise was enacted into law.

The premium increase aside, however, PBGC's financial picture could be helped drastically if the agency is successful in returning to LTV the responsibility for administering its three pension plans. While the PBGC took the plans over in January 1987, in September, after LTV had reported substantial operating profits, the PBGC won a court decision to return the plans to the company. LTV subsequently filed suit to return the plans to the PBGC. While LTV maintains that its business situation has not improved enough to warrant the return of the plans, others argue that if LTV is allowed to reduce its liabilities through bankruptcy, other firms will feel free to do so. The LTV case is still pending, but a decision is expected sometime in 1989. Should the PBGC be successful, however, its $4 billion deficit would be cut in half.

(2) Reversions of Assets from Termination of Overfunded Plans

Concern in the Congress continued in 1988 over the termination of well-funded defined-benefit pension plans to enable plan sponsors to recapture the surplus assets. Under ERISA, sponsors of plans with assets that exceed ERISA funding standards can recover these surplus assets over time by reducing their contributions to the plan. Withdrawals of assets are not permitted as long as the plan remains in operation. Employers can recover assets, however, when a plan is terminated.

In recent years, a substantial increase in plan surpluses due to bond and stock market gains and an increasing awareness of the potential for recovering plan assets, has caused employers to consider terminating well-funded defined-benefit plans for a variety of business reasons unrelated to the purposes of the retirement plan. The major reasons for termination have included: Financing or fending off corporate takeovers, improving cash flow or redirecting the company's assets, and modifying the company's retirement income plans.

Originally, employers were loathe to terminate pension plans simply to recover assets because of a concern that plan participants might lose benefits and the PBGC would prevent them from offering a similar successor plan. The issuance of Implementation Guidelines for Asset Reversions by the PBGC, Treasury Department, and Department of Labor in May 1984 helped clarify that an employer could terminate one plan and establish a similar successor plan as long as all plan participants were vested and benefits were fully covered under annuity contracts. This clarification has given rise to a host of new plan terminations that have left participants covered under identical or similar, and often less secure successor plans.

The number and size of reversions from plan terminations has been increasing steadily in recent years. Since 1980, employers have terminated more than 1,300 pension plans and recovered nearly $16 billion in assets. Much of this money has gone for mergers, takeovers and other purposes which are often contrary to the interests of the workers covered by the raided pension plans. The largest reversion in history occurred in 1985 when United Airlines recovered over $962 million through the termination of five pension plans. The acceleration of plan reversions is likely to continue until Congress takes action.

Employees whose company terminates a pension plan to recover its assets usually remain covered under the old plan or a successor plan. The two common methods for leaving participants covered under a defined-benefit plan—"spinoff" termination and "re-establishment" termination—essentially leave participants benefits unchanged. Under a spinoff, the old pension plan is split in two—one-half covering retirees and the other half active employees. While active employees remain in the old plan, the surplus assets are placed in the retiree plan, which is terminated, and annuities are purchased for the retirees. Under a re-establishment, the old pension plan is terminated and a new similar plan is created, with past service credits normally provided in the new plan for all

active employees. By using either approach, employers are doing in two steps what they would not be allowed to do in one.

Many have raised serious concerns about the equitability of employer recovery of excess pension plan assets. Critics argue that retirees can be harmed in a spinoff termination because they lose the potential for future cost-of-living increases in their benefits. They also contend that reversions draw needed assets from the plans and may increase the risk for the PBGC because newly created plans are not required under ERISA to maintain a funding level as high as plans that have been in existence for some time. This risk became apparent during the October 19, 1987, stock market crash, when pension plans lost billions of dollars in assets.

Plan sponsors counter that the real problem is that to recover excess assets, employers are currently forced to terminate pension plans. They believe that since the company, in a defined-benefit plan, promises specified benefits to employees, only the benefits earned to date—not the assets in the plan—belong to participants. The sponsors argue that employers are responsible for adequately funding these benefits and should be permitted to recover funds not needed to pay benefits. Under current law, employers can reduce their contributions to recover surpluses over time. Employers argue they should not have to wait.

Some observers have suggested that the recovery of these additional assets is weakening the funding of pension plans and undermining the purposes of the ERISA funding standards. They have proposed that sponsors should be permitted to recover the assets not needed on a continuing basis but be prevented from recovering additional assets if they are going to continue coverage for their employees under a successor plan.

In the 100th Congress, the reversion debate centered around whether or not employees should share the benefits of asset recovery. Proposals of the Senate Finance Committee and the House Ways and Means Committee essentially retained current law by disallowing asset withdrawals from ongoing pension plans. The House version, however, called for an asset cushion in the event of a termination withdrawal and a 20 percent excise tax on plan reversions. A 10 percent excise tax was passed as part of the Tax Reform Act of 1986.

Critics of the tax committee proposals argued that preventing firms from withdrawing excess assets acts as an incentive for plan terminations, thus jeopardizing retiree benefit security. They added that such prohibitions could encourage plan underfunding. Proponents, on the other hand, claimed that excess assets should be used to fund plan improvements such as cost-of-living adjustments. While they believed that these strict rules are the only way to effectively guarantee benefit security, critics contend that benefit security necessitates discouraging plan terminations.

The submissions of the House and Senate Labor Committees would have allowed asset withdrawals, but would have required that employers share the spoils with their employees. Withdrawals, of excess funds would be permitted if a cushion of 125 percent of liabilities was left in each plan maintained by the company. Were a plan to be terminated, employers would be required to share a portion of its assets with their employees.

Pension rights advocates proposed that employers only be allowed to withdraw excess assets if they also restored the value of retirees' pensions. Such an undertaking would entail increasing the monthly benefits for retirees by 100 percent of the increase in the Consumer Price Index since the date of their retirement. Unlike Federal retirement programs, private pension plans are not required to provide for increases in the cost-of-living. Advocates argued that only when both pension benefits and their value are protected can employers justifiably recover excess assets.

Despite the intense debate over this issue, no resolution was reached in 1988. Companies may still terminate plans without regard to their employees' future benefit security, and without sharing the profits. Simply because reversion provisions were not included in OBRA, however, does not mean that the issue has been resolved in the eyes of Congress. During 1989, the reversion issue will likely continue receiving attention. Similar arguments will be made once again, with the strong possibility that this time, change will be made.

(3) Investment Performance of Pension Funds

Over the last few decades, pension funds have become one of the largest single-purpose pools of capital in the economy. As of 1986, the Employee Benefit Research Institute (EBRI) estimated that the assets in private trusteed pension funds had grown to $1.015 trillion—an amount representing approximately 54 percent of all private, State, and local pension assets. According to findings published by the Department of Labor after a series or hearings in 1985, pensions have been becoming a dominant factor in stock trading markets. The Labor Department viewed the recent increase in pension fund assets as concomitant with an increase in daily trading on the Stock Exchange, annual turnover rates of up to 70 percent of pension funds a year, and a growing trend toward corporate takeovers.

With the stock market plunge of October 19, 1987, $210 billion in pension assets vanished—10 percent of the country's pension portfolios. This prompted concerns in many circles that, because some plans are heavily invested in the stock market, the pension benefits of many retirees could be in grave danger. Despite the catastrophe many believed the collapse could portend, however, the benefits of most retirees remain relatively secure. The major exception involves defined-contribution pension plans.

According to the (EBRI), private defined-contribution plans lost about $60 billion in direct stock holdings—13.3 percent of total assets—on Black Monday. Prior to the crash, defined-contribution plans had approximately $450 billion in total assets, at least $200 billion of which was in equities. At the same time, defined-benefit plans lost 12.4 percent or, $88 billion of $707 billion, of total assets.

The diminution of benefit security for those covered by defined-contribution plans as opposed to defined-benefit plans derives from who bears the investment risk. Defined-benefit plans promise a certain benefit level to employees, while defined-contribution plans do not. Under a defined-contribution plan, an employer simply promises to contribute a certain annual amount to an employee account.

Since defined-contribution plans, which often are heavily invested in stock, have lost such a large portion of their assets, many covered employees experienced at least a temporary loss of retirement security.

The Crash was the culmination of the longest bull market in the country's history. It demonstrated that while pension plans could benefit from stock market jumps, they were equally open to the adverse effects of collapses. Not only were the assets of many defined-benefit and defined-contribution pension plans diminished by the stock market downfall, but defined-benefit plan liabilities were moderately increased due to a simultaneous reduction in interest rates. Reacting to the market dive, the Federal Reserve injected liquidity into the system by lowering interest rates. The interest rate decline lowered the assumed rate of return for employee pension plans, thus increasing the cost, at least on paper, of meeting future plan liabilities. This occurred because the present value of future liabilities is computed using a combination of assumed interest rates, salaries, growth, and inflation. All else remaining equal, should interest rates decline, liability estimates can dramatically increase. A change of only 1 percent in interest rate assumptions can alter plan costs by 25 percent.

While plan liabilities may have been appreciably altered between October 16, 1987, and October 19, 1987, however, longer range estimates show something different. According to a preliminary Department of Labor estimate, defined-benefit plan liabilities only rose from $658 billion to $659 billion between December 31, 1986, and October 19, 1987. This resulted, in part, from an increase in interest rate assumptions between December 1986 and the time of the crash. That increase served to partially offset the interest rate reduction that occurred as a result of the crash. Therefore, while assets were down by almost 19 percent, plan liabilities at the end of Black Monday stood approximately where they had been in late 1986.

While most overfunded plans do not appear to have been appreciably jeopardized by Black Monday, the story may be quite different for some underfunded plans. For example, some estimates show that the pension plans at LTV, Corp., which were already underfunded by about $1.3 billion prior to the crash, may now have an additional shortfall of more than $100 million. Many companies with large unfunded liabilities other than LTV were also adversely affected by the crash. The result could be the collapse of certain pension plans which were already on the brink of disaster.

While the stock market crash may have adversely affected some retirees' pensions, among its most important outcomes may be its effect on the pension reversion issue. The crash highlighted the fact that sharp falls in the market can drastically decrease the level of pension plan overfunding. For many, Black Monday raised the question of whether pension assets should be drawn down at all, due to the potential added risk to retiree benefit security. It also flared concerns about the cushion that should be left in a plan from which assets are recovered. After Black Monday, many expressed concern that if asset reversions are allowed, a cushion of 125 percent of plan liabilities may be too low. Whatever the case,

this issue promises to receive continued attention, which will most likely be colored by thoughts of the October 19, 1987, plunge.

(D) PENSION ACCRUAL

A provision in the Omnibus Budget Reconciliation Act of 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. Under Public Law 99-509, the IRS, followed by the EEOC and the Department of Labor, were required to develop regulations in accordance with the new law.

In April 1988, the IRS proposed a rule providing that in defined-benefit plans all years of service be taken into account in determining retirement benefits. 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 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. According to the IRS, until a final rule is issued, the proposed regulations are in effect. On December 9, 1988, the EEOC announced that it would issue a regulation conforming to the IRS rule. (See Chapter 4, pension accrual section.)

(E) PENSION COVERAGE BY SMALL EMPLOYERS

During the 100th Congress, a bill introduced by Senator David Pryor to encourage small businesses to provide their employees with pension coverage received attention. Entitled "The Small Business and Retirement Extension Act" (S. 1426), the bill would have provided a new tax credit for administrative costs incurred in connection with maintaining a pension plan, as well as repeal top-heavy rules which currently assure lower paid employees of receiving meaningful pension benefits under plans in which 60 percent of the pension benefits go to key employees.

While a number of small business representatives supported repealing the top-heavy rules, critics complained that bill supporters could not substantiate that the rules now place an excessively heavy burden on small businesses. While proponents of the bill maintained that the pension reforms in the Tax Reform Act of 1986 regarding integration and vesting make the top-heavy rules unnecessary, critics argued that there was little evidence to suggest that their repeal would cause an increase in new plans.

Hearings on S. 1426 were held in October 1987 by the Senate Subcommittee on Private Retirement Plans and Oversight of the Internal Revenue Service. Testimony was heard from a variety of organizations, most of which were representatives of small business. Although proponents of the bill maintained that the pension reforms in the Tax Reform Act of 1986 regarding integration and vesting make the top-heavy rules unnecessary, critics argued that there was little evidence to suggest that a repeal would cause an increase in new plans.

Critics also cited a number of studies showing that lower paid workers would receive higher pension benefits under the top-heavy rules than if they were replaced with certain provisions of the Tax Reform Act. Female workers, they contended, would be hardest hit by such a change. Proponents, on the other hand, argued that the bill would promote the interests of small business, which employ nearly half of the American work force, and would enable small employers, most of which do not currently provide pensions, to more easily and cost-effectively provide and administer such plans.

Due to a number of unresolved issues, no final action was taken on the legislation by the close of the 100th Congress. Senator Pryor, however, is expected to renew his efforts in 1989 with modified legislation designed to address these issues while promoting increased pension coverage of workers in the Nation's small businesses.

3. Prognosis

Many of the pension issues that have commanded attention in recent years were resolved in 1986. Pension funding issues, however, remain a major concern. While the financial picture of the Pension Benefit Guaranty Corporation should be aided by the premium increase scheduled for 1989, other issues such as reversions of excess pension assets promise to receive a great deal of attention in the near future. Among the cogent issues which must be addressed is whether employees are entitled to receive a portion of recovered assets. In addition, the question of whether or not an employer should be allowed to withdraw excess assets without terminating a pension plan is extremely important.

The issue of pension portability also promises to receive increasing attention. Pension benefit portability involves the ability to maintain 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 will likely receive attention during 1989 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 preretirement distributions to an employer plan or an IRA.

B. STATE AND LOCAL PUBLIC EMPLOYEE PENSION PLANS

1. Background

State and local government pension plans cover 11.4 million active and 3.1 million retired participants in more than 6,600 plans. As of December 31, 1987, State and local pension plans had assets of $513.5 billion. More than 80 percent of these plans have fewer than 100 active members each. About 95 percent of active membership are included in the largest 6 percent of plans. Nearly three-quarters of the State and local plans provide coverage under Social Security, but most do not integrate Social Security and pension benefits.

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 an 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, preretirement 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 were 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 will be effective beginning January 1, 1989.

(C) TAXATION OF DISTRIBUTIONS

The tax treatment of distributions from public employee pensions plans also was modified by the Tax Reform Act to develop consistent treatment for employees in contributory and noncontributory pension plans. Under prior law, 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

nontaxable 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 preretirement 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 under the new law 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 new tax law also repealed the use of the advantageous 10-year forward-averaging tax treatment for lum-sum distributions received prior to age 59½, and provides for a one-time use of 5-year forward averaging after age 59½.

The Act also made a number of changes that apply to tax-qualified pension plans, but do not apply directly to government plans. These include a reduction in the vesting period from 10 years to 5 years, modifications in the rules for integration of pension and Social Security benefits to require payment of at least half of a nonintegrated pension benefit, tighter pension coverage, and nondiscrimination rules to encourage broader participation in pension plans by lower paid employees.

2. Issues

(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, including:

Government retirement plans, particularly smaller plans, frequently were operated without regard for 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 inadequate 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 antidiscrimination 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. Recent studies suggest that the growth rate of public funds is outstripping the growth of private plans as public fund administrators move aggressively to fund unfunded liabilities. 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 versus Usery,*[1] 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. The Supreme Court's decision in 1985 in *Garcia* v. *San Antonio Metropolitan Transit Authority*[2] 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 pension with respect to financial disclosure only. Some experts have testified that much of what is wrong with State and local pension plans could be cleared 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.

(B) INVESTMENT PERFORMANCE

The most important occurrence to affect State and local pension funding during 1987 was the October 19 stock market crash, known as Black Monday. On Black Monday, the Nation's pension plans lost $210 billion in fund assets, much of this involving State and

[1] 426 U.S. 883 (1979).
[2] 83 L.Ed.2d 1016, 53 U.S.L.W. 4135 (1985).

local plans. It is important to note, however, that while these plans lost a large portion of their assets as a result of the crash, they also had benefitted appreciably from the preceding bull market. As of December 2, 1987, State and local government plan assets totaled approximately $479 billion. While this was appreciably lower than the $562 billion in assets these plans had accumulated as of August 25, 1987, it was closer to the $503 billion in assets they owned on December 31, 1986. In fact, assets after Black Monday were higher than at the end of 1985, when State and local pension plan assets totaled about $432 billion.

State pension funds were seriously weakened by Black Monday. The Wisconsin State Employees Pension Fund for example, suffered a 20-percent loss in market value for the week of October 19, 1987, seeing its assets drop by well over $1 billion. The Michigan retirement fund also lost approximately $1 billion. While these losses were significant, they must be put in the proper perspective. For example, prior to the crash, the Michigan fund had assets of $16 billion. While one-sixteenth of those assets was lost on Black Monday, the Michigan State Treasurer's office has said that because of the previous bull market, Michigan's pension fund remains nearly $10 billion richer than it was in 1983. The story was similar in Wisconsin. According to the State of Wisconsin's Investment Board, Wisconsin's stock values on November 9, 1987 were about the same as they had been on January 1, 1987.

Like private plans, State and local plans were insulated partially from the market collapse by diversification in bonds, cash, and other nonequity investments. State and local plans were hardest hit by a decrease in the value of their equity holdings. The total value of State and local plans' equity holdings as of December 2, 1987 was $177 billion. This compares with pre-crash holdings of $255 billion on August 25, 1987 and $180 billion on December 31, 1986. The decline put State and local plan equity holdings in December 1987 within 2 percent of their value at the end of 1986.

The value of bonds held by State and local plans also experienced a slight decline. While their value had been $282 billion at the end of 1986, they had declined to $266 billion, by August 25, 1987, with a further decline to $261 billion by December 2, 1987.

On the whole, State and local pension plan investments recovered losses from the October 1989 plunge. Nevertheless, Black Monday served as a grim reminder that the stock market moves in two directions.

3. Prognosis

Some observers have suggested that the sheer size of the public fund asset pool will lead to its inevitable regulation. 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 have opposed 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. However, it is unlikely that Federal standards for public employee plans will get much serious Congressional consideration in the near future.

C. FEDERAL CIVILIAN EMPLOYEE RETIREMENT

1. Background

From 1920 until January 1, 1987, the Civil Service Retirement System (CSRS) was the staff retirement plan for all Federal civilian employees. That was changed with the introduction of the new Federal Employees Retirement System (FERS), established by Public Law 99-335. CSRS covers all employees hired before January 1, 1984, who did not, by December 31, 1987, transfer to FERS. FERS also covers all Federal employees hired on or after January 1, 1984.

A key difference in the plans is that FERS benefits include Social Security payments unlike CSRS. Inclusion of Federal workers in the Social Security Program was considered, but rejected, during enactment of the Social Security law in 1935. In subsequent years, it often was proposed, and always rejected, until enactment of the Social Security Amendments of 1983, which 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, or rehired on or after that date after separation from Federal service for more than 365 days.

Social Security coverage of Federal employees compelled the Congress to consider additional retirement benefits for such employees and to examine various retirement options. The addition of Social Security coverage duplicated some CSRS benefits and would have increased combined employee tax contributions to more than 13 percent. Therefore, by Public Law 98-168 in 1983, Congress established an interim arrangement, pending enactment of a permanent new plan. After extended debate, the new permanent plan was enacted in June 1986 as the Federal Employees' Retirement System Act of 1986 (P.L. 99-335).

Public Law 99-335 established the new Federal Empoyees Retirement System (FERS) in effect, designating CSRS as a closed system. Under current law, the CSRS system will no longer function at that time when the last employee in the system hired before January 1, 1984, retires and/or dies.

Two 1987 laws made necessary technical corrections in the law for both CSRS and FERS, Public Law 100-43 and Public Law 100-238, including: Making FERS early retirement available for law enforcement officers and firefighters after 3 years of primary duty instead of 10, and changing the FERS disability benefit to avoid a serious reduction at age 62.

(a) Civil Service Retirement System

CSRS is the largest pension plan in the country, a pay-as-you-go system financed about one-fifth by employees' payroll taxes, one-fifth by the employing departments and agencies, and the balance

(about $15 billion annually), from Federal general revenues. Federal employees make up about 3 percent of all U.S. workers.

The annual cost of the CSRS system increased from $2.5 billion in 1970 to $27.5 billion in fiscal year 1988. The number of annuitants grew from 962,000 to an estimated 2.1 million-plus during this same period. During the 1969–86 period, CSRS retirement benefits increased 197 percent, military retirement benefits 197 percent, and Social Security benefits 262 percent. During the same period the CPI for Urban Wage and Clerical Workers (CPI–W) increased 190 percent while Federal civilian pay increased only 133 percent. CSRS participants' contribution continues to be 7 percent of total basic pay with no Social Security tax.

CSRS main benefits structure remains the same: After 5 years of service, vested benefits equal to a percentage of the highest 3 years of pay; unreduced benefits at age 55 with at least 30 years of service; unreduced benefits at age 60 with at least 20 years of service; unreduced benefits at age 62 with at least 5 years of service; credit for unused sick leave if employees continue to work until retirement; payment of benefits for those who leave Federal service before eligible for retirement cannot start before age 62, no matter how many years of service; employees have the right to withdraw their own contributions without interest and forfeit all CSRS benefits at age 62.

The Omnibus Budget Reconciliation Act of 1986 (P.L. 99–509) protects CSRS COLA's from cancellation by sequestration under the Gramm-Rudman-Hollings Act. However, Congress through 1991 can still mandate reductions and cancellations of the CSRS COLA's to meet budget deficit reduction targets under the Gramm-Rudman-Hollings law.

On January 1, 1988, a COLA of 4.2 percent was provided to retirees under CSRS. On January 1, 1989, the COLA was set at 4 percent.

Since 1987, a new Thrift Savings Plan (TSP) option has been available through CSRS, under which up to 5 percent of an employee's pay can become tax-deferred. The Omnibus Budget Reconciliation Act of 1987 (P.L. 100–203) exempts TSP from antidiscrimination rules which apply to similar tax-deferred plans in the private sector. Therefore, all CSRS participants will be able to contribute the maximum 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 CSRS TSP.

CSRS is characterized as a good retirement plan for employees who know that they will remain in the employ of the Federal Government until they retire. However, it is described as not being well-suited to employees who may not spend their entire working careers in Federal service, since CSRS retirement benefits come from just one source. That source, because of inflation, gradually can lose its value for a person who leaves his or her job before retirement.

(B) THE FEDERAL EMPLOYEES RETIREMENT SYSTEM (FERS)

(1) Social Security Integrated With a Basic Defined-Benefit Plan

The FERS plan actually is comprised of two benefits: FERS retirement benefits and an individual's Social Security benefit. The FERS benefit was designed to reduce the financial pressures that have increased in CSRS because of its generous early retirement benefits. FERS is less generous to early retirees in both the base benefit paid and COLA increases than it is to those who delay retirement. The FERS benefit plan is similar to private-sector plans in many respects, and allows workers 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 for retirement 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 with 30 years of service.

The minimum retirement age (MRA) is 55 for workers who reach that age by the year 2002, and increases by 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 past the MRA with 10 years of service, but insufficient service to be eligible for a full benefit. The reduction is 5 percent for each year under age 62. 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.

Retirees with full 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 cease Federal work before retirement, provided they have at least 5 years of civil service and have not withdrawn their contributions at separation. 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 age 62.

Cost-of-living adjustments will be paid annually based on changes in prices measured by the Consumer Price Index (CPI) except that regular retirees under age 62 will not receive any increase. 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.

(2) Employee Contributions

Unlike CSRS, 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 beginning in 1988, and 6.2 percent beginning in 1990 up to the taxable wage ceiling ($45,000 in 1988). 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 which is 0.94 percent in 1988 and 1989, and 0.8 percent beginning in 1990.

At separation of service or retirement, employees will have the option of withdrawing their own contributions to FERS in an actuarially reduced lump-sum payment. For those not retiring, this choice becomes a relinquishment of the employer's contribution, and they will be ineligible for deferred pension benefits at retirement. When the lump-sum is taken at retirement, it actuarially reduces the monthly retirement annuity the retiree (and any surviving spouse) will receive.

(3) Disability Benefits

Employees are eligible at any age for disability retirement after 18 months of creditable service 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 by offset, to an extent, by Social Security benefits.

(4) Survivor Benefits

The survivor benefit plan feature of FERS provides lump-sum payments to all surviving spouses of workers who die before retirement plus, in some cases, annuities to such survivors. Survivors of retired workers are eligible for an annuity if the couple elects 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 payable.

(5) The Thrift Savings Plan (TSP)

FERS supplements the defined-benefit plan with a contribution plan that resembles the popular 401(k) plans used by many 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 will be automatically contributed to the TSP by the employing agency. Employees will be permitted to contribute up to 10 percent of their salaries to the TSP, and the employing agency will match

the first 3 percent of pay contributed on a dollar-for-dollar basis, and will match the next 2 percent of pay contributed at the rate of 50 cents per dollar. Thus, the maximum matching contribution to TSP by the Federal agency will equal 4 percent of pay, and the automatic contribution of the agency will add another 1 percent of pay. Therefore, employees contributing 5 percent or more of pay will receive the maximum agency match.

An open season will be held every 6 months to permit employees to change levels of contributions and direction of investments. Optional investment opportunities will be phased in over a 10-year period, including special government securities, fixed-income securities, or a stock portfolio. Employee will be allowed to borrow from their accumulated TSP beginning in 1988 for the purchase of a primary residence, educational or medical expenses, or financial hardship.

All Federal employees covered by FERS on January 1, 1987, are eligible to participate in the FERS TSP. Employees hired after that date will generally have a 6 to 12 month waiting period.

At the end of 1988, FERS covered approximately 800,000 Federal civilian employees.

(6) Comparison of FERS Benefits and CSRS Benefits

The inclusion of FERS participants in the Social Security Program allowed the plan's drafters to provide Federal workers with two design elements which should help to build a strong Government work force: Benefit portability and income replacement rates comparable to those found in the private sector.

Workers who do not expect to make a career of Federal service or who come in and out of Federal employment will be able to accrue Federal retirement benefits that can be accumulated with benefits from other employment. In addition, Social Security contributions will help workers build work quarters as they move in and out of the public sector.

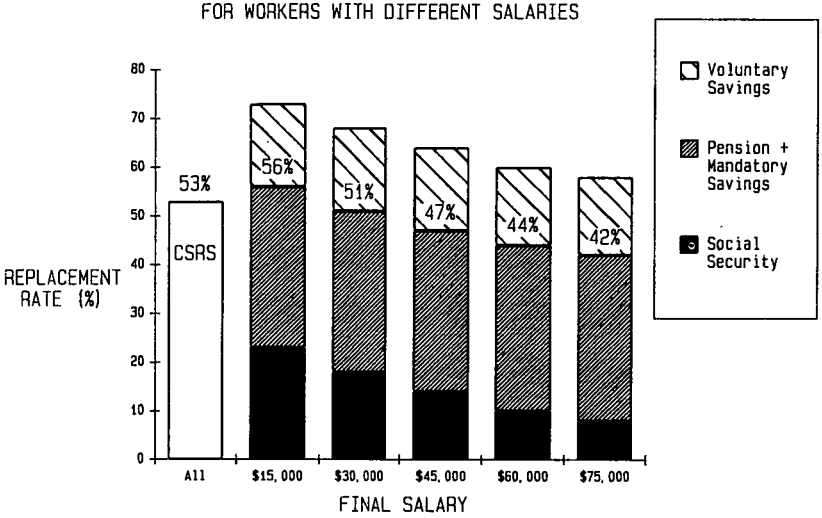
Benefits under CSRS provide replacement rates on the basis of years of service, not level of service, whereas Social Security is "tilted" toward lower income workers by taking into account both eligible work quarters and salary levels. The chart below illustrates how the replacement rates for FERS will differ from CSRS, with the example of a 62-year-old worker retiring in the year 2030 after 30 years of Federal service. Adjusted to 1985 dollars, the gross replacement rate for this employee under CSRS would be 53 percent, regardless of the employee's salary level. Under FERS, however, the replacement rate will vary considerably with salary level. Assuming this employee made only voluntary contributions to the Thrift Savings Plan, the replacement rate would be 56 percent at a $15,000 final salary level, but would fall to 42 percent at a $75,000 level. These differences are attributable to the benefit structure of Social Security, since the pension portion of the retirement benefit is constant regardless of salary level.

It is estimated that the redesigned employee contribution feature of FERS will result in the cost of FERS being 22.9 percent of payroll (25 percent of CSRS).

It has been estimated that voluntary contributions under FERS will average 2.8 percent of salary.

CHART 1

BENEFIT VALUE AT RETIREMENT
FOR WORKERS WITH DIFFERENT SALARIES



NOTE: Assumes worker retiring in the year 2030 at age 62 with 30 years of service.
SOURCE: Congressional Research Service, Report No. 86-137 EPW

2. Issues

(A) LUMP-SUM WITHDRAWAL OF CONTRIBUTIONS

Public Law 99-335 contained a provision allowing those retiring under CSRS or FERS to withdraw, at the time of retirement, their contributions to the system in exchange for a reduction in their annuity to reflect the withdrawn sum. This would mean a full actuarial pension reduction so that over the retiree's lifetime, the amount received together with the withdrawal would be the same amount which would have been received if the withdrawal had not been made.

This was a new option for Federal workers under CSRS. It is said that it was intended to partially offset the 1986 Tax Reform Act (P.L. 99-514) repeal of the 3-year pension-contribution-recovery tax rule. What was given with one hand may have been taken away with the other; before the 1986 tax law, that type of withdrawal would have been untaxed; the 1986 tax law made much, or most, of it taxable.

The Administration's budget proposed repeal of that withdrawal provision as too costly, estimating that 85 percent of all retirees would opt for it, resulting in an estimated net cost of $3.7 billion over fiscal years 1988-90.

Much to the surprise of some, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (P.L. 100-203) changed the withdraw-

al rule for those voluntary retirees whose retirement annuities commence after January 3, 1988, and before October 1, 1989. The changes are: Beginning January 4, 1988, the lump-sum payable to nondisability retirees will be paid in two installments, 60 percent at retirement and 40 percent (with interest) 1 year after retirement. The change did not affect those who separated from service on or before January 2, 1988, or those whose last day of pay was January 2, 1988, or earlier.

The new withdrawal provision applies to both CSRS and FERS.

(B) SOCIAL SECURITY PUBLIC PENSION OFFSET

Social Security benefits payable to spouses of retired, disabled, or deceased workers generally are reduced to take account of any public pension the spouse receives as a result of work in a Government job not covered by Social Security. The amount of the reduction equals two-thirds of the Government pensions—$2 of the Social Security benefit for each $3 of the Government pension. The offset does not apply to workers whose Government job is covered by Social Security on the last day of the person's employment.

By transferring to FERS between July 1 through December 31, 1987, a worker covered by CSRS and not Social Security could become exempt from the public pension offset, immediately upon becoming covered by FERS. As a result of provisions in OBRA 1987 this exemption was limited to workers with at least 5 years of Federal employment that is covered by Social Security who elect to transfer from CSRS to FERS during any election period on or after January 1, 1988. The provision also applies to certain legislative branch employees who become covered under FERS on or after January 1, 1988.

(C) SOCIAL SECURITY WINDFALL BENEFIT REDUCTION

A provision of the Social Security Amendments Act of 1983 (P.L. 98-21) contains a formula for reduction of the Social Security benefits of workers who also have pensions from work not covered by Social Security (such as CSRS). The reduction formula applies only to those who have less than 30 years of Social Security coverage. Workers with 30 or more years of Social Security coverage are fully exempt from the reduction formula.

That new provision is being phased in over a 5-year period beginning in 1986 with those first eligible for Social Security benefits and non-covered pensions. The resulting reduction in the Social Security benefit is limited to one-half of the amount of the noncovered pension.

(D) MEDICARE PART B CATASTROPHIC ILLNESS COST PROTECTION ACT

(1) Supplemental Premium Formula

On July 1, 1988, following extended debate over legislation to provide catastrophic illness insurance for the Nation's 32 million elderly and disabled Medicare beneficiaries, the President signed into law the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). Under the law, anyone eligible for Medicare who pays taxes will pay an extra premium based on their taxable income. In 1989,

the premium will be $22.50 per $150 of tax liability up to a maximum of $800.

Due to the different tax treatment of Social Security and Government pensions under the Federal tax code—the former being tax-free except for certain higher income beneficiaries, while the latter are almost fully taxable—special consideration was given to the design of a supplemental premium formula in the new catastrophic law for Federal retirees. To avoid financing inequities, the formula was adjusted, exempting a portion of a Federal retiree's Government annuity.

(2) Medigap Insurance for Federal Retirees

During consideration of the catastrophic health care legislation, the Office of Personnel Management (OPM) informed Congress that a medigap-type health insurance policy could not be offered to Federal retirees through the Federal Employees Health Benefits Plan (FEHB). OPM also reported that the policies authorized by FEHB provided coverage that largely duplicated the increased coverage offered by the catastrophic health care legislation.

Unless medigap-type policies become available through FEHB, Federal retirees will be confronted with higher than necessary premiums for duplicative coverage, and will be paying twice for the same coverage—the supplemental premium mentioned above and the FEHB policy premium.

According to reports, the Federal Government pays 75 percent of the cost of each FEHB plan up to a certain level. Some of these plans exceeded the cutoff level to the point where the worker or retiree pay as much as half the cost. In 1987 Congressional hearings, witnesses said that Medicare-eligible retirees, through premiums for duplicative coverage (because Medicare is the primary payer and their insurance secondary), are subsidizing the FEHB system.

During the development of the catastrophic health care legislation, experts contended that it would not be possible to offer medigap policies through FEHB without first completely restructuring FEHB and the 430 insurance plans now available through it. To address this issue, the catastrophic care law called upon the OPM to carry out a study for the Congress by April 1, 1989, on what change would be needed to resolve this problem.

(E) TAXATION OF LUMP-SUM PAYMENTS AT RETIREMENT

The Tax Reform Act of 1986 treated 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 remaining annuity amount were combined and the proportionate shares of the employer's and employee's contributions were assessed. This rate then was applied to both the monthly annuity payments and the total lump-sum payment even though the lump-sum payment is paid in two installments under the 1987 Act.

The new law places a penalty on the withdrawal of an employees' contributions in certain limited circumstances. The 10 percent penalty on early withdrawals from Individual Retirement Accounts (IRA's), except in cases of hardship, is extended to early withdraw-

als from qualified pension plans. This penalty will affect Federal workers under age 55 who retire under special early retirement provisions pertaining to job abolishment, or corporate reorganizations or reductions-in-force, and other Federal employees for whom normal retirement is age 50 with 20 years of service. Under the 1986 tax law, the withdrawal cannot be rolled over into an IRA or other qualified plan because it generally will not constitute 50 percent of the amount of the employee's lifetime annuity and, therefore, will not meet the IRS requirement for rollovers.

3. Prognosis

Congress probably will not make major changes in the structure of FERS in the foreseeable future. For CSRS participants, although Congress has demonstrated an intent to leave the system unchanged for those workers currently covered by it, some have expressed a fear that down the road, as FERS participants begin to outnumber CSRS participants, the voice of those dependent on CSRS will fade and beneficiaries will be forced to bear a disproportionate share of budget-cutting efforts. Already, CSRS retirees lost their 1986 COLA's as Congress and the President searched for ways to reduce the mounting Federal deficit. It remains to be seen whether this annual task can be accomplished without further reduction of retirement benefits for civil servants.

It is reasonable to expect a new open period for CSRS transfers to FERS. Pension experts, surprised by the small numbers of transfers, claim that 40 percent of Federal workers would be better off under FERS. But some nontransfers reportedly have said: "If it ain't broke, don't fix it."

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. As a participant only becomes vested in the military retirement program after 20 years of service, the first retirees affected by the new law will be those with 20 years of service retiring on August 1, 2006.

In 1987, 1.6 million retirees and survivors received military retirement benefits. For fiscal year 1988, total Federal military retirement outlays have been estimated at $18.9 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, 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 Consumer Price Index (CPI). In the event of an across-the-board budget cut under the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings), military retirement cost-of-living adjustments (COLA's) are exempt from sequestration. Under the Military Retirement Reform Act of 1986, however, COLA's will be held at 1 percentage point below (CPI) for military personnel beginning their service after August 1, 1986.

2. Issues

(a) cost

The military retirement system repeatedly has been criticized for providing lavish benefits, costing too much, and contributing to inefficient military personnel management. The Military Retirement Reform Act of 1986 was enacted in response to these opinions. 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 1.5 million retired officers, enlisted personnel, and their survivors received nearly $18.9 billion in annuity pay-

ments in 1987. At the current rate of growth, this expenditure will reach an estimated $45 billion annually by the end of the century. In 1986, military retirees received an average of $12,671 in annuities.

In particular, four identifiable features of the military retirement system greatly contribute to its cost:

(1) Full benefits begin immediately upon retirement; the average retiring enlisted member begins drawing benefits at 42, the average officer at 46. Benefits continue until the death of the participant.

(2) Military retirement benefits are 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.

Supporters of the current military retirement scheme have identified several characteristics arguably unique to military life that they feel 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 ostensibly part compensation for this exigency.

(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. Only a small minority 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. And the full cost of the program appears as an agency expense in the budget, unlike the civilian retirement system where one-fifth of the cost is paid by employee contributions.

Finally, since the beginning of Social Security coverage for military personnel in 1945, military retirement benefits have been paid without any offset for Social Security. Taking into account the frequency with which military personnel in their middle 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 generally adds to the perception that military retirement benefits are overly generous.

Military retirement is fully indexed for inflation, 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 become the object of most deficit-reduction measures. As a result of the original provisions of the Gramm-Rudman-Hollings Act, the 1986 military retiree COLA was cancelled. Since that time, however, legislation was enacted that excluded the COLA from sequestration.

(B) RETIREMENT ADEQUACY

The temptation to use strict economic arguments in comparing military pensions to those found in the private sector is difficult to avoid, especially absent any immediate threat of war. The pivotal issue in evaluating the military retirement system, however, is not cost, but the system's ability to provide adequate retirement income to those men and women who serve in the armed forces. Several recent studies of the military retirement system have suggested that the 20-year service requirement is unfair to the majority of military personnel. Nearly 65 percent of officers and 90 percent of enlisted personnel leave before completing the requisite 20 years of service. It has been suggested that this design is likely to prolong the careers of marginal military personnel beyond their usefulness, while simultaneously providing an incentive for highly skilled and experienced personnel to leave the armed services for second careers as soon as they complete 20 years of service, in order to capitalize on private sector employment opportunities and pensions. The result is a system that pays relatively high benefits to a disproportionately high number of officers when compared to the composition of the military as a whole.

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 annuity to a spouse, spouse and child, child only, person with an "insurable interest," or a former spouse. As a result of the SBP, a military retiree can provide for an annuity of up to 55 percent of his or her total retired pay at the time of death to be paid to a surviving spouse. Upon reaching age 62, the SBP annuity automatically is reduced to 35 percent of military retired pay for all surviving spouses. This offset occurs regardless of whether the survivor is eligible for Social Security retirement or survivors benefits and regardless of any other sources of income available to the surviving spouse.

A retiree automatically is enrolled in the plan upon retirement at the maximum rate unless he or she chooses, in writing, not to participate or to do so at a lesser level of protection. If such a choice is made, the spouse must be notified. SBP annuities are ad-

justed for the cost-of-living on the same basis as military retired pay. No coverage reductions were made by the Military Reform Act. However, SBP benefits will be subject to the changes made in the formula for determining cost-of-living adjustments.

(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 the deceased retiree's active duty military service. The Military Survivor Benefit Plan is integrated with Social Security. Since the original intent of the SBP was to provide a portion of the deceased military member's retired pay to the surviving spouse, it was considered appropriate that all sources of survivor benefits attributable to military service be included in the survivor benefit computation. As a result, Social Security survivor benefits payable because of military service were subtracted from the SBP so that the SBP and Social Security together would provide 55 percent of the retired pay to the surviving spouse.

(2) The Two-Tiered SBP

Some have questioned the equity of the SBP. Military SBP benefits become payable immediately upon the death of the retiree, regardless of the age of the surviving spouse. Social Security widow(er)'s benefits are not paid until the survivor reaches age 60, while retirement benefits for a spouse with their own earnings record do not begin until age 62.

Under the "two-tier" system, if the surviving spouse is, for example, age 57 at the time of a retiree's death, full SBP benefits are payable immediately, and will continue until the survivor reaches age 62. Surviving spouses without their own Social Security earnings record are able to draw full benefits for several years before having them reduced. However, survivors who will receive their own retirement benefits from Social Security must wait for them until age 62, the point at which their SBP annuity is reduced. For survivors who are not eligible for any Social Security benefits, SBP annuities will be reduced even if they do not have additional retirement income when they reach age 62.

This difference in treatment of survivors may lead to future legislative activity. Although the "two-tier" SBP does provide certainty as to benefits payable, the fact that it may result in less than optimal targeting of limited Federal funds makes it ripe for further changes as Congress continues to wrestle with mounting deficits.

(3) Cost-of-Living Adjustment

Military retirees, along with Social Security and other Federal retirees, received a 4 percent COLA effective January 1, 1989. The President's budget submission for fiscal year 1990 proposes that the January 1990 COLA be eliminated, which would result in a $620 million cut in benefits. Also, in 1991, the President's budget would hold COLA's to 1 percent below the rate of inflation.

3. Prognosis

In 1989, the issue which will undoubtedly generate controversy and hence receive Congressional attention will be the President's proposed elimination of the January 1990 COLA for military retirees. Without the COLA, military retirees would receive an estimated $620 less in benefits that year. In addition, military retirees can be expected to actively oppose the proposal in the President's budget to begin charging a user fee for the provision of medical care at military hospitals. As for other issues, interest will likely continue about the current system's inequities, but no major legislative changes are anticipated in the immediate future.

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 1988, railroad retirement, disability, and survivor benefits totalled $6.7 billion. There was a total of 925,100 retirement, disability, and survivor beneficiaries, receiving the following average monthly benefits according to the categories listed below.

Type of benefit	Number	Amount/month
Age 65 or over	3,000	$628
Age 60 to 64, unreduced	5,000	1,339
Age 60 to 64, reduced	8,500	923
Age retirements, total	16,500	996
Disability retirements	4,800	1,089
Regular employee annuities, total	21,300	1,017
Unreduced spouse annuities	10,600	392
Reduced spouse annuities	6,700	328
Divorced spouse annuities	400	193
Spouse and divorced spouse annuities, total	17,800	363
Aged widow(er)s	13,500	544
Disabled widow(er)s	400	506
Widowed mothers and fathers	400	478
Remarried widow(er)s	600	325
Divorced widow(er)s	800	376
Children	1,300	484
Parents	(1)	409
Survivor annuities, total	17,000	521
Total	56,100	

Type of benefit	Number	Amount/month
Lump-sum death payments	8,100	840
Residual payments	300	4,949
Total	8,400	

Source: RRB and its January 1989 Information Conference Handbook, p. 17.

The highest individual annuity awarded in 1988 was $1,662. The highest combined retiree and spouse annuities awarded in 1988 totalled $2,432.

2. Issues

(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 organizational 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 second Reagan Administration consistently attempted to dismantle the railroad retirement system, proposing to convert to a private pension administered by a private corporation all benefits in excess of Social Security, and turning over to Social Security the Social Security-equivalent benefits of the system. The Administration's rationale was that the Government should not administer an industry pension, and that given the intended equivalency of Tier I and Social Security, it was appropriate for Social Security to absorb the Social Security equivalent benefits. Nonetheless, each Congress during that period rejected the proposal on the grounds that it could lead to a cut in benefits for present and future retirees and undermine confidence the system. It was further argued that such a conversion would compound the agency's administrative burden.

(B) RECENT FINANCING PROBLEMS

(1) The 1983 Retirement Fund Crisis

Because railroad retirement benefits are financed by payroll tax revenues, the number of rail employees has always been a crucial factor in determining the financial viability of the system. Through the late 1970's, the rail industry was financially troubled, with falling rail traffic and employment opportunities. As a result, payroll

tax revenues declined, leaving inadequately funded the 60–30 early retirement benefit (which allows workers with at least 30 years of experience to retire at age 60 with full Tiers I and II benefits as if 65) initiated by the 1974 law and the vested "dual" benefit. By 1980, the retirement trust fund was faced with financial difficulties and cash-flow problems.

Since the end of World War II, the worker/beneficiary ratio has been decreasing, as noted in the following table:

EMPLOYEES IN THE RAILROAD INDUSTRY AND BENEFICIARIES OF THE RAILROAD RETIREMENT SYSTEM SINCE 1945

[In thousands]

	Average employment	Beneficiaries	Ratio of workers to beneficiaries
Year:			
1945	1,680	210	8.04
1950	1,421	461	3.08
1955	1,239	704	1.76
1960	909	883	1.03
1965	753	930	.81
1970	640	1,052	.61
1975	548	1,094	.50
1980	532	1,084	.49
1981	503	999	.50
1982	440	988	.44
1983	395	981	.40
1984	395	980	.40
1985	372	954	.39
1986	342	941	.36
1987	320	928	.34
1988	302	915	.34

Source: Railroad Retirement Board, 1986, Annual Report, dated October 23, 1987.

The 1980 long-term financing problem worsened because Congressional appropriations for "windfall" benefits were far from sufficient to pay for those benefits that year, and appropriations shortfalls consequently were paid from the railroad retirement trust fund. At the same time, funding for the 60–30 early retirement benefits had not been improved.

To improve the system's financial condition, Congress included a number of provisions in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97–35) and the Economic Recovery Tax Act of 1981 (P.L. 97–34). Those provisions raised payroll taxes on employers and employees, modified benefits, created a separate account for windfall benefits, and provided the railroad retirement trust fund with authority to borrow from the General Treasury when near-term cash-flow difficulties arise.

Unfortunately, in the final quarter of 1982, an economic recession devastated the railroad industry and thwarted the intended benefits of the 1981 laws, bringing the railroad retirement system to the brink of insolvency and threatening a 40-percent cut in 1983 Tier II benefits. Another financial drain on the fund stemmed from borrowing from the fund by the Railroad Unemployment Insurance Account. By 1983, those unpaid borrowings totaled $575 million.

In 1983, rail labor and management, following Congressional instructions, collectively negotiated a comprehensive rescue package and submitted it to Congress. As enacted in the Railroad Retirement Solvency Act of 1983 (P.L. 98–76), the package was composed of payroll tax increases, benefit reductions, and general revenue contributions, and was designed to ensure the solvency of the railroad retirement system through the 1990's, even under pessimistic employment assumptions. In the short-run, passage of the measure averted the threatened 40-percent reduction in Tier II benefits scheduled for 1983. Key provisions of the Act include:

(1) A COLA offset which required that the next 5 percent of Tier I (both rail and nonrail credits) COLA increases be subtracted, dollar for dollar, from Tier II (pension) benefits. This effectively eliminated the 3.5 percent COLA scheduled for 1984 and reduced the 1985 COLA from 3.5 percent to 2 percent. That COLA offset provision applied only to beneficiaries on the rolls before January 1, 1984, and was estimated to reduce their Tier II benefits by a total of $920 million through fiscal year 1988. The effect of that Tier II benefit cut is compounded over the life of the beneficiary.

(2) The 60–30 early retirement unreduced benefit, which allowed employees with at least 30 years of service to retire at age 60 with full Tiers I and II benefits as if 65, was reduced to a 62–30 early retirement full benefits rule and a 60–30 reduced Tier I benefit rule. The reduced 60–30 early retirement Tier I benefit remains frozen in amount until the retiree reaches age 62. At age 62, the reduced Tier I benefit is recomputed, not as a 62–30 full early retirement benefit, but to reflect increases in national wage levels. (The law did not change the 60–30 early retirement full Tier II benefits.)

(3) Three annual Tier II payroll tax increases of 0.75 percent were levied on rail employees, and three annual payroll tax increases of 1 percent were levied on rail employers. This raised total payroll taxes from 13.75 percent to 19 percent—from 2 to 4.25 percent the employee rate and from 11.75 to 14.75 percent the employer rate.

(4) The wage base on which the employer-paid railroad unemployment insurance tax is levied was increased by 50 percent from the first $400 of monthly earnings to the first $600. A temporary unemployment tax was levied on employers on July 1, 1986, to repay the unemployment account debt to the retirement fund.

(5) Tier II benefits and vested dual benefits were subjected to Federal income taxation under the same guidelines as private pension earnings to the extent the pension income exceeds the employee's contributions. The revenues collected from this tax were to be transferred to the rail trust fund to finance benefit payments through October 1, 1988. After that, the revenues remain with the Federal Treasury. (Tier I benefits were made subject to the Federal income tax, the same as Social Security benefits, by the Social Security Act Amendments of 1983, P.L. 98-21.)

(2) The 1986-87 Fund Crisis

Following enactment of the Railroad Retirement Solvency Act of 1983, there was optimism that the retirement fund finally was on a firm financial foundation and that the decline in rail industry employment that had threatened the system would level off. In 1985, the Railroad Retirement Board (RRB) forecasted that the even substantial declines in rail employment would not bring about cash-flow problems in the next 10 to 20 years. However, the RRB did characterize the fund's long-term stability "still questionable."

Because the Tier II tax had not been increased and rail employment continued to decline, the chief actuary's 1987 report recommended that the Tier II tax be increased 4.5 percent, effective January 1, 1988. The report projected possible cash-flow problems as early as 2001, under pessimistic assumptions and the present financing structure. To address these concerns, the report also recommended that a panel be formed to examine possible sources of revenue for the system.

In response, the Omnibus Budget Reconciliation Act of 1987 (1987 OBRA), Public Law 100-203, increased the employer Tier II tax from 14.75 to 16.1 percent and the employee Tier II tax from 4.25 to 4.9 percent, on wages up to $33,600, effective January 1, 1988. The estimated revenue from those tax increases was: $144 million in 1988, $182 million in 1989, and $183 million in 1990. In addition, the Act increased revenue to the fund by an estimated additional $400 million by extending from October 1, 1988, to October 1, 1989, the cut-off date for transfer to the fund of revenue from the income taxation of Tier II and windfall benefits and removing the $877 million cap on such transfers. Acting on the recommendation in the 1987 report of the RRB's chief actuary, the Act also authorized the establishment of a Commission on Railroad Retirement Reform to report to the Congress on possible solutions to the system's long-term financial problems. The Reform Commission's report is to be submitted to the Congress by October 1, 1990.

(3) Current Actuarial Status

The 1986 and 1987 annual reports of the RRB were not rosy, recommending that the Congress take immediate steps to increase revenue to the system. However, the 1988 report paints a much more favorable financial picture, due to the establishment of the Commission on Railroad Retirement Reform, the revenue increases to the system under the 1987 OBRA, and the increase in the tax rates for the Unemployment Repayment Tax. No recommendations for immediate revenue increases are contained in the 1988 report.

(C) THE RAILROAD UNEMPLOYMENT INSURANCE ACCOUNT DEBT

(1) The Consolidated Omnibus Budget Reconciliation Act of 1985

Prior to the 1983 Railroad Retirement Solvency Act, there were no requirements for repayment of the debt to the retirement fund. The debt was to be paid, in whole or in part, only if excess funds were available in the unemployment fund. The Act instituted the first tax for repayment of that debt.

Provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (1985 COBRA), enacted as Public Law 99–272, increased the rates of that tax to 4.3 percent, 4.7 percent, and 6 percent for 1986, 1987, and 1988, respectively, under the 1983 Act. The 1985 Act did not change the 2.9 percent rate or the 3.2 percent rate for 1989 and 1990, respectively, under the 1983 Act.

Revenue from the repayment tax can be used only for repayment of the debt incurred prior to September 30, 1985, plus interest, and is scheduled to expire on September 30, 1990. It is estimated that the unpaid balance on that date would be about $600 million. In fiscal year 1987, payments on the debt totalled $182.9 million, consisting of $138.6 million on principal and $44.3 million in interest. At the end of that fiscal year, the debt, including accrued interest, totalled $744.6 million.

(2) The Technical and Miscellaneous Revenue Act of 1988

In 1988, Congressional concerns over the debt in the railroad retirement fund led to the enactment of a number of provisions in the Technical and Miscellaneous Revenue Act of 1988, enacted as Public Law 100–647. First, the Act increased the repayment tax rate to 4 percent, effective 1989, until the debt incurred prior to October 1, 1985, with interest, is repaid. Second, a new surcharge tax schedule was instituted—namely, 1.5 percent when the unemployment account's net assets fall below $100 million, 2.5 percent if less than $50 million, and 3.5 percent if below zero. Third, the Act required the RRB to submit a report to the Congress on July 1 of each year, commencing in 1989, on the status of the railroad unemployment insurance system.

(D) TAXATION OF RAILROAD RETIREMENT BENEFITS

(1) Taxation of Tier I

(a) The Social Security Act Amendments of 1983

In the Social Security Act Amendments of 1983, enacted as Public Law 98–21, the Congress acted on a labor-management recommendation that Tier I benefits be subject to the same taxation as Social Security benefits. Consequently, the amount subject to tax is one-half of the excess of the total of adjusted gross income, plus one-half of the total Tier I benefits for the year, plus nontaxable interest income over the base of $25,000 for an individual ($32,000 for joint filers), not to exceed one-half of total Tier I benefits for that year. (Adjusted gross income does not include Tier I benefits.)

As an example, for an individual with an adjusted gross income of $20,000, $6,000 in Tier I benefits, and $3,000 in tax-exempt interest income, the computation would be $20,000 plus $3,000 (half of the Tier I benefit) plus $3,000 (the tax-exempt interest income) minus $25,000 (the base amount for single filers), yielding $1,000. The amount of Tier I benefits subject to tax is one-half of $1,000, or $500.

In 1987, 9.014 million returns reported a total of $74.2 billion in Social Security benefits. Approximately 3.3 million of those returns had a total of $11.7 billion of Social Security benefits in taxable income, an average of $3,260 of Social Security benefits per return.

(b) The Railroad Retirement Solvency Act of 1983

The Railroad Retirement Solvency Act of 1983, Public Law 98-76, established the Social Security Equivalent Benefit Account (SSEBA), under the Railroad Retirement System, separate from the Railroad Retirement Account (RRA). The Report of the Office of Tax Analysis explains SSEBA as follows: "From the SSEBA, retired rail workers receive the amount of Tier I benefits equivalent to the Social Security benefits they would have received had their service been covered under the Social Security system rather than the Railroad Retirement System. The tax liability of the Social Security-equivalent benefits is transferred to the SSEBA. The remainder of Tier I benefits is paid from the Railroad Retirement Account with the tax liability for this portion transferred to the Railroad Retirement Account. In 1985, the first full year in which taxes on the Tier I benefits were divided between the two accounts, 84 percent were classified as SSEBA payments, with the remaining 16 percent classified as RRA benefits" and, therefore, in excess of Social Security equivalent benefits.

(c) The Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, restricted the Social Security income tax formula to only the part of a Tier I benefit equivalent to the amount of the SSEBA. The Act made the part of a Tier I benefit in excess of the non-SSEBA subject to same tax as Tier II and all private pensions, effective the 1986 tax year. The rationale for the change was that as the rail employee Tier I tax is the same as the employee Social Security tax, the retired rail employee should not have a greater income tax advantage than the Social Security beneficiary.

The non-SSEBA is funded by employees' and employers' Tier II tax contributions, the same as are Tier II benefits. As a result, the RRB must annually make the necessary calculations to enable it to inform each annuitant of the amount of the Tier I benefit that is equivalent to Social Security and the amount, if any, that is in excess of the non-SSEBA. For fiscal years 1988 through 1993, the RRB has made the following projections of the respective SSEBA and non-SSEBA:

	SSEBA (billions)	non-SSEBA (millions)
Fiscal year:		
1988	3.94	568
1989	4.11	571
1990	4.26	585
1991	4.41	591
1992	4.54	584
1993	4.61	587

The RRB estimates that the change in taxation will generate an additional $40 million in revenues each year. Under the 1987 Act, these additional revenues will be credited to the RRA account until

October 1, 1989, the same as are revenues from the taxation of Tier II benefits.

(2) Taxation of Tier II Benefits

The labor-management negotiated recommendation for the taxation of Tier II benefits was implemented by the 1983 Solvency Act (P.L. 98–76). However, before final passage, the original bill was amended to deny Tier II annuitants "a fresh start." The tax became effective with the 1984 tax year, with all Tier II benefits received before 1984 charged against the recovery of the annuitant's tax contributions to the benefit, even though the benefits were tax-exempt under the tax law when they were received. That increased the income tax liability of Tier II annuitants who had retired before 1984.

The Tax Reform Act of 1986 (P.L. 99–514), eliminated the 3-year rule for the recovery of private pension contributions, including the employee Tier II tax. Under that rule, the pension benefits did not become taxable until the total contribution of the annuitant was recovered in benefits over an initial period not to exceed 3 years. Under the 1986 change, the non-SSEBA portion of Tier I benefits and all of Tier II benefits become taxable immediately upon receipt, but on a prorated basis as to the annuitant's contributions, taking into consideration the life expectancy of the annuitant. The same rule applies to all private pensions.

Under the 1983 Solvency Act vested "dual" benefits have been subject to income tax the same as Tier II benefits, effective the 1984 tax year.

(E) BENEFIT FORMULAS, QUALIFICATION RESTRICTIONS AND LIMITATIONS

(1) "Last Person Service" Rule

Perhaps the most troublesome qualification rule was the "last person service" rule, which required a retiree to give up a job (full or part-time) outside the rail industry to be eligible for an annuity. That rule became even more problematic in recent years because to reduce employment many railroad employers instituted combined early retirement and separation pay plans applicable to employees who would not be eligible for railroad retirement benefits for many years after leaving that employment. Many former rail employees found satisfactory jobs in other industries, only to learn that they had to give up that employment to collect those benefits upon reaching the prescribed age. Under the rule, they could quit that job and apply for the benefits, then go to work for another employer (but, not a railroad) and continue to receive the benefits, subject to the applicable earnings limitations. However, they could not return to work for the last non-railroad employer immediately preceding the application for benefits. This restriction applied to the spouse benefit as well as the retiree's benefit, part-time employment as well as full-time employment.

As a result of provisions enacted in the Technical and Miscellaneous Revenue Act of 1988 (P.L. 100–647), the "last person service" rule was replaced with a new rule, one which reduces the Tier II

benefit by an amount equal to 50 percent of earnings from the last non-railroad employer, subject to the limitation that the total reduction in Tier II plus supplemental annuity benefits cannot be more than 50 percent. The new rule continues to apply at age 70 and beyond, but does not affect Tier I. In post-retirement employment, Tier I is affected only by the earnings limitations and the prohibition against railroad employment.

(2) Earnings Limitations

Tier I and vested dual benefits are subject to the same earnings limitations as Social Security: $1 deduction for each $2 earned over the limit. For 1989, the maximum earnings limits for the 65–69 age group are $8,880 (1988—$8,400), and $6,480 for those under 65 (1988—$6,120). The estimated limit amount for 1990 for the 65–69 age group is $9,120. From age 70 on, there is no earnings limitation.

During the first year of benefits only, the earnings limits are applied on a monthly basis only in those months in which the amount earned exceeds one-twelfth of the annual limit for that year. After the first year, the limits are applied to total annual earnings, without regard to either the number of months worked or the amount earned in any 1 month.

Those earnings limitations do not apply to Tier II, nor, in all cases, to all of Tier I. The earnings deduction cannot reduce the Tier I amount to an amount less than the Tier I amount would be, if computed only on the annuitant's railroad service through December 31, 1974. Also, the non-SSEBA portion of a Tier I benefit is not subject to a reduction for earnings over the limit.

In 1990, the deduction will change to $1 for each $3 earned over the limit for the 65–69 age group. For the 62–64 age group, the deduction will remain $1 for each $2 earned over the limit.

Any railroad retiree contemplating returning to work should first ask the RRB's district office for a computation of the amount of the Tier I benefit that would not subject to reduction for excess earnings.

Opponents of the earnings limitations claim it discourages the elderly from working and discriminates against those who need the additional income most—namely, those with lower-than-average Social Security benefits. Conversely, those receiving the highest benefits can earn the same amount, without penalty.

A January 1989 Labor Department report, entitled "Older Worker Task Force: Key Policy Issues for the Future", cites that 61 percent of workers 63 and older are working because they "need the money." The report also points out that the "earnings test hurts those who must rely on earned income to supplement retirement income but does not affect those who have substantial income from savings." In 1986, according to the Labor Department, 48 percent of the males and 61 percent of the women 65 and older were working part-time. However, those statistics do not reveal what percentage of each group was working because they needed the income, nor the percentage who would prefer to work full-time.

Although bills were pending in the 100th Congress to repeal or phase-out the Social Security earnings limitations, no final action

was taken on that legislation. No doubt the 101st Congress will see a renewal of efforts to repeal, phase-out, or otherwise modify, the Social Security earnings limitations. (For additional discussion of this issue, please see the Social Security chapter.)

(3) Social Security "Notch"/Railroad Retirement "Notch"

Legislation in the 100th Congress to adjust the Social Security benefit formula for retirees born between 1917 and 1928 to eliminate the so-called "notch" benefit disparities would benefit railroad retirees as well as Social Security beneficiaries born in those years.

In the 100th Congress, the Special Committee on Aging and the House Ways and Means Subcommittee on Social Security, each held a hearings on this issue. However, the Congress did not take any final action on notch legislation.

There seems to be no dispute that a result of the 1972 amendments followed by the 1977 amendments to the Social Security Act was comparatively lower benefits for those born after 1916 than for those born before 1917. Supporters of the "corrective" legislation claim that this result was not intended by Congress and that the benefits of that group should be increased to bring their benefits more in line with the benefits of the group born before 1917. Proponents claim that the notch has already affected almost 10 million retirees, and that each year about 1.6 million new retirees born in the 1920's will experience the notch. On the other hand, opponents of the proposed legislation contend that the pre-1917 group are getting an unintended "bonanza," that the post-1916 birth group are receiving what was intended, and that "corrective" legislation would be too costly.

A 1988 General Accounting Office (GAO) Report on "The Notch Issue" concluded, among other things, that "Additional payments . . . through 1996 could range from about $20 billion to over $300 billion. Using current trust fund balances to finance notch remedies would slow attainment of minimum contingency reserve levels and could put the system at additional risk should there be an economic downturn. Also, in comparing the notch with patterns of income, assets, and health status, retirees likely to experience larger disparities have, on average, higher incomes and more assets. Those who tend to be in poorer health are more likely to experience smaller benefit disparities."

The GAO study also points out that: "Under 1983 legislation, current workers (who would be taxed to pay higher benefits to notch beneficiaries) already pay higher taxes than would be necessary under the pay-as-you-go concept to partially fund their own future benefits and reduce future workers' tax burden. Imposing additional taxes on these current workers to finance a higher replacement rate for the notch group (many of which already receive a higher replacement rate than can be anticipated by current workers) would raise significant issues of equity."

Nevertheless, as long as enough Social Security beneficiaries believe they are being victimized by notch, there likely will be legislative proposals in the Congress to address this issue. (For further discussion of this issue, please see chapter 1.)

(F) THE 1988 REDUCTION IN THE DUAL BENEFIT

Under current law, payment of the "dual" benefit depends on an annual appropriation by Congress from the General Treasury. If the amount appropriated for a particular year is not sufficient for payment of the benefit in full for that year, the RRB must reduce the benefit payments accordingly.

That occurred in fiscal year 1988. As a result of the "Budget Summit" agreement between Congress and the Administration, providing for an across-the-board budget cut, for that fiscal year, dual benefits were reduced. That agreement was implemented by the Continuing Resolution for fiscal year 1988 (P.L. 100-202), enacted December 22, 1987.

Because of the resulting appropriation shortfall for the dual benefit payment account, the RRB made the 1-year reduction in dual benefit payments in the six monthly payments on April 1, 1988, through September 1, 1988. The appropriated for fiscal year 1989 is sufficient to finance monthly payments in full for that period.

(G) THE 1987 COMMISSION ON RAILROAD RETIREMENT REFORM

To address the long-term financing concerns of the railroad retirement system, provisions in the Omnibus Reconciliation Act of 1987, Public Law 100-203, authorized the establishment of a Commission on Railroad Retirement Reform. The Act called for a seven-member commission, to include four members appointed by the President (one recommended by rail labor, one by rail management, one by commuter railroads, and one representing the general public), one public member appointed by the president pro tempore of the Senate, one public member appointed by the Speaker of the House, and one public member appointed by the Comptroller General. By early 1989, a fully appointed membership was ready to commence its work.

Specifically, the Reform Commission's mandate is to conduct a study of the railroad retirement system's short-term and long-term solvency and to recommend to the Congress revisions to the system to assure the provision of retirement benefits to former, present, and future railroad employees on an actuarially sound basis. The financing revisions the Reform Commission are to examine include the advisability of restructuring the financing of railroad retirement benefits through increases in the Tier II tax rate, increasing the Tier II tax wage base, imposing a tax on operating revenues, revising in the investment policy of the railroad retirement pension fund, and establishing a privately funded and administered railroad industry pension plan.

The Reform Commission's study is to be submitted to the Congress by October 1, 1990.

3. PROGNOSIS

No substantive structural changes in the railroad retirement system are likely before the 102d Congress because the Reform Commission's report is not due until October 1, 1990. If any railroad retirement benefits become an issue in the 101st Congress, the

issue likely will be raised by the budget process in connection with efforts to reduce the Federal deficit.

As of early 1989, the Bush Administration was seriously considering retaining a number of railroad retirement proposals in the Reagan budget proposal for fiscal year 1990. Included was a proposal to shift from the Federal Treasury to the rail industry 25 percent of the annual cost of "the Federal Subsidy" for the dual benefit. Under current law, all of those benefits are paid out of the Federal Treasury. In addition, the Fiscal Year 1990 Reagan budget proposed to pay uniform rail pension COLA's for all non-Social Security equivalent benefits. That would mean that the non-SSEBA portion of Tier I would receive the same COLA as Tier II, 32.5 percent of the Tier I SSEBA COLA.

In addition, other railroad retirement proposals may be included in the report of the National Economic Commission, established under Public Law 190–203, "to reduce the Federal budget deficit while promoting economic growth and encouraging saving and capital formation." The report is due March 1, 1989.

Chapter 3

TAXES AND SAVINGS

OVERVIEW

In both design and application, the Federal tax code long has reflected a recognition of 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 objective of tax policy relating to the elderly.

Until 1984, Social Security and railroad retirement benefits, like veterans' pensions, were exempt from Federal taxation. That year, to help restore financial stability to Social Security, up to half of Social Security and railroad retirement Tier I benefits of higher income beneficiaries became taxable under a formula contained in the Social Security Act Amendments of 1983 (P.L. 98-21).

More recently, the Tax Reform Act of 1986 (P.L. 99-514), resulted in a number of other changes to tax laws of concern to older men and women. Under the Act, longstanding tax advantages to the elderly were repealed or reduced, while increases in the personal exemption were to be phased-in, a higher increase in the standard deduction for the elderly provided and tax rates reduced (except for the lower income bracket rate, which was increased). The impact of these changes will not be fully known until early in the next decade.

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 elderly tax credit for the elderly, 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 repealed or altered to less advantageous effect a number of tax provisions of importance to older persons. At the same time, other changes made by the Act, such as the increase the standard deduction provided for the elderly, may more than offset losses.

(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 Con-

gress 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 if Congress had intended to make Social Security benefits taxable, it would have provided the legislative authority to tax them when Social Security was created.

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. Since 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. In 1987, approximately 12 percent of Social Security beneficiaries were subject to this tax.

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 time, beneficiaries of more modest means will also be impacted.

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 1985, that figure rose to $3.4 billion, and in 1986, to $3.7 billion.

In 1987, as a result of the lower tax rates provided under the Tax Reform Act of 1986, tax revenues from Social Security are expected to slip to $3.5 billion. But they are expected to resume their climb each year thereafter. In 1991, the last year for which projections are available, these tax revenues are expected to exceed $5 billion.

(B) ELDERLY TAX CREDIT

Officially named the Tax Credit for the Elderly and the Permanently and Totally Disabled, the elderly tax credit was enacted in 1954 with the codification of the Internal Revenue Code. Under this provision, qualifying retirees receive a tax credit equal to 15 percent of the first $5,000 (for single filers) and $7,500 (for joint filers) both of which are qualified individuals.

Congress established the credit to correct inequities in the taxation of different types of retirement income. Prior to 1954, retire-

ment income generally was taxable, while Social Security and railroad retirement (Tier I) benefits were tax-free. To provide roughly similar treatment of these different types of retirement income, the new provision allowed retirees, 65 and older, a tax credit equal to 15 percent of the total of all retirement income.

In the Social Security Act Amendments of 1983, the Congress limited the credit to those 65 and older, or disabled. The Act also increased the initial amounts which qualify for the credit.

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

The one-time home sale capital gains exclusion originated in the Internal Revenue Act of 1964. It was viewed as a way to protect homeowners from incurring tax liability on gains which were thought to result largely from inflation. In addition, proponents asserted that the Government should not tax away assets people had accumulated for retirement through home-ownership, nor discourage elderly persons from selling their homes to reduce expenses or to move to smaller quarters.

Originally, capital gains of $20,000 of the adjusted sales price of the house for persons 65 and older were excluded. Over the years, Congress raised the maximum excludable gain to $125,000 to reflect increases in average market prices for housing and lowered to 55 the age at which the exclusion can be taken.

(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 has not occurred since 1954. As a result of the Act, the elderly were provided an increase in the amount of the standard deduction as well as other advantages available to the general population. Partially offsetting these benefits are the repeal of the extra personal exemption for the elderly (effective after 1987), the lowering in the medical deduction, and the end of the initial tax-free status of private pensions.

TABLE 1.—PERSONAL INCOME TAX RATES

1988		1989	
Taxable income	Tax rate (percent)	Taxable income	Tax rate (percent)
Married filing jointly:			
$0–$29,750	15	$0–$30,950	15
$29,750–$71,900	28	$30,950–$74,850	28
$71,900–$149,250 [1]	33		
Over $149,250	28		
Single:			
$0–$17,850	15	$0–$18,550	15
$17,850–$43,150	28	$18,550–$44,900	28
$43,150–$89,560 [1]	33	$44,900–$93,130	33
Over $89,560	28		

[1] The benefit of the 15 percent bracket is phased out when taxable income exceeds $43,150 (single) and $71,900 (joint). The top figure for the 33 percent bracket increased by $10,920 in 1988 for each exemption. For example, the 33 percent bracket for a family of 4 was $71,900 to $192,930.

(1) Extra Personal Exemption for the Elderly

The extra personal exemption for elderly persons was enacted in 1948 to provide some relief from the effects of the postwar economy on the elderly. 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 rolls, and reduced the tax burden for another 3.7 million. Effective in 1987, the exemption was no longer available.

(2) Deduction of Medical and Dental Expenses

Under prior law, medical and dental expenses, including insurance premiums, copayments, 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 tax law raised the threshold to 7.5 percent.

Since the elderly require more health care per capita than the nonelderly, the cut in the medical deduction could have a disproportionately negative impact on some elderly persons. Although persons 65 and older constitute about 12 percent of the population, their health care expenditures account for about one-third of the national total. In 1984, the annual average per capita expenditure for the elderly was $4,200, compared with $1,200 for those under 65. However, it should also be noted that the availability of Medicare lessens, to some extent, the importance of the medical deduction to elderly persons.

(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 being 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 are likely offset over the long run by the tax break on the retired worker's share of the pension during his or her estimated life time.

(4) Personal Exemptions and Standard Deductions

The new tax law provides for phased-in increases in the personal exemption. In 1988, the personal exemption was increased to $1,950, and for years 1989 and beyond, it will be increased to $2,000.

TABLE 2.—STANDARD DEDUCTIONS BY FILING STATUS

Filing status	Standard deduction	
	Under 65 and not blind	Age 65 or older or blind
1988:		
Single	$3,000	$3,750
Married filing jointly [1]	5,000	5,600
Married filing separately	2,500	3,100
Head of household	4,400	5,150
Qualifying widow(er)	5,000	5,600

[1] Use 2d column if either spouse is 65 or older or blind.

(5) Filing Requirements and Exemptions

An estimated 6 million additional taxpayers—many of them elderly—were exempted from filing income tax forms under the 1986 tax law. The law raised the levels below which persons are exempted from filing Federal income tax forms. Single persons 65 or older do not have to file a return if their income is below $5,650. For married couples filing jointly, the limit is $9,400 if one spouse is 65 or older or $10,000 if both spouses are 65 or older. Persons who are claimed as dependents on another individual's tax return do not have to file a tax return unless their unearned income exceeds $500 or their gross income exceeds their maximum allowable standard deduction ($3,100 for persons 65 or older or blind, $3,700 for persons who are both 65 or older and blind).

(6) Repeal of Other Provisions

A number of other provisions repealed by the 1986 Act also are of interest to elderly taxpayers. These include:

The dividend exclusion of up to $100 per taxpayer;

The 60 percent exclusion on capital gains (after 1986, capital gains will be treated as ordinary income);

The deductions for contributions to IRA's by taxpayers above certain income levels who participate in employer-provided pension arrangements;

The deduction for nonmortgage interest expense will be phased out through 1991;

The deduction for State and local sales tax (not a discretionary expenditure on necessities such as groceries, medicines, and prescription drugs); and

The income-averaging method of computing income tax.

2. Issues

(A) THE IMPACT OF TAX REFORM

The full impact of the tax reform measure will not be felt by many Americans until 1990. While some provisions already have taken full effect, such as the new treatment of civil service retirement pensions, others have not. Most notably, the increases in the personal exemption are phased in through 1989.

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 on the whole 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) SOCIAL SECURITY EARNING LIMITATIONS

Under current law, the working Social Security beneficiary loses $1 of benefits for every $2 earned over a specified limit. In 1988, the earnings limitation was $8,400 for the 65–69 age group (in 1990, the deduction will change to $1 for every $3 earned over the limit) and $6,120 for those under 65. For those over 69, there is no limit on earnings.

After the first year in which Social Security benefits are received, the earnings limitation is applied to total annual earnings, without regard to the number of months worked or the amount earned in any particular month. During the first year, the limits are applied on a monthly basis.

In 1988, bills were proposed to reduce or repeal the Social Security earnings limitation. Backers of this legislation have emphasized that the law discourages older men and women from working, and, when taken together with deductions, FICA and income taxes, the limitation can amount to a tax rate of 50 percent or higher. This poses particular hardships on older workers who cannot afford to retire and must continue working. In 1984, earnings accounted for one-quarter of the aggregate income of older taxpayers.

Additionally, opponents of the Social Security earnings limitation pointed out that the law discriminates against Social Security recipients with less benefits because they are subject to the same earnings ceiling as those receiving larger benefits.

On broader grounds, opponents contended that tax and public policies should encourage older men and women to continue working as long as they are willing and able. By eliminating the earnings limitation, more older men and women likely woud continue contributing to the economic production of the Nation.

The principal obstacle facing such proposals is financial: Over a 5-year period, the cost of repealing the Social Security earnings limitation is estimated at $16 billion. In times of record Federal budget deficits, revenue losses of this magnitude pose larger economic implications. However, under a modified proposal (discussed in chapter 1), costs would be significantly less, thus increasing the chances of Congressional action.

B. SAVINGS

1. Background

Since 1981 there has been considerable emphasis on increasing the amount of capital available for investment. By definition, increased investment must be accompanied by an increase in savings. Total national savings comes from three sources: Individuals saving their personal income, businesses retaining their profits, and the Government savings when tax revenues exceed expenditures. As part of the trend to increase investment generally, new or expanded incentives for personal savings and capital accumulation have been enacted in recent years.

At the same time, retirement income experts have suggested that incentives for personal savings be increased to encourage the accumulation of greater amounts of retirement income. Many retirees are dependent 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 preretirement savings efforts.

The life-cycle theory of savings has helped support the sense that personal savings is primarily saving for retirement. This theory postulates that individuals save little as young adults, increase their savings in middle age, then consume those savings in retirement. Survey data suggests that savings 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 savings theory raises questions for Federal savings policy. Tax incentives may have their greatest appeal to those already saving at above-average rates: Taxpayers who are reaching maturity, earning above-average incomes and subject to relatively high marginal tax rates. Whether this group presently is responding to these incentives by creating new savings or simply shifting after-tax savings into tax-deferred vehicles is a continuing subject for disagreement among policy analysts. For taxpayers who are young or have lower incomes, the tax incentives may be of little value. Expanding savings in this group necessitates a trade-off of increased savings 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 those at the lower end of the income spectrum.

The dual interest in increased capital accumulation and improved retirement income adequacy has sparked an expansion of tax incentives for personal retirement savings over the last decade. However, in recent years, Congress has begun to question the importance and efficiency of expanded tax incentives for personal savings as a means to raise capital for national investment goals, and as a way to create significant net 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.

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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 indicates, 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.

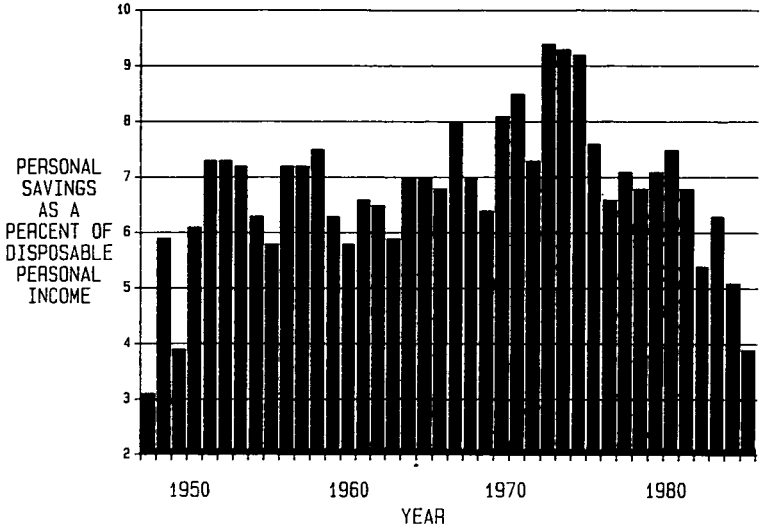
Finally, the likelihood of asset income receipt is directly proportional to total income. Asset income is much more prevalent among individuals with high levels of retirement income. Only 27 percent of elderly persons with incomes less than $5,000 receive income from assets, while 84 percent of those 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 one in three retirees receive pension benefits.

The effort to increase national investment springs from a perception that governmental, institutional and personal savings rates are lower than the level necessary to support a healthy economy. Except for a period during World War II when personal savings approached 25 percent of income, the personal savings rate in the United States has ranged between 5 percent and 8 percent of disposable income. (Chart 1 shows the variation in personal savings rates as a function of disposable personal income from 1947-87.) Many potential causes for these variations have been suggested, including demographic shifts in the age and composition or families and work forces and efforts to maintain levels of consumption in the face of inflation. Personal savings 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.

CHART 1

PERSONAL SAVINGS RATE
UNITED STATES: 1947 - 1987



SOURCE: National Income Product Accounts. Bureau of Economic Analysis, Department of Commerce.

For 1987, Commerce Department figures indicate that the personal savings rate was 3.8 percent, about the same as 1986. For the third and fourth quarters of 1987, the rates were 2.8 percent and 4.5 percent, respectively. Analysts suggest that without savings in corporate pensions, the country actually experienced a decline in savings overall. In part, this dramatically low figure may reflect an increase tendency to purchase goods on consumer credit. Given the additional expansion of tax incentives for retirement savings in recent years, the low rate of personal savings raises serious doubts about the effectiveness of those incentives. If retirement savings only take place in employer-sponsored plans, then policy analysts argue that retirement income goals might be better served by policies favoring these, rather than individual savings vehicles.

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

Recent studies of national retirement policy have recommended strengthening individual savings for retirement. Because historical rates of after-tax savings have been low, emphasis has frequently

been placed on tax incentives to encourage savings 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 savings, 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 IRA's. 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 IRA's, Keogh plans, or the pension plan itself.

These recommendations reflected ongoing interest in increased savings opportunity. In each Congress since the passage of the Employee Retirement Income Security Act (ERISA) in 1974, there have been expansions in tax-preferred savings 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 IRA's, 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 savings. When there is increasing competition 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 (IRA's)

(1) Pre-1986 Tax Reform

The extension of IRA's 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 IRA's rose to 13.6 million, 15.2 million in 1984, and 16.2 million in 1985. In 1986, contributions to IRA's 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 IRA's posed a dilemma for employers as well as Federal retirement income policy. The increasingly important

role of IRA's 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 unlikely to save for retirement otherwise? Second, does the IRA tax incentive encourage additional savings or does it merely redirect existing savings to a tax-favored account? Third, are IRA's retirement savings or are they tax-favored savings 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 IRA's. The participation rate among those with less than $20,000 income was two-fifths that of middle-income taxpayers. ($20,000–$50,000 annual income) and one-fifth that of higher-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 IRA's 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 IRA's by a desire to reduce their tax liability than to save for retirement.

One of the stated objectives in the creation of IRA's was to provide a tax incentive for increased savings 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, IRA's 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 IRA's 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, that 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 IRA's as short-term 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, since the small percentage of low-income taxpayers who utilized IRA's 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 AGI's 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 AGI's 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.

(B) EMPLOYEE STOCK OWNERSHIP PLANS (ESOP'S)

(1) Pre-1986 Tax Reform

Employee stock ownership plans were promoted as a means for transferring the ownership of a company's capital to its workers. Although ESOP's can become a valuable source of retirement income to supplement Social Security, pension benefits and personal savings, they are not designed (or intended) to be an employee's sole or primary retirement savings vehicle, or a replacement for a traditional pension arrangement. Such a plan can offer an employee a potential investment return exceeding that of a standard pension plan if the company is growing at a substantial rate or is consistently profitable.

However, under an ESOP, an employee not only bears the risk of the plan's investment performance, but also the additional risk of relying on a nondiviersified investment portfolio. As the value of a company's shares can fluctuate over a wide range in response to the employer's fortunes, an ESOP cannot be considered a secure primary retirement vehicle for participants. In recent years, there was considerable concern when some corporations terminated their defined benefit pension plans and replaced them with ESOP's.

The most sensitive issue surrounding employee stock ownership plans was their expanding use in closely held corporations, where the value of the stock to employees is uncertain. For employees to have meaningful ownership interest in their employer through participation in an ESOP, the stock must be fairly valued and the employees must have some control over the way in which the stock is voted. But in a privately held corporation, one or both of these elements may be missing or constrained. It is difficult to value ESOP-contributed stock of a privately owned corporation because there is no ready market for its resale. This creates an enormous potential for abuse. By overvaluing stock contributions an employer-owner can inflate the tax benefit received while employees may be hurt because the real value of the stock is less than its nominal worth.

Although Congress clearly had expressed its intent to encourage employee stock ownership, the effectiveness of the ownership and productivity incentives, which form the basis of congressional policy, became debatable. In the case of ESOP's in closely held corporations with limited voting rights passthrough, the absence of voting rights and of a ready market for resale, cast doubt on the existence of any realistic incentive at all. Even in publicly traded corporations with full passthrough voting, some employee organizations have argued that stock in the ESOP does not accumulate fast enough compared to the total amount of stock outstanding to give employees any significant voice in corporate decisionmaking. As a result, several employee organizations opposed the implementation of ESOP's unless coupled with representation on the employer's board of directors.

The ESOP concept had been supported by Congress in spite of these unresolved issues. It is important to note, however, that since an ESOP's value is inextricably tied to the financial health of the employer, their implementation should be traded off against current wages rather than retirement benefits when being used to save financially distressed employers. If an ESOP is used to replace pension benefits, the demise of the employer could wipe out a substantial portion of an employee's retirement income as well. However, by exchanging the ESOP for current wages, an employee's retirement benefit remains insulated to some degree from the consequences of the employer's potential demise, while a much stronger link is forged between productivity incentives and the employee's present compensation.

(2) Post-1986 Tax Reform

The Tax Reform Act of 1986 significantly affected ESOP's, both in their taxation and the manner in which they may be managed. Generally, the new rules were aimed at increasing the attractive-

ness of ESOP's and the protections available to participating workers.

To reduce the risk associated with ESOP's the Act requires that partial diversification of a plan for workers nearing retirement be allowed. As result, a worker at 55 with at least 10 years of service may diversify up to 25 percent of his or her account. At age 60, the amount that which can be reinvested in other securities increases to 50 percent. At least three investment options must be provided.

In addition, the Act shortened the period within which distributions to participants must be made. Under current law, unless the retired worker elects otherwise, distributions must begin no later than 1 year after retirement, disability, or death.

The 1986 law also established a number of tax incentives, including an estate tax deduction of 50 percent of the proceeds from a sale of an ESOP's assets. The deduction is effective for estate sales through 1991.

(C) RESIDENTIAL RETIREMENT ASSETS

(1) Pre-1986 Tax Reform

Tax incentives, which long have promoted the goal of home ownership, include the income tax deductions for real estate taxes and home mortgage interest. As in the one-time exclusion of capital gains on the sale of a home these tax breaks recognize that for many elderly persons a home may represent their principal or only retirement asset.

(2) Post-1986 Tax Reform

Prior to the 1986 Tax Reform Act, all real estate mortgage interest was tax deductible. To generate new Federal revenues, the Act limited the deduction to interest on home mortgages or home equity loans taken out on a principal residence or a second home to purchase a home, make home improvements, or pay medical or educational expenses. Thus, interest paid on any part of the loan used for other purposes no longer qualifies for the deduction. (The deduction for real estate taxes remains unchanged.)

The home mortgage interest deduction was further restricted under the Omnibus Budget Reconciliation Act of 1986 (P.L. 100–203). The Act placed a ceiling on the amount of a mortgage that qualifies for the tax deduction. For loans used to acquire or improve a principal or second residence, the limit is $1 million. For home loans used for other debt purposes (limitation to medical or educational debts eliminated), the cap is $100,000.

C. PROGNOSIS

In coming years, the full impact of the 1986 Tax Reform Act will unfold. On the one hand, the elimination of the additional tax exemption for the elderly and the lowering of the medical deduction will be sources of concern for some elderly taxpayers. On the other, increases in the personal exemption and the additional increase in the standard deduction will provide clear tax advantages.

Most likely, the new rules will have a mixed effect on the elderly. Some many be dropped from the tax rolls, while others may pay

additional taxes. Some may pay reduced taxes, while others may pay the same as before. The extent to which the considerable benefits under the 1986 Act fail to offset potential losses from less advantageous changes, certain tax provisions may be a source of controversy. However, the massiveness of the tax overhaul make unlikely any significant tax or savings incentive legislation in 1989 or soon thereafter.

As in the past, the Federal tax and savings policy will continue to take into account the vulnerable financial status of many older Americans in their post-working years. At the same time, broader financial concerns, particularly the need to reduce the Federal budget deficit, can be expected to play an increasing role in future debates in this area.

Chapter 4

EMPLOYMENT

OVERVIEW

Concurrent with the rapid aging of the U.S. population has been a dramatic lengthening of the time older Americans spend in retirement. Not only are people living longer, but many are choosing to retire at a much earlier age. In fact, early retirement is a concept which is fast becoming a part of the American way of life. At the same time, however, many persons desire or need to continue working in their later years. For them, age discrimination often remains 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 tradition in America of barring arbitrary policies which discriminate against individuals on the basis of their beliefs or their personal characteristics. The nearly unanimous opposition to mandatory retirement policies by the American public shows the strong sentiment against arbitrary age bias in employment. Nevertheless, statutory protections against age discrimination remain incomplete and somewhat ineffectual.

While the unemployment rate for older persons is approximately half of that for younger persons, once an older worker loses a job, his or her duration of unemployment tends to be much longer. While a job seeker between age 20 to 24 experiences an average unemployment period of 9.5 weeks, one aged 55 to 64 years is out of work for an average of 23.2 weeks.

A. BACKGROUND

1. Age Discrimination

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 which make it difficult to remain in the labor force, such as early retirement incentives. For the most part, these obstacles have their roots in age discrimination.

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 employment discrimination. Indeed, retirement is a concept which has become imbedded in the American consciousness.

Although there is no agreement on the extent of age-based discrimination, nor how to remedy it, few would argue that the prob-

lem exists for millions of older Americans. Despite Federal laws banning most forms of age discrimination from the workplace, most Americans view age discrimination as a serious problem. Two nationwide surveys by Louis Harris & Associates, one in 1975 followed by another 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 perception of widespread age discrimination held by the public 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 on the basis of age; 22 percent claim it is unlikely that, without the present legal constraints, 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 of an 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 pervasive belief that all abilities decline with age has fostered the myth that older workers are less efficient than younger workers. The forms of age discrimination range from the more obvious forced retirement, to more subtle job harassment and early retirement incentives. Part of this problem is that younger workers, rather than older workers, 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 workforce does little to guarantee greater longevity on the part of a younger worker. According to the Bureau of Labor Statistics, the median job tenure for a current employee is as little as 4.2 years.

Another discriminatory practice involves the proposed relocation of an older employee to an undesirable area in the hopes that the employee will instead decide to resign. In a related effort, an employer may begin to give an older employee poor evaluations to build a record for justifying the employee's later dismissal.

Without question, age-based discrimination in the workplace poses a serious threat to the welfare of many older persons. While the number of older persons receiving maximum Social Security benefits is increasing, most retirees get less than the maximum. According to Census Bureau data for 1986, of the approximately 27.4 million Americans aged 65 or older, more than 16.9 million had a total annual monetary income of less than $10,000. Other reports reveal that only slightly more than half of the workforce 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 National Commission for Employment Policy, in 1980, several million older workers suffered severe labor market problems, including unemployment or underemployment. In 1984, 315,000 Americans age 60 and over, 97,000 of whom were age 65 or over, were out of work. Although these numbers may not be large when compared with unemployment data for younger groups, dura-

tion of unemployment is significantly longer among older workers. Further, because the number of discouraged older workers—namely, those who report that they want a job, but are not looking because they believe that they cannot find one—is not included in the official unemployment rate, this statistic does not provide a full picture of the extent of joblessness among older persons.

According to the Bureau of Labor Statistics (BLS), because older job seekers are more likely to be unemployed for a longer period than younger persons, they are more likely to exhaust available unemployment insurance benefits and suffer economic hardships. The 1978 Employment and Training Report of the President indicates that that the problems of older unemployed workers are worsened by the fact that many persons over 45 still have significant financial obligations.

Not surprisingly, evidence suggests that there is a link between the longer duration of unemployment for older workers and the higher rate of discouraged workers in this age group. For men age 65 and over, the annual average level of discouraged workers is almost as large as the number of unemployed. The BLS reports that the prospects of an older male worker finding work are so low that he is three times more likely to become discouraged than his younger counterpart. Further, when older workers are fortunate enough to find work, they generally face a cut in earnings and experience a diminished status compared to their previous employment.

Psychologists report that discouraged workers can face wrenching psychological stress, including hopelessness, depression, and frustration. In addition, medical evidence suggests that forced retirement can adversely affect a person's physical, emotional, and psychological health even to the point where a life span may be shortened. According to the American Association of Retired Persons (AARP), 30 percent of the Nation's retirees are believed to suffer from serious adjustment problems.

Although the attitude persists that older workers hinder management efforts to improve productivity, there nevertheless is a growing recognition of their value. A 1985 study by Waldman and Avolio revealed little evidence for the "somewhat widespread belief that job performance declines with age." Among their findings was a strong correlation between performance improvements 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 have reported that older workers stay on the job longer than younger workers. Notwithstanding a widespread bias against age, some employers view older workers as offering experience, reliability, and loyalty. As supporting evidence, a 1985 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 give older workers their highest marks for productivity, attendance, commitment to quality, and work performance. As many as

90 percent stated that older workers are cost-effective, while a majority reported that the cost of older workers are justified.

Gradually, discriminatory attitudes toward older workers are changing, but much more must be done to ensure employment opportunities for older workers. At present, it is clear that age discrimination is reducing the work efforts of older persons, encouraging premature labor force withdrawal, and increasing the draw on Social Security and private pensions. Without effective solutions to age discrimination in the workplace, these problems promise to persist.

(A) THE AGE DISCRIMINATION IN EMPLOYMENT ACT

Over two decades ago, the Congress enacted the Age Discrimination in Employment Act of 1967 (ADEA) "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." The ADEA was signed into law as Public Law 90-202.

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. Nevertheless, 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 the older worker to be free from age discrimination in employment with the employer's prerogative to control managerial decisions. The provisions of the ADEA attempt to balance these competing interests by prohibiting age discrimination based upon an employer's arbitrary policies which would prevent employment of individuals above a certain age. The law provides that arbitrary age limits may not be used as conclusive determinations of nonemployability, and that employment decisions regarding older persons should be based on an individual assessment of each applicant's or employee's potential or ability.

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

Under the ADEA, actions otherwise deemed unlawful may be permitted if only if they are based upon the following considerations: (1) Where age is a bona fide occupational qualification reasonably necessary to normal operations of a particular business; (2) where differentiation is based on reasonable factors other than age (e.g., the use of physical examinations relating to minimum standards reasonably necessary for specific work to be performed on a job); (3) to observe the terms of a bona fide seniority system or a bona fide employee benefit plan such as a retirement, pension, or insurance plan, with the qualification that no seniority system or benefit plan may require or permit the involuntary retirement of any individual who is covered by the ADEA; and (4) where an em-

ployee is discharged for good cause. Also, an executive or high-ranking, policymaking employee in the private sector entitled to annual private retirement benefits of at least $44,000 could be compulsorily retired at age 65, simply because of age. This is known as the executive exemption, and it was designed to allow turnover at the top levels of the organization. While the exemption has strong support among business leaders, recent evidence shows that it is used only infrequently by a small number of employers.

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 provisions of the law were extended to include Federal, State, and local government employers. The number of workers covered also was increased by limiting exemptions to employers with fewer than 20 employees. (Previous law exempted employers with 25 or fewer employees.) In 1978, the ADEA was amended to extend 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. While this provision was designed to be a cost-saver for Medicare, it poses an obstacle to employment for older workers because it increases the costs of their employment.

Amendments to the ADEA were also contained in the 1984 reauthorization of the Older Americans Act, Public Law 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 many 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, representing the annual private retirement benefit level for determination of exemption from the ADEA for persons in bona fide executive or high policymaking positions.

Effective January 1987, mandatory retirement was eliminated altogether by the Age Discrimination in Employment Amendments of 1986. 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.

Currently, there are more than 2.9 million Americans age 65 and over in the work force. Many of them continue working for reasons of self-fulfillment, but more often it is out of economic necessity. 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.

(B) 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; and (4) Sections 501 and 505 of the Rehabilitation Act of 1973.

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.

Since taking over responsibility for the ADEA, the EEOC has alternately been praised and criticized for its enforcement performance of the ADEA. In recent years, concerns have been raised over EEOC's decision to move away from broad complaints against large companies and entire industries to more narrowly focused cases involving few individuals. Critics also point to the large gap between the number of age-based complaints filed—during fiscal year 1988, the EEOC received 11,454 ADEA complaints—and the EEOC's modest litigation record. In fiscal year 1988, the EEOC filed 106 suits on behalf of complainants.

2. 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.

(A) THE JOB TRAINING PARTNERSHIP ACT

The Job Training Partnership Act (JTPA), enacted in 1983, established a nationwide system of job training programs administered jointly by local governments and private sector planning agencies. For the program year from July 1, 1988, through June 30, 1989, $3.75 billion was authorized in appropriations. This compares to the $3.67 billion appropriated for JTPA in fiscal year 1987.

JTPA established 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,

1985 through June 30, 1986, about 11,888 persons 55 and older participated in the title II-A program, representing 3 percent of total 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.

For workers who have been or are about to be laid off, are eligible for or have exhausted their entitlement to unemployment compensation, and are unlikely to return to their previous occupation or industry, Congress created Title III. The dislocated workers program is administered by the States and includes such services as job search assistance, job development, training in job skills for which demand exceeds supply, 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, 1985 and June 30, 1986, approximately 9,000 persons 55 and over were served by the Title III program (about 8 percent of total program terminations).

As a result of enactment of the Worker Adjustment and Retraining Act of 1988, Public Law 100-379, 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. However, the new law required that States establish a number of specific subgroups to carry out the program and placed a stronger emphasis on job training. The new program is expected to begin in July 1989.

According to 1987 findings of the National Commission for Employment Policy (NCEP), the JPTA is working well and, with minor exceptions, is meeting its legislative mandate. The report did acknowledge that conversations with State Job Training Coordination Council chairs confirmed that some States are having difficulty using the 3 percent set-aside funds for older workers due to recruitment problems and difficulty in placing this population.

The need for services provided under JTPA is underscored by a November 1984 Department of Labor study of displaced workers. According to the study, 5.1 million workers lost their jobs due to the decline of an industry or a plant closing between 1979 and 1984. The chance of reemployment for these displaced workers declined significantly with age. Only 41 percent of those between 55 and 64 were able to reenter the labor force in any capacity (as compared to 70 percent for those between the ages of 20 and 24). Only 21 percent of those over 65 became reemployed and of those who found a job, almost half (45 percent) received lower pay than at their previous position and 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 completely dis-

couraged and drop out of the labor force altogether. Overall, there are more than 1.2 million "discouraged" workers in the Nation.

(B) 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 responds to certain identified needs of older persons by providing opportunities for part-time employment and income. It also serves as a source of labor for various community service activities and can assist unemployed older persons in moving into permanent unsubsidized employment. Amendments passed in 1978 redesignated the progrm as title V of the Older Americans Act and it was reauthorized through fiscal year 1987 by Public Law 98-459, the Older Americans Act Amendments of 1984. The Act was again reauthorized during 1987.

The program is administered by the Department of Labor, which awards funds to national sponsoring organizations and to State agencies. Persons eligible under the program are those who are 55 years of age and older (with priority given to persons 60 years and older), who are unemployed, and whose income level is not more than 125 percent of the poverty level guidelines issued by the Department of Health and Human Services. Enrollees are paid the lessor 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 13,000 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 jobs skills.

The SCSEP is one of the few remaining direct job creation programs since the elimination of the Comprehensive Employment and Training Act and the Public Service Employment programs. Nearly 80 percent of the participants are age 60 or older, and nearly half are age 65 or older. Over 60 percent are females, half of whom have not completed high school, and over 85 percent have a family income below the poverty line.

The SCSEP has seen steady increases in funding and participant enrollment since its inception. In the 1968-69 program year, the first full year of its operation in a form similar to the current program, participant enrollment was 2,400 with a budget of $5.5 million. In program year July 1, 1988 to June 30, 1989, Title V funding appropriations are $331 million. This includes $258 million for national contracts and $72.9 million for State grants. Nonetheless, the fiscal year 1988 appropriation represents a funding decrease of $4.7 million from fiscal year 1987, resulting in reduction from 65,741 to 64,813 participants.

In recent years, the program has received generally positive reviews. In fiscal year 1986, a number of reports were issued that

confirmed the general view that the program was successful and provided useful suggestions for improvements.

B. ISSUES AND RESPONSES

1. 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 requires 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 faculty.

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 is age. Finally, they claim that there is no evidence that many professors would stay past 70 even if they could, and that predictions 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 begin collecting their pensions—which usually represents a retirement date—has been declining over the past 10 years.

2. State and Local Public Safety Officer Provision

As previously noted, the ADEA allows an exception against 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. In general, courts have allowed maximum hiring ages and mandatory retirement ages for bus drivers and airline pilots, and, on occasion, police officers and firefighters because the safety of the public was at stake. The courts, however, have been inconsistent and the lack of clear judicial guidance has prompted calls for reform.

Under the 1986 amendments to the ADEA, a temporary exemption from the law was provided for State and local public safety officers. 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.

The issue of whether public safety officers should be treated like other employees under the ADEA arose after the Supreme Court, on March 2, 1983, in *EEOC* v. *Wyoming,* 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 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 favorable to employees who had challenged the mandatory retirement policies of their employ-

ers. The first case, *Johnson* v. *Mayor and City Council of Baltimore,* Nos. 84-518 and 84-710 (June 18, 1985), involved six firefighters who challenged the City of Baltimore's municipal code provision that established a mandatory retirement age at 55 for firefighters. The Court of Appeals, accepting the city's argument, had 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,* No. 84-127 (June 18, 1985), raised a challenge under the ADEA to Western Airline's requirement that flight engineers, who do not operate flight controls as part of the cockpit's crew unless the pilot and copilot become incapacitated, were 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 proving 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 be looking very critically upon attempts to expand the BFOQ defense beyond specific high risk occupations. The Court also stressed the relationship between individual performance and employment in a particular task, rather than reliance on a standard of chronological age disqualification. Thus, by adopting a very narrow reading of the BFOQ exemption, the Court appears to have strongly endorsed individualized determinations.

Many States and localities with mandatory retirement age policies below age 70 for public safety officers were concerned about the impact these decisions were going to have. As of March 1986, 33 States or localities had been or were being sued by the EEOC for the establishment of mandatory retirement or minimum hiring age laws. Amid these actions, legislation was proposed to exempt public safety officers from some or all of the ADEA provisions.

Supporters of the exemption legislation argue that the mental and physical demands and safety considerations for the public, the individual, and coworkers 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 conflicting court decisions and 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 decisions 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 preestablished 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 Federal agencies which 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 shows 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.

3. Pension Accrual

In May 1979 the Department of Labor (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 pension 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 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 accrual 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-benefits 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 Public Law 99-509, the Internal Revenue Service (IRS), followed by the EEOC and the Department of Labor, 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, the lead agency, 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 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 and who turns 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. 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.

4. Waivers of Rights

Although certain substantive sections of the ADEA were taken from Title VII of the Civil Rights Act, in passing the 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] selectivity 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 caselaw 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*, 34 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 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.

Those who believe that unsupervised waivers of rights are, in fact, not permitted under the ADEA have been 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 has prompted many to argue that *Runyan* is more the exception than the rule. Indeed, according to a 1981 Louis Harris survey conducted for the National Council on 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 argue 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 which to permit unsupervised waivers.

The exemption allows 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 cites the similarities between the ADEA and Title VII of the Civil Rights Act of 1964 and notes 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 derived *in haec verba* from 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 relies 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 note that EEOC's proposed regulation was cited in the final *Runyan* decision. Therefore, they argue, EEOC's heavy reliance on the court's ruling is somewhat misplaced.

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

Following a September 1987 hearing of the Senate Special Committee on Aging on the EEOC and the waiver rule, legislation to nullify the rule during the 1988 fiscal year was enacted in Fiscal Year 1988 Continuing Resolution (P.L. 100-202). Nevertheless, at a May 24, 1988, hearing of the Senate Labor Subcommittee 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 appropriation bill, enacted into Public Law 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 wiavers of older workers' rights. Although the bill was not

enacted, similar legislation in S. 54 was introduced by Senators Metzenbaum, Heinz, Pryor, and others in 101st Congress.

5. 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 ever since 1969, when the Department of Labor published interpretive guidelines which provided that apprenticeship programs are not subject to the requirements of the ADEA. Since then, the Labor Department has viewed the elimination of the exemption as detrimental to the promotion of such programs in the private sector since 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 Labor Department interpretation, however, attempts to do so were unsuccessful. Subsequently, a 1983 decision in *Quinn* v. *New York State Electric & 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 and, on June 13, 1984, 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 Department of Labor 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 above) permitting employees to waive their ADEA rights without EEOC supervision. By retaining the old Labor Department interpretation, EEOC has effectively precluded midlife and older workers seeking critical new job skills from receiving needed training through these programs.

6. Health Costs

While we have witnessed a steady decline in labor force participation by older people over the past several decades, concerted efforts are now being directed toward reversing this trend. "Worklife extension" is the term used to describe the move to extend the worklife of older persons willing and able to work. An important theme in the discussion of worklife extension is the health of the

older population. Employers and policymakers are interested in the health implications of extended worklife, especially as they relate to issues of labor supply, productivity, employee health costs, and health maintenance.

A February 1985 information paper entitled "Health and Extended Worklife," prepared for use by the Special Committee on Aging, presents information about the health status of older persons as it may relate to extended worklives. The findings of the study indicate that the noninstitutionalized older population, and particularly the younger members of that population, are healthier than is widely believed. Health is one of several variables which affect the supply of workers, their level of productivity, and their utilization of health services and the new data presented in the paper will assist the Congress and employers in making informed decisions about employment and retirement issues.

Conventional wisdom suggests that older workers are paid more than younger workers for the same job and that, therefore, older workers are more expensive. This rationale has frequently been used to support early retirement programs on the assumption that younger workers can be hired at lower cost to replace older workers. There is, unfortunately, a dearth of empirical information to help discern whether it costs more to employ older workers than younger workers. In September 1984, the Senate Special Committee on Aging released an information paper which examines factors related to patterns of labor costs by age, and discusses direct compensation, employee benefits, turnover, training, performance, and productivity.

The evidence indicates that there are some types of employment costs which vary by age, and that overall compensation costs increase by age, largely because of increasing employee benefit costs. There is, however, no statistical evidence that direct salary costs on an economywide basis increase by age. Employee benefit costs are not usually separated by age, and individual employers do not generally make hiring and retention decisions on the basis of benefit costs. General increases in medical care costs, combined with an expanding set of laws and regulations, have served, however, to focus the spotlight on employers will give more consideration to this issue in the future.

The belief that older workers cost more seems generally related to feelings about performance and productivity. There is no statistical evidence to indicate generally poorer performance or productivity by age, and the limited data available refutes the basic notion that older workers are less capable. However, there is a significant issue relating to maintenance of skills and training. Over time, as the nature of work changes and the skills of the employee are not kept up to date, there will be an increasing mismatch of skills to the job, leading to deterioration of performance on that specific job. If older workers are to be cost-effective, their skills must be continuously updated through training and education to assure continued productivity. The two major conclusions of the information paper are as follows:

> It is extremely important to encourage the maintenance of skills and lifelong education to prevent older worker obsolescence and to provide individuals with the skills to compete on

a fair basis for jobs within or outside of their companies. Up-to-date skills are more important than any age-related capabilities in human resource cost and older worker productivity.

Legislative and regulatory requirements affecting employment costs for older workers should not place undue cost or administrative problems on employers. Such requirements can discourage the employment of older workers.

A 1986 report by the American Association of Retired Persons entitled, "Workers Over 50: Old Myths, New Realities," found that 62 percent of responding firms found that the extra cost of health insurance for employees age 50 and over was insignificant compared with total company health care costs. Only 16 percent of the employers rated a 55-year-old employee as being extremely costly to insure, as compared to 34 percent of firms which rated a 30-year-old with two dependents very expensive to insure.

Employer's concerns about the rising cost of providing health insurance for older workers, however, has been worsened by recent legislative action. In the last decade there has been an increasing trend by the Federal Government to seek ways to curb the rising costs of Medicare by shifting costs to private payors. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), legislated changes in Medicare coverage for older workers. As of January 1983, employers could no longer advise workers that they were to be dropped from company group health insurance plans at age 65 because they were eligible for Medicare. TEFRA requires that company plans bear the primary insurance costs of illness, while Medicare becomes secondary. The TEFRA requirement raised employer costs in two ways. First, costs will rise for employees age 65 through 69 who previously were covered by employer plans, because these plans now are the primary payer of benefits. Second, employees age 65 through 69 who previously were excluded from employer health plans must now be covered if the employer offers a plan to any of its employees.

A report released in June 1983, by ICF, Inc., estimated that about 434,000 private sector workers age 65 through 69—about 37 percent of all private sector workers in this age group—will be affected by these changes, at a total cost to employers of about $500 million. About 286,000, or 66 percent, of these workers were previously covered by employer plans. The additional health plan costs for these workers are estimated to be about 8 percent of their total compensation costs before the amendments. In addition, about 148,000 workers who were previously excluded from coverage are likely to be covered by employer plans. The health plan costs of these workers is estimated to be about 13 percent of their total compensation costs before the amendments. The study concludes that these changes may initially reduce the demand for workers of this age by about 1 percent.

Two major provisions in the Deficit Reduction Act of 1984 (DEFRA) also have some effect on the costs of employing older workers and on the costs to older workers of remaining employed longer. The first is Section 2301 of DEFRA, which modified the working aged provision—originally included in TEFRA—such that employers must offer group health coverage to an employee who has not reached age 65, if the employee has a spouse age 65

through 69. If such an employee elects the group coverage—versus Medicare coverage for the spouse—the employer must offer coverage that is the same as that offered to employees with spouses under age 65. In such cases, Medicare would be the secondary payer, while the employer-sponsored plan would be primary. The implications of this provision for employers are relatively minor when taken alone, but when added to the effects of already existing cost factors they are significant. Now employers under age 65—because if they have an older spouse, the employer, rather than Medicare, is required to pay the health costs for the spouse. These added costs may encourage employers to steer clear of older workers.

The second provision, section 2338 of DEFRA, removed a disincentive to older workers of remaining on their employer's health plan. Under the TEFRA provision, those employees who elected, after age 65, to remain in the employer health plan would have been penalized for not enrolling in part B of Medicare upon their 65th birthday. This penalty amounted to a 10-percent increase on annual premiums for each 12 months that the employee does not enroll after his or her 65 birthday. Since the Medicare coverage was duplicative of the employer plan there was no need to enroll in part B until after retirement—except for the stiff penalty imposed. DEFRA waived the part B premium for workers and their spouses aged 65 through 69 who elect private coverage under the provisions of TEFRA. It also established special enrollment periods for such workers. The waiver applies for the period during which an individual continues to be covered under an employer's group health plan.

Finally, employers health care insurance obligations to older employees under the ADEA were expanded by the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-272), signed by the President on April 7, 1986. The law removed the upper age limit of 69 and employers will now be required to offer employees and their spouses aged 69 and over the same group health insurance coverage provided to younger workers.

Another issue is the difficulty some employers—particularly those with few employees—are having in finding adequate health insurance coverage for their older workers. Indeed, in 1983 the Wall Street Journal reported that insurance companies know that groups containing older people will run up bigger medical bills than those with younger participants. As a result, insurance premiums for the group plans have soared and some insurance companies have gotten out of the small-group business altogether because they concluded these plans were unprofitable. Higher insurance premiums for veteran employers create another disincentive for those employers to hire and retain older workers.

Despite concerns among employers about the costs of older workers, the Federal Government is seeking ways of keeping older workers in the labor force. The most notable example of this are the 1983 amendments to the Social Security Act. The compromises that resulted in the amendments (P.L. 98-21) reflect the belief in Congress that older people are healthier today and therefore, can continue to work longer. The desired effect of the amendments is that older workers will be discouraged from leaving the labor force

by an increase in the penalty for early retirement, an increase in the age at which full retirement benefits are paid, an increase in the delayed-retirement credit, and a reduction in the penalty on earnings after retirement.

7. Personnel Practices for an Aging Work Force

One of the most important issues before the Congress today is the need to expand employment opportunities for those older men and women who want to work full or part time. Substantial numbers of retired people both need additional income through employment and would like to do productive work, rather than retire full time. However, many of these retirees depend upon the availability of more appropriate and flexible employment opportunities, and the removal of existing financial disincentives. The Bureau of National Affairs reported 1986 survey results which showed that only 6 percent of responding employers had a policy of encouraging older workers to stay on the job and just 2 percent of the firms provide retraining specifically for the older employee.

A major problem in the proliferation of innovation among business leaders with regard to older worker policies is the absence of information about models that have been tried in the private sector. Examples of new personnel policies and innovative work options to accommodate the unique needs of older workers are given in a February 1985 information paper, "Personnel Practices for an Aging Work Force: Private Sector Examples," prepared for use by the Special Committee on Aging. The information paper fills an important information gap by providing employers, policymakers, and the general public with descriptions of successful employment practices designed to capitalize on the contributions of older workers.

A relatively recent development has been the use of early retirement options, with enhanced benefits for senior employees. Many employers, faced with having to tighten their belts and reduce the size of their work force, have begun offering their older employees (with high salaries), financial incentives to leave the workplace. In 1986, for example, three major companies (Du Pont, IBM, and Xerox) announced early retirement incentives to trim their work forces.

As the use of exit incentives have risen, so have questions about their discriminatory effect. The ADEA states that certain exit incentive programs can include provisions which would otherwise be considered discriminatory, but only if they are not used as a subterfuge to evade the purposes of the ADEA. This has been interpreted to permit differential benefits, but only where justified by the increased cost of providing benefits to older workers. At this time, there are divergent circuit court rulings on the cases testing the legality of exit incentives. While it is too soon to understand all of the implications of this new trend, economists have expressed concern at the loss of so many productive workers. The use of early retirement incentives is of growing interest to older worker advocates, as well as to employers, and the issue will assuredly continue to be closely monitored by watchdog interest groups.

8. EEOC Enforcement of the ADEA

(A) HEARINGS

In September 1987, the Senate Special Committee on Aging held a hearing examining the Equal Employment Opportunity Commission's (EEOC's) effectiveness in carrying out its obligations under the ADEA. During the hearing, the Committee heard testimony on several subjects, including EEOC litigation, charge processing, rulemaking and staffing. Critics charged that the Commission often allows cases to languish for months, even years at a time, without taking any substantive action, and that many EEOC staff have lost or misplaced charges which have been filed.

Some also contended that the Commission has not only been lackadaisical in its protection of older workers, but has actually taken steps that diminish their rights. Charges were made regarding the Commission's delay in issuing regulations requiring continued pension accrual for those working beyond normal retirement age, its decision to condone early retirement and exit incentive programs which offer decreased awards to older workers and its decision to allow unsupervised waivers of ADEA rights. The Commission was also criticized for shifting its litigation emphasis away from systemic discrimination to cases involving individual complaints. Critics charged that by failing to pursue large scale age discrimination cases involving an employer's scheme of hiring, EEOC has chosen to attack age discrimination in an ad hoc fashion. Statistics were also cited which show that of all ADEA charges filed with the agency, fewer than 1 percent are even recommended for litigation.

In response, the Commission argued that its ADEA enforcement performance has been improving. EEOC cited an increased litigation caseload, an investigative compliance policy designed to enable EEOC to deal more effectively with uncooperative respondents in Commission investigations and an increase in monetary relief recovered by the EEOC through litigation to show that they have been effectively enforcing the ADEA. EEOC testified that while $2.3 million went to victims of age discrimination in 1980, in 1986 the Commission recovered $36.6 million through ADEA litigation.

In a related effort, the Committee held hearings on similar issues on June 23-24, 1988. Testimony from a number of EEOC officials from field offices revealed that there were serious shortcomings in the EEOC's computerized case-tracking system, hampering efficient management of charges filed with the agency. Proposed remedies included revamping the computers and improving the lines of communication between the district, regional, and Federal offices of the EEOC. To assist the EEOC in this area, the Committee requested that the General Accounting Office examine the current computer system and recommend improvements.

(B) LAPSES IN THE ADEA STATUTE OF LIMITATIONS

As a result of the investigation carried out by the staff of the Senate Special Committee on Aging in 1987, it was revealed that the statute of limitations for many age discrimination cases had lapsed due to EEOC inaction. Under the ADEA, a person who files

a complaint of age discrimination has up to 2 years in which to file a civil action in Federal court. Unless a complaint is processed by the EEOC within that period, a complainant loses the opportunity to pursue the case in court.

Estimates of the number of age-discrimination cases that had been adversely affected ranged from hundreds to thousands. Initially, the EEOC reported that the statute of limitations had lapsed in approximately 800 cases. In November 1988, however, the EEOC submitted a report to the Committee showing more than 8,800 cases in which the 2-year processing deadline may have been missed.

To remedy this problem, legislation was introduced in S. 2117, the proposed Age Discrimination Claims Assistance Act of 1988, to extend for an additional 18 months the period in which a person with a neglected EEOC age charge could file suit in federal court. Under the bill, an individual who had filed a charge with the EEOC on or after January 1, 1984, but whose charge was not processed in time to meet the applicable statute of limitations, would have the additional time from the date of the bill's enactment to pursue his or her rights to pursue a civil action. With the backing of EEOC Chairman Clarence Thomas, S. 2117 was enacted as Public Law 100-283.

9. Age Discrimination Awareness

Age discrimination continues to pervade the American workplace. While many industries recognize the value of hiring experienced older workers, others continue in their attempts to subvert the law. In addition, not only do many older workers fail to realize when they are being discriminated against, but many do not understand their rights and protections under the Age Discrimination in Employment Act. According to a 1981 Louis Harris survey, approximately half of the older workers polled were unaware of their ADEA rights and protections. Given the fact that no concerted awareness campaign has taken place since that time, these statistics are unlikely to have improved.

In response to this lack of awareness, legislation was enacted in 1987 to require the Department of Labor to furnish Title V contractors with printed materials regarding age discrimination in employment. The contractors will, in turn, distribute this information to program participants to apprise them of their lawful rights.

The Senior Community Service Employment Program under Title V of the Older Americans Act provides many seniors with needed jobs and income. Title V is the most visible federally supported employment program and is one of the few remaining job creation programs. For this reason, supporters of the amendment believe that Title V contractors will provide an excellent vehicle for increasing awareness.

10. Older Labor Force Reentrants

In recent years, there has been an increasing trend toward early retirement from the work force. 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 re-

tirement. 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 at too early an age are attempting to return, there is presently little proof.

Legislation was enacted on December 22, 1987, as Public Law 100-202 to require a study of older persons who are attempting to re-enter the work force. The purpose of the study was to provide the Congress with a better understanding of the issues and obstacles facing older persons seeking to reenter the workplace.

The Labor Department report, entitled "Labor Market Problems of Older Workers" was released in January 1989. The report reiterates long standing 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 obstacles to reentering the job market persist, including the low pay of part-time work and the Social Security earning limitation. Looking ahead, the report states 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.

C. PROGNOSIS

A variety of issues must be resolved in the years to come with respect to the employment of older and midlife workers. These include whether to extend the ADEA to tenured university faculty, public safety officers and older workers in apprenticeship programs. Although stereotypes abound regarding unproductive, fractious older employees, there is a growing realization that older workers are a very diverse group.

The phenomenon of an aging work force presents a variety of potential problems, especially when considered in tandem with the trend toward early retirement. In attempting to downsize their work force, many companies chose to absorb the cost of offering early retirement packages to their employees. However, there is growing concern that in so doing, many companies merely consider short-term savings without regard to long-term costs due to lost experience, increased pension liabilities, and increased training costs.

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 business interests 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 of a 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.

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Chapter 5

SUPPLEMENTAL SECURITY INCOME

OVERVIEW

The Supplemental Security Income (SSI) Program provides monthly cash payments to 4.4 million low-income elderly, disabled, and blind. Although SSI has escaped budget-cutting efforts directed at other means-tested programs in recent years, it is unclear how long the program will remain intact as competition for restricted funding escalates under a mandated reduction of the budget deficit.

Despite progress in recent years in reducing poverty among the elderly, a substantial number remain poor. Advocates label SSI's benefit level as deficient because it does not provide recipients with an income that meets even the poverty threshold.

In response, a major overhaul of the SSI program was proposed in a bill introduced on July 6, 1988, by Representative Edward R. Roybal of California, Chairman of the House Select Committee on Aging. The bill would broaden Federal benefit standards and expand eligibility.

Since the SSI program's inception in 1974, no major legislative reforms to the program have occurred. However, within the last 2 years, changes which are relatively minor but have significance for older individuals have been inserted into legislation on other subjects.

A. BACKGROUND

The SSI program, authorized by Title XVI of the Social Security Act (P.L. 92-603) in 1972, began operating in 1974 to provide a nationally uniform guaranteed minimum income for the elderly, disabled and blind. Congressional policy in enacting SSI was based on three goals: To construct a coherent, unified income assistance system; to eliminate large disparities between States in eligibility standards and benefit levels; and to reduce the stigma of welfare through administration by the Social Security Administration (SSA). Congress assumed that a central, national system would be simple and efficient to administer and would protect recipients from many of the demeaning rules and procedures that had been part of State-operated programs.

The program was designed to supplement the income of those whose work experience and circumstances did not qualify them for Social Security benefits or whose Social Security benefits were not adequate for subsistence and to provide recipients with the opportunity for rehabilitation and incentives to seek employment.

At the Federal level, SSI consolidated three State administered public assistance programs: Old age assistance; aid to the blind;

and aid to the permanently and totally disabled. States play both a required and an optional role in the SSI program. They must maintain the income levels of former public assistance recipients who were transferred to the SSI program. States may also use State funds to supplement SSI payments for both former public assistance recipients and subsequent SSI recipients. States have the option of either adminsitering their supplemental payments or transfering that responsibility to the 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. The blind are defined as individuals 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.

The 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.

Eligibility is also determined by a means test under which two basic conditions must be satisfied. First, after taking into account certain exclusions, income must fall below the benefit standard—$354 for an individual and $532 for a couple. Second, assets must meet a variety of asset tests.

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, housing or, 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. 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 indivduals and immediate family members; a maximum of $1,500 in burial funds for an individual and the same amount for a spouse; and the cash value of life insurance policies with face values of $1,500 or less.

In 1988, the asset limit was $1,900 for an individual and $2,850 for a married couple. In 1989, the limit is set at $2,000 and $3,000 respectively. The income of an ineligible spouse who lives with an

SSI applicant or recipient is included in determining eligibility and amount of benefits.

The Federal SSI benefits standard is also calculated according to the 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 1988, that totaled $236 for a single person and $354.67 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 1987, 5.7 percent, or 248,000 recipients came under this "one-third reduction" standard. Sixty-eight percent of those recipients were receiving benefits on the basis of disability.

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

B. ISSUES

1. Benefits

From the program's start-up in 1974, benefit levels were set below poverty lines. Critics of the program point out that SSI benefit levels have relieved extreme poverty but have done little to reduce poverty rates of the elderly and disabled. The poverty rate among the elderly has declined only marginally from 14.6 percent in 1974 when the program began operating to 12.2 percent in 1987. For black elderly, the poverty rate is even greater, at 34 percent. The poverty rate is highest for black elderly women, at 40 percent.

The 1988 benefit of $354, left an elderly individual 25 percent below the projected poverty level of $5,649. For elderly couples, the maximum benefit level of $532 was 10 percent below the projected poverty level of $7,126 in 1988.

In 1987, out of a total population of 29.8 million elderly 65 and over, 3.6 million elderly had income below the poverty level and 6 million elderly had incomes below 150 percent of the poverty level. In 1987, 33 percent of the elderly poor received SSI benefits.

A study by the National Council of Senior Citizens in 1988 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.

Beneficiary advocates contend that one of two changes should be made: the Federal benefits should be raised to the poverty level or States should be required to provide a supplement that ensures at least a poverty-level income.

Federal benefit standards were initially set lower than Old Age Assistance (OAA) levels in 25 of the States. Congress required that those States continue to pay OAA benefits that were higher than

the Federal payment. States may also voluntarily supplement the Federal SSI benefit standard.

Approximately 44 percent of SSI recipients receive State supplements. However, the median State supplement is only $36 per month and seven States provide no supplemental benefits at all. Only four States—Alaska, California, Massachusetts, and Connecticut—supplement SSI enough to bring benefits up to the poverty level.

2. Income and Assets Limits

Critics point out that a major flaw in the SSI program is that cash income disregards have not been updated to reflect inflation. The Urban Institute has calculated that if the 1983 values of cash income disregards had been indexed for price inflation they would have increased from the current $20 of monthly income from any source and $65 of monthly earned income of $40 and $130 respectively. The $20 disregard affects more than 71 percent of elderly beneficiaries.

Assets limits have also failed to keep up with inflation. For 10 years, from the program's inception in 1974 and 1984, the allowable asset limits remained constant at $1,500 for individuals and $2,250 for couples. The Deficit Reduction Act of 1984 (P.L. 98-369) raised these limits beginning in 1985 by $100 a year for individuals and by $150 a year for couples through 1989. However, advocates for recipients charge that the assets test is still too stringent and disqualifies potentially eligible persons who are poor by almost any other standard. Advocates also maintain that excluded assets under the SSI program are more narrowly defined than in other means-tested programs.

A 1988 study conducted by the Policy Center on Aging of Brandeis University for the American Association of Retired Persons (AARP), examined for the first time the assets actually owned by low-income elderly. Previous studies simply estimated the value of assets held by this group. The Brandeis study indicated 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 found a significant number of individuals with assets close to the cutoffs. 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 life insurance and although many of these were relatively small in terms of face value, they contributed to asset ineligibility.

Researchers and advocates have proposed several possible changes in the SSI asset test. These include indexing of asset test limits to adjust for inflation, complete elimination of the test, and the use of the more liberal Food Stamp asset test.

Using 1984 costs, the Brandeis study estimated the impact of such changes. Elimination of the asset test would be the most expensive, the study found, because it would increase the eligible population by 42 percent and increase the cost of Federal benefits by 34 percent. This approach was estimated to cost between $800 mil-

lion and $1.2 billion annually. Use of the Food Stamp test, which in 1988 permitted $3,000 in assets, would increase those eligible by 15 percent and Federal benefits by 12 percent, a total of between $300 million and $400 million. Indexing for inflation would increase the eligible population by 7 percent and increase Federal costs by only 5 percent, or between $100 million and $200 million.

Although the Brandeis study did not recommend one of these options, it posed the question of whether the current asset test fosters the Federal goal of accurately identifying the truly needy. The study concluded that these elderly individuals are not ineligible because they are "well-off" but because the Government has ignored the impact of inflation on program eligibility criteria. The study found that there are many individuals with assets close to the current cutoffs and in many cases, these assets are not in liquid form. These elderly would not be helped very much or for very long if they "spent down" their assets, the study concluded.

Another concern regarding assets is that the limit contributes to the problem of overpayment and SSA recovery of overpayment. In cases in which there is an overpayment based on an excess of assets of $50 or less, SSA waives the necessity of repaying unless it is found that failure to report the excess was knowing and willful. But if a recipient's assets rise over the limit, for example through bank account interest, that person becomes ineligible for SSI benefits during that period. The errors are usually not detected until after the full benefits have been paid. SSA's policy is to recover overpayments. In the 1984 Deficit Reduction Act, Congress recognized the inequities that resulted when overpayments were collected by withholding of a person's full benefit for as many months as it took to fully recover the overpayment. The rate of recovery was subsequently limited to not more than 10 percent of the person's monthly income. This limitation does not apply if there has been fraud, willful misrepresentation, or concealment of material information. In a minority of cases, the obligation to repay overpayments is waived completely.

3. Participation

The SSI program has been characterized by low participation rates since its inception. Despite initial projections that over 7 million Americans were eligible for SSI, the caseload has never exceeded 4.5 million. There is also the problem of a shrinking population of elderly participating in the program. The number of those 65 and over receiving SSI benefits declined from 2.3 million in 1975 to 1.5 million in 1986. 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 older elderly, single women living in poverty.

Estimates of persons who receive SSI benefits vary between 40 and 60 percent of those who are eligible. For example, a 1980 study based on 1975 population data by the Institute for Research on Poverty found a 41–47 percent participation rate for the elderly. And in 1981, Urban Systems found a rate of 60 percent in a report that used a nonrepresentative 1979 survey of low-income elderly. This range of estimates indicates the difficulties researchers have

in estimating the size of the population which may be eligible for SSI.

Beneficiary advocates maintain that a major reason for SSI's failure to eliminate poverty among the elderly and disabled is that many who are eligible never apply because they are unaware of its existence.

SSA has been criticized for making ineffective attempts to reach potential recipients and for failing to provide adequate training to SSA staff who work with current recipients. Advocates point to SSA's closing of field offices and lack of bilingual field intake workers to conduct SSI enrollment and informational efforts in minority communities. In 1984, a Congressionally mandated effort by SSA to inform 7.6 million potential SSI recipients by mail of possible eligibility resulted in 79,000 applications. This represented 1 percent of potential recipients who were alerted. A total of 58,000 of those applicants were awarded benefits.

A 1988 Lou Harris survey indicated that lack of information and negative attitudes about welfare may be major factors contributing to nonparticipation. The survey found that only 37 percent of poor persons age 65 and over knew where to go to apply for SSI. Asked why eligible persons might not apply for SSI benefits, 65 percent of respondents cited misinformation about eligibility; 65 percent cited dislike for "welfare;" and 55 percent cited never having heard of the program.

Final results of a 1988 national pilot project conducted by the American Association of Retired Persons (AARP) to demonstrate methods of conducting successful SSI outreach activities at the local level showed a significant increase in SSI applications and claims awarded. Conducted from April 1988 to July 1988 in El Paso, Pittsburgh, and Oklahoma City, the project resulted in a 97 percent increase in applications and a 58 percent increase in awards of benefits compared to the previous 3 years. AARP reported that in the three demonstration sites, it actively cooperated with local area agencies on aging to form a coalition of 40 to 50 agencies to assist with the project. Methods used included extensive use of the media, training of SSI advocates, conducting community education presentations, and individual counseling of potential SSI recipients. The program is designed to serve as a model for similar outreach efforts across the country and will be expanded by AARP to 10 new sites this year.

4. Eligibility of SSI Recipients for Other Public Assistance Programs

In all but two States, SSI recipients may qualify for food stamps if they meet income and assets requirements. However, this additional assistance, even when it is combined with State and Federal SSI benefits, has little effect on the poverty rate of the elderly population. An Urban Institute study found that in 1983, the poverty rate of single elderly persons dropped only slightly, from 28 percent to 25 percent, when Federal and State SSI benefits and food stamps were added to their incomes.

Table 1 and Table 2 compare the Federal SSI benefit for single individuals and for couples to the poverty threshold. Both tables

also show that even when Federal SSI benefits, Social Security, and food stamps are combined, SSI recipients are still below the poverty level.

TABLE 1.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE INDIVIDUALS RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 to 1988

	Calendar year					
	1975	1980	1982	1984	1986	1988
Poverty threshold	2,572	3,941	4,630	4,980	5,255	[1] 5,649
Federal SSI benefits:						
Dollars per year	1,822	2,677	3,294	3,768	4,032	4,248
Percent of poverty	70.8	67.9	71.1	75.7	76.7	75.2
Federal SSI and social security:						
Dollars per year	2,062	2,917	3,534	4,008	4,272	4,488
Percent of poverty	80.2	74.0	76.3	80.5	81.3	79.4
Federal SSI, social security, and food stamps: [2]						
Dollars per year	2,350	3,345	3,906	4,294	4,488	4,848
Percent of poverty	91.4	84.9	84.4	86.2	85.4	85.8

[1] Projected on basis of CBO projected increases in the consumer price index.
[2] In computing for food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standard deduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

TABLE 2.—COMPARISON OF COMBINED BENEFITS TO POVERTY THRESHOLDS FOR ELIGIBLE COUPLES RECEIVING SSI; SSI AND SOCIAL SECURITY; AND SSI, SOCIAL SECURITY AND FOOD STAMPS FOR SELECTED YEARS: 1975 to 1988

	Calendar year					
	1975	1980	1982	1984	1986	1988
Poverty threshold	3,232	4,954	5,840	6,280	6,630	[1] 7,126
Federal SSI benefits:						
Dollars per year	2,734	4,016	4,940	5,664	6,048	6,384
Percent of poverty	84.6	81.1	84.6	90.2	91.2	89.6
Federal SSI and social security:						
Dollars per year	2,974	4,256	5,180	5,904	6,288	6,624
Percent of poverty	92.0	85.9	88.7	94.0	94.8	93.0
Federal SSI, social security, and food stamps: [2]						
Dollars per year	3,430	4,906	5,792	6,393	6,696	7,200
Percent of poverty	106.1	99.0	99.2	101.8	101.0	101.0

[1] Projected on basis of CBO projected increases in the consumer price index.
[2] In computing the food stamp benefit for 1975, average deductions among all elderly households are assumed. For later years, the applicable standard deduction plus average shelter and medical deductions among all elderly households is assumed.

Source: Congressional Research Service.

Federal Medicaid statutes require that SSI recipients be covered by Medicaid, but several States have chosen the most restrictive of eligibility options. Medicaid, even when combined with Medicare, covers only about two-thirds of health care costs for the elderly. The result is that out-of-pocket health care costs often take a significant share of their budgets.

Federal Medicaid statutes allow States three options: They can provide automatic eligibility; require SSI recipients to file separate applications for eligibility; or impose more restrictive income and resource criteria and more restrictive definitions of blindness and disability than those used in the SSI program if those restrictions

were in effect in the State in 1972 under the State's cash assistance program.

About 22 percent of SSI recipients live in the 14 States that use the most restrictive option. Six States have chosen the option of filing separate applications and about 2.5 percent of all SSI recipients live in these States. A total of 75 percent of all SSI recipients live in the 30 States that have chosen the automatic option.

5. Employment and Rehabilitation for SSI Recipients

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 who could work or could have tried 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 the disability program more effective. At that time, the House Ways and Means Committee asked the Department of Health and Human Services (DHHS) to evaluate the effectiveness of the Section 1619 program. In a report released in July 1986, DHHS reported that the program had benefited 55,000 individuals since its inception in 1981.

The 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" (average countable earnings of over $300 a month up to 9 months) 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.

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 valuable and 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.

C. FEDERAL RESPONSE

In 1987 and 1988, Congress revised provisions that deal with SSI benefits, income, and resource limits. The goal was to make SSI more sensitive to the needs of recipients. Public Law 100-203, the 1987 Omnibus Budget Reconciliation Act (OBRA), for example, included provisions that made it more difficult for the Department of Health and Human Services to force the sale of property; expanded the definition of eligibility for benefits to individuals and couples in nursing homes; and broadened eligibility for disabled widows and widowers.

Congress also responded to the growing problem of homelessness among elderly and disabled individuals who may be eligible for SSI. OBRA extended the time an individual could receive SSI while staying in a public emergency shelter and authorized demonstration projects for States to ensure that homeless persons receive SSI and other benefits.

Among most recent Congressional responses to the needs of SSI beneficiaries was action on the problem of impoverishment of a spouse who stays at home when one member of a couple enters a nursing home. Congress expanded income and resource protections for the community spouse under the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360).

1. The Older Americans Act Amendments of 1987 (OAA)

A provision in OAA amendments of 1987 (P.L. 100-175) authorized a program to expand outreach services to older persons who may be eligible for, but are not receiving, benefits under the SSI, Medicaid, and Food Stamp programs. It authorized $10 million for each of fiscal years 1989 and 1990 for grants to States to inform older persons about their potential eligibility and to assist them in applying. Each State would receive at least $50,000 to implement the outreach programs and is directed to give priority to elderly in greatest economic need. Funding for this program is, however, subject to an "appropriations trigger," under which funds for new programs under the act may not be appropriated unless total appropriations for programs in effect in fiscal year 1987 increase by at least 5 percent over the previous year.

2. The Omnibus Budget Reconciliation Act of 1987 (OBRA)

The basis for SSI provisions in OBRA were two bills: H.R. 2795, introduced by Representative Matsui of California and S. 1635, in-

troduced by Senator Pryor of Arkansas and Senator Melcher of Montana, Chairman of the Special Committee on Aging. The bills were drafted to ease some of the SSI program's strict eligibility and benefit standards. For example, the bills sought to extend Medicaid coverage to individuals who, at age 60, lose their SSI eligibility status because of their eligibility for early widow's or widower's benefits under Social Security, and to broaden the circumstances under which real property cannot be counted as a resource for SSI purposes. Unless otherwise stated, all provisions became effective on April 1, 1988.

(A) INCOME LIMITS

Among the changes regarding income limits, OBRA made permanent a temporary exclusion of in-kind non-cash assistance from nonprofit organizations if it is based on need. The provision is effective retroactively to October 1, 1987.

OBRA also eliminated the requirement that several kinds of non-SSI benefits be counted as income in determining SSI eligibility in the first and second months after application. These were Aid to Families with Dependent Children (AFDC) benefits, foster care payments, refugee assistance, Cuban/Haitian entrant assistance, or general and child welfare provided by the Bureau of Indian Affairs. For many individuals, this requirement resulted in a reduced SSI benefit that was in some cases lower than the AFDC or other benefit the person previously received.

Another provision excluded from countable income the interest on burial trusts. Previously, the interest was counted as income in certain circumstances. Any payments provided to the beneficiary as the result of another's death to the extent that these funds were used for payment of the last illness or burial of the deceased were also excluded from the SSI income limits.

(B) RESOURCE LIMITS

Under the new law, the Social Security Administration (SSA) excludes from countable resources real property which cannot be sold in cases where the property is jointly owned and its sale would cause undue hardship due to loss of housing for the other owner or its sale is barred by a legal impediment; or the owner's reasonable efforts (determined by SSA regulations) to sell it have been unsuccessful.

DHHS is also required to issue regulations regarding the suspension of penalties for transfer of an asset for less than fair market value provided the DHHS Secretary determines it is necessary to avoid undue hardship.

In addition, SSI or Social Security back awards received by SSI recipients between October 1, 1987, and September 30, 1989, are excluded from countable resources for 9 months instead of the previous 6-month period.

(C) BENEFITS

OBRA provided for continued full SSI benefits for institutionalized persons who are expected to be released within 3 months and who must pay the costs of maintaining the place in which they

intend to live when discharged. This provision took effect on January 1, 1988. Under prior law, SSI recipients who were institutionalized for more than a month would have lost their SSI benefits or received only a small personal needs allowance.

Effective January 1, 1988, the time a person can receive SSI while residing in a public emergency shelter was expanded from 3 months in any 12-month period to 6 months in any period of 9 consecutive months. All SSI eligible individuals living in shelters prior to this date could continue to receive SSI without having to account for the previous benefits.

A provision under which States could treat a husband and wife who had shared a room in a Medicaid facility for 6 months as an eligible couple if this prevented a reduction or termination of their Medicaid benefits was expanded. The revised provision allows inclusion of couples who live in the same facility but not in the same room effective retroactively to November 10, 1986.

Previously, disabled widows or widowers lost eligibility for SSI and Medicaid because of a requirement that they apply for retirement benefits at age 60. Since the retirement benefits sometimes exceed the SSI level, the individual was often left without health care coverage between the ages of 60 and 65. Under the new provisions, disabled widows and widowers will retain their SSI status and consequently their Medicaid eligibility until they begin to receive Medicare.

The SSI monthly personal needs allowance for individuals in nursing homes and other institutions was increased from $25 to $30 and for couples from $50 to $60. This was the first increase in the personal needs allowance since the SSI program began in 1974.

The DHHS Secretary was authorized to pay up to a full month's benefit (Federal and State) to an individual in the case of a financial emergency. The previous limit on the advance was $100. This provision took effect on December 22, 1987.

(D) OTHER PROVISIONS

Under OBRA, SSI applicants and recipients who are eligible because of blindness were given three options to choose from regarding the form of special notice of SSA's actions or decisions in their cases: A supplementary notice by telephone, within 5 working days after the initial notice is mailed; the initial notice in the form of a certified letter; or notification by some alternative procedure established by the DHHS Secretary and agreed to by the individual.

A provision which barred SSA from terminating SSI benefits to a recipient participating in an approved vocational rehabilitation program even if the recipient's disability has ceased, was extended to individuals receiving SSI benefits based on blindness.

The DHHS Secretary was authorized to fund State projects designed to assist the homeless in securing SSI and other Social Security Act benefits and to assist the homeless in obtaining permanent housing, food, and health care.

As of January 1989, States began to be reimbursed for interim assistance they provided a person between suspension or termination of SSI benefits and the time they were reinstated. Formerly,

States were reimbursed only for assistance provided while a person applied for SSI.

3. The Medicare Catastrophic Coverage Act of 1988

Concern by Congress about the devastating impact of institutionalization on a spouse left at home resulted in approval of a provision in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360), containing mandatory income and resource protections.

Previously, Medicaid regulations required that, in determining eligibility for Medicaid coverage of institutional care, the income and assets of both spouses be counted for the first month when one spouse entered an institution. This meant that many couples had to pay the first month's nursing home bill themselves at higher private rates. A couple with modest savings often lost most of those savings as a result. Also, after the first month, almost all income and assets in the name of the spouse in the institution had to be used to pay for that person's care. This was particularly devastating for couples whose pension income was in the name of the institutionalized spouse only. A ceiling on the amount the spouse at home could receive was generally equal to the SSI income level for one person ($354 for one person in 1988).

Effective September 30, 1989, the Catastrophic Coverage bill provides for a considerably higher amount of protected income for the spouse left at home. First, income in the name of the spouse who remained in the community is labeled as not available to the institutionalized spouse from the day of institutionalization. Second, a community spouse monthly maintenance needs allowance was established consisting of 122 percent of the poverty level for a two-person household and an excess shelter allowance if shelter costs (rent or mortgage, taxes, insurance, and utilities) exceed 30 percent. Third, the bill provides for community spouses to receive a contribution from the institutionalized spouse's income in order to bring their income up to the amount of the maintenance needs allowance. This allowance is not to exceed $1,500 except by court order or as the result of a fair hearing.

In contrast, resources are treated differently from income. The bill required that all nonexempt resources owned by either spouse, jointly or separately, must be pooled together as of the beginning of a continuous period of institutionalization. The community spouse may keep $12,000, or one-half of the resources, whichever is greater, but not more than $60,000. States have the option to increase the $12,000 floor, but not the $60,000 ceiling.

New uniform transfer of assets provisions replaced the current law for both SSI and Medicaid. States must deny eligibility to any institutionalized individual who transferred any asset for less than fair market value within 30 months prior to application. Under certain circumstances, transfers for less than fair market value will not be penalized. States cannot have any additional transfer of assets penalties. There is no longer any penalty denying SSI eligibility for transfers on or after July 1, 1988.

4. The Family Support Act of 1988

The Family Support Act (P.L. 100-485) contains amendments refining the transfer of assets and spousal protections sections of the Medicare Catastrophic Coverage Act of 1988.

The effective date for the new transfer of assets penalties, for transfers between spouses only, was set at October 1, 1989. Transfers between spouses before that date are governed by laws and policies in effect in individual States on June 30, 1988. The July 1, 1988 effective date for transfers to other people was not changed.

Transfer of assets penalties were narrowed with respect to medical institutions to apply only to people in nursing facilities. The original law applied to all persons in medical institutions. At the same time, the assets penalties were broadened to include people receiving services under a home and community based services waiver.

5. Stewart B. McKinney Homeless Assistance Amendments Act of 1988

A provision in the McKinney Act Amendments (P.L. 100-628) set up the Jobs for Employable Dependent Individuals Program, which provides incentive bonuses to service providers who successfully train and place "long-term" recipients of the SSI and Aid to Families With Dependent Children programs. Long-term is defined as having received welfare assistance for 24 of the 28 months preceding participation in the program.

6. Proposed Legislation

Other bills that were introduced in 1988 contained provisions pertaining to SSI. While Congress did not act on them prior to adjournment in October, it is expected that these bills will be reintroduced when the 101st Congress convenes in 1989.

(a) The SSI Comprehensive Improvements Act of 1988

Introduced on July 6, 1988, by Representative Edward R. Roybal of California, this bill represents a significant step toward eliminating poverty among the elderly. It is designed to respond to criticisms from advocates for poor elderly, and especially minority poor elderly, regarding inadequacies of the SSI program. If passed by Congress, this bill would accomplish the first major overhaul of the program since its inception.

The Roybal bill would raise the Federal benefit standard to the annual poverty guideline. Annual increases would be tied to changes in the Consumer Price Index. It also would raise the asset test to $4,208 for an individual and $6,311 for a couple. These are the levels that would be in effect if the 1974 levels had kept pace with inflation. Annual increases would be tied to changes in the Consumer Price Index.

Other important provisions would: Eliminate the reduction in benefits for married couples by treating every recipient as an individual; eliminate the one-third reduction in benefits for individuals living in someone else's household; exclude in-kind assistance from the definition of income; increase the cash income disregard to $40

(now $20) of monthly income from any source and $130 (now $65 plus one-half of remaining earnings) of monthly earned income with future indexing based on the Consumer Price Index; and disregard interest income below $100 so that it does not reduce monthly SSI income. Present law discourages SSI recipients from saving by reducing benefits if they receive interest income of over $20 a month.

Budgetary constraints have spurred a search for options for financing such reforms of the SSI program. The Urban Institute has analyzed options that involve various ways of broadening the tax base. These include mechanisms such as freezing the current $600,000 estate tax threshold that triggers filing requirements or lowering it to $400,000. The Urban Institute estimates that if the estate tax exemption were lowered to $400,000 and held there, Federal revenues would increase by about $9 billion between 1987 and 1991.

(b) The Social Security Beneficiaries Protection Act of 1988

S. 2755, introduced September 7, 1988, by Senator Donald W. Riegle of Michigan, and H.R. 5250, introduced by Congressman Sander M. Levin of Michigan, includes a provision that requires the Social Security Administration Secretary to establish a program under which homeless individuals who may be eligible for SSI benefits will be identified and provided assistance in applying for such benefits.

D. PROGNOSIS

SSI has been protected so far from major program cuts because it is perceived as a principal element of the safety net of programs for the Nation's most vulnerable citizens. This perception was made formal in 1985 when Congress exempted SSI from automatic budget cuts which the Balanced Budget and Emergency Deficit Control Act (P.L. 99-177) will impose if the Federal Government fails to meet deficit reduction targets.

At the same time, budgetary pressure has kept the program from expanding and from keeping pace with inflation. Protection from cuts is expected to continue, but program growth is unlikely.

Despite this negative outlook, advocates plan to continue to press for reform of SSI income, assets, and benefits rules, and for more effective efforts to reach potential recipients. Expressing the view of many, the executive director of Villers Foundation, which focuses on the needs of low- and middle-income elderly, has said that "SSI is half an idea whose time has come . . . we are all waiting for the second coming."

No major improvements have occurred since 1981 when the same set of reforms now being sought were recommended at the White House Conference of Aging. Advocates conclude that the need for reform is even more urgent now in view of the growing population of elderly and an increase in poverty among minority elderly.

Chapter 6

FOOD STAMPS

OVERVIEW

Appropriations for the Food Stamp Program were authorized through fiscal year 1990 by the 1985 Food Security Act (P.L. 99-198). This same law made significant changes that liberalized the program and are expected to add more than $1 billion in new spending through 1990. As a result, in 1986 and again in 1987, Congress chose to address only a limited agenda of revisions to the Food Stamp Program. However, in 1988, because of concerns about increasing hunger problems among the poor and the homeless, Congress enacted significant program expansions and liberalizations for eligibility and rules in the Hunger Prevention Act of 1988 (P.L. 100-435).

Legislation passed by Congress in 1986 increased homeless households' access to the program (P.L. 99-570); gave States greater flexibility in verification of applicants' and recipients' income through information from other Government programs (P.L. 99-509); enacted an automated system for verifying aliens' eligibility (P.L. 99-603); and expanded the degree to which Federal education assistance is disregarded in determining food stamp eligibility and benefits (P.L. 99-498).

The most significant 1986 food stamp amendment affecting the elderly was the requirement, enacted in Public Law 99-425, that benefits under the Low-Income Home Energy Assistance Program (LIHEAP) not affect food stamp benefits. LIHEAP benefits are not counted as income for food stamp purposes and recipients are allowed to deduct all utility expenses (including those paid by LIHEAP) when their income for food stamp eligibility is calculated.

In the 1987-88 100th Congress, legislation was passed to include benefit increases in the Stewart B. McKinney Homeless Assistance Act (P.L. 100-175) and the Charitable Assistance and Food Bank Support Act (P.L. 100-232). In addition, the House of Representatives adopted further program liberalization in the Food Stamp Family Welfare Reform Act (H.R. 3337, as included in H.R. 1720). Under the Hunger Prevention Act of 1988, Congress enacted legislation to increase food stamp benefits across-the-board; to provide specific benefit increases for individuals with dependent care expenses and for certain disabled persons; to ease eligibility for farm households; to simplify and ease the application process and to revamp the food stamp quality control system.

A. BACKGROUND

The Food Stamp Program attempts to alleviate malnutrition and hunger among low-income persons by increasing their food purchasing power. It forms a national benefit floor by issuing food stamps to combine with income already available to the recipient household to purchase a more nutritious diet than would be possible without food stamps.

In 1988, an estimated 20.1 million low-income persons participated in the program, with an average monthly benefit of slightly over $50 per person. This includes about 1.4 million persons a month in Puerto Rico under the nutrition assistance block grant program that has replaced the Food Stamp Program there. The Food Stamp Program is available to households meeting its assets and income tests or who already are receiving benefits from the Aid to Families with Dependent Children (AFDC) or the Supplemental Security Income (SSI) programs. It is estimated that a minimum of 30 million people 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 17.7 million persons in fiscal year 1979 to a high of 23.2 million in fiscal year 1983.

The origins of the Food Stamp Program began as a group of pilot projects set up by Executive Order in 1961 when the Federal Government began a small, experimental anti-hunger program in eight counties. Today's Food Stamp Program began with the Food Stamp Act of 1964, which offered States the option of operating a Food Stamp Program in lieu of existing commodity donation programs. In 1977, Congress enacted the Food Stamp Act of 1977, which completely revamped the Food Stamp Program's operation. Since then, Congress has enacted amendments intended to improve the program and strengthen its integrity.

Eligibile applicants receive food coupons in amounts determined by household size and income to buy food through normal market channels, primarily in authorized grocery stores. The stamps are forwarded by the grocery stores to commercial banks for cash or credit. The stamps then 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. 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, confirming a correlation between nutritional status and health, particularly to the elderly and children, underscore the tremendous importance of the Food Stamp Program. The program has some special rules for the elderly—including more liberal treatment of shelter costs, medical expenses, and assets. The program, for example, recognizes that elderly people with high medical bills may have total incomes higher than the poverty line, but no more money actually available for food than those with lower incomes and no medical bills. For the 12.5 percent of the elderly that took the medical deduction for the elderly and disabled, the average deduction was $61 per month.

Although 20 percent of food stamp households have at least one elderly member (age 60 or older), they make up only 8 percent of all food stamp recipients and receive 8 percent of food stamp benefits (an average of $31 per month) because of the typical small size of elderly households (an average of 1.5 persons) and relatively higher income compared to other recipient households of the same size. Twenty-nine percent of the elderly who receive food stamps receive only the minimum benefit of $10 a month. Ninety percent of all elderly participants live alone or with one other person, usually elderly as well. Seventy percent live alone, of which 84 percent are single elderly females. More than 13 percent of elderly households also include children. Eighty-nine percent of elderly recipients have assets of $500 or less, with an average of $154 per household.

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 75 percent Federal funding. The Food and Nutrition Services 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.

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—automatically are eligible for food stamps, although in California and Wisconsin increased SSI benefits replace food stamp assistance. The 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.

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

Certain able-bodied adult (older than 16–18, depending on their school and family status) household members who are not working must register for employment and accept a suitable job if offered in order to maintain eligibility. States are required to operate work and training programs under which adults registered to work and not exempted 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 specific level of benefits—generally in the form of food coupons, which

are accepted by authorized grocery stores in exchange for food. A food stamp household is expected to spend 30 percent of its cash income for food with the food stamp benefit making up the difference to buy an adequate low-cost diet based on USDA's Thrifty Food Plan, which determines the benefit level. In fiscal year 1989, the maximum food stamp benefit is $90 a month for a one-person household and $165 for a two-person household. Monthly benefits in 1988 averaged $50 per person and $130 per household although the average was significantly lower for the elderly. In fiscal year 1989, the average monthly benefit per person is expected to be $52.

B. ISSUES

In the first session of the 100th Congress, and after many years of debate about the extent of hunger in the United States, legislative attention focused on expansion of benefits and liberalizing certain rules of the Food Stamp Program with the intent of targeting the very poor, improving the nutrition of the homeless and increasing access to the program. Framing this debate were alternative assumptions about the extent of hunger in the United States and the role and adequacy of food stamps in combating it. Previous debate of the 99th Congress on whether the program had become too liberalized, justifying further cutbacks and tighter eligibility requirements, or needed to be expanded, faded in the wake of new research findings about eligibility and participation rates and congressional failure to recognize Administration efforts to curtail programs.

Involvement in "welfare reform" initiatives by making changes in the Food Stamp Program to complement proposed legislation in the House of Representatives for the cash welfare system was another continuing issue as welfare reform legislation progressed in the 100th Congress. The long-standing controversial issues regarding quality control, by which States are required to identify and measure incorrect food stamp eligibility determinations and issuances, gained increased attention. Congressionally mandated studies and fiscal sanctions owed by the States, totaling more than $500 million, accelerated the pressure for a legislative reworking of the system which was accomplished in 1988.

1. The Hunger and Program Expansion Debate

The first major publicity about hunger in America came after a visit to the rural South in April 1967, by members of the Senate Subcommittee on Employment, Manpower and Poverty to hold hearings on the effectiveness of the so-called war on poverty. Members of the subcommittee were told of hunger and poverty and 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. When the physicians returned in 1977 to evaluate progress made in combating hunger, they found dramatic improvements in the nutritional status of individuals in those same areas which were attributed to the expansion of Federal Food Programs in the 1970's.

Throughout the 1980's, considerable attention has focused on the re-emergence of widespread hunger in the United States. Since 1981, at least 32 national and 43 State 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 serious emergency. In 1983, the Conference issued a report which detailed a dramatic increase in requests for emergency food assistance with unemployment cited as a primary cause.

Closely following that report, the General Accounting Office reported significant increases in the number of persons seeking food assistance during the past few years, including increasing numbers of persons who recently had 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 of 1983. In his report, Senator Kennedy found that hunger was on the rise in America and that Congress must 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 on Food Assistance concluded in its report 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 are 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 of 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 had 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 in the number of households served nationally by emergency food providers and a 17 percent per month increase between 1984 and 1985. The 1983 study concluded that, as a result of budget cuts and changes in the law, the Food Stamp Program no longer was adequately assisting the eligible poor nor reaching the population 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 elderly frequenting emergency food programs in greater numbers and often suffering in the privacy of their homes, either because it was difficult for them to get out or because they choose to suffer alone and no longer had anyone to prompt them to leave their home for food. The staff also expressed concern over what had been noted in clinical practices: 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. Its first report in 1984 concluded that hunger was of epidemic proportions across the Nation, was getting worse and was the result of Federal policies. The report estimated that up to 20 million Americans may be 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 related to a county's effort to enroll the poor in the program rather than a high poverty rate in the county.

Later that year, the Task Force issued another report about 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 and limited State and local Food Stamp Programs from reaching more needy people. Many recommenda-

tions 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 had not been reduced significantly. More people are living in poverty, many of them the working poor and the long-term unemployed, the report found. It 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. It argued that whole new categories of individuals have entered the hunger ranks, citing field investigations into the situations of former oil workers in the South, farm families in the Midwest, and service workers of California as well as miners and steelworkers. It noted that 25 percent of the population lives at the poverty level at some time during the year, that the income gap between rich and poor families had reached its widest point in four decades and that Government programs designed to assist the poor have less impact 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 levels of 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, according to 1983 data, while the highest percentage of the elderly population who live in poverty live in rural areas, only 31 percent of these rural poor elderly households receive food stamp benefits. The study also concluded that the rural poor were significantly less likely to participate in most assistance programs.

According to medical experts on aging, malnutrition may account for a substantially greater portion of illness among elderly Americans than long has been assumed. The concern about malnutrition is rising fast as the numbers of elderly climb and as surveys reveal how poorly millions of them eat. The New York Times reported in 1985 that scientists estimate that from 15 percent to 50 percent of Americans over the age of 65 consume too few calories, proteins, or essential vitamins and minerals for good health. According to the article, gerontologists are becoming alarmed by evidence that malnourishment may cause much of the physiological decline in disease resistance seen in elderly patients—a weakening of 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. The 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 out the promise that many individuals can lighten the disease burden of old age by eating better. And being poor 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 General Accounting Office (GAO), based on research conducted by private organizations and the U.S. Department of Agriculture (USDA) as well as the President's Task Force on Food Assistance concluded that nonparticipation in the Food Stamp Program by many low-income households was attributable to many factors. They include:

(1) A lack of information regarding eligibility,

(2) The amount of potential aid not being enough to warrant the time and effort 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 potentially eligible applicant, and

(5) Attitudinal factors, such as households being sensitive to the social stigma associated with receiving food assistance.

One 1982 study estimated that only 50 percent of eligible elderly in the United States participate in the Food Stamp Program. Participation was very low among elderly people living alone, and the older people are, the less likely they are to participate. A lack of information about eligibility seems to be a key factor; 33 percent of eligible nonparticipants did not think they were eligible for food stamps and another 36 percent said they did not know whether they were eligible.

A November 1988 study by the Congressional Budget Office reiterates the low rate of participation in the Food Stamp Program by those eligible. According to the latest available 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 lowest income households and individuals who are also eligible for higher benefits. Participation rates ranged from 67 to 90 percent for those who would receive benefits over $100 per month. Eligible families with children also had higher participation rates as many also participated in the Aid to Families with Dependent Children program (AFDC). Households with elderly members had lower participation rates of 34 to 44 percent. But the lowest participation rates were for households without children or elderly members.

Studies released by the GAO in July and October of 1988, examined data and analyzed nonparticipation, including administrative hindrances, in the Food Stamp Program. Lack of information about the program or problems with administrative practices were given as the most common reasons for not taking advantage of the program. GAO examined eight studies of which all found that the likelihood of a household participating in the Food Stamp Program decreases as the age of the household head increases, or as the number of people aged 65 or older in the household increases. Administrative procedures which discouraged participation included

limited office hours and restricted interviewing schedules, requiring households to complete screening forms before filling out food stamp applications or being interviewed, not considering applicants for expedited benefits and not helping applicants get all of the documents they need to complete their applications.

Critics of the adequacy of the Food Stamp Program have made a number of recommendations for improvement and expansion of the program, many of which have been incrementally enacted into law. They cite that the Food Stamp Program had been subject to substantial budget reductions through Congressional budget cuts and administrative changes designed to limit abuse of the program. Overfall, the Congressional Budget Office (CBO) has estimated that legislative measures taken in 1981 and 1982 held food stamp spending for fiscal years 1982–85 nearly $7 billion below what would have been spent under pre-1981 law. This translated into a 13 percent reduction at a time when poverty was at its highest level in nearly two decades. For most recipients, the changes did not lead to a direct reduction in benefits, but simply delayed or lowered benefit increases scheduled under previous law. About 1 million people, however, lost eligibility for food stamps due to changes in the law and some recipients received reduced benefits due to administrative changes.

Opponents of expansion and liberalization of the Food Stamp Program criticize the accuracy of some of the studies and the alleged cause of extended hunger as being due to Federal program reductions. They maintain that Federal food assistance programs have been expanded in recent years, that benefits are available to any eligible person and generally are inflation-indexed and protected from budget reductions. Critics of proposals for expansion also argue that the Federal budget deficit is a limiting factor and that the loosening of eligibility and other limits might undermine program integrity.

Proposals to improve access are the most common recommendations for expansion of the Food Stamp Program. These include increased funding, easing procedures for applying for and receiving benefits, and expanding participation through outreach and other activities. Others argue that food stamp benefits are not sufficient and should be expanded through an increased allotment or adjustments in deduction levels. Other proposals include easing eligibility rules for assets and household makeup.

2. Food Stamp Family Welfare Reform

More comprehensive efforts to tie the Food Stamp Program into the rest of the welfare system was being attempted with this proposed legislation. However, it would primarily affect families with children rather than elderly households. It would increase coordination between the benefits and administration of the Food Stamp Program and the rest of the welfare system, complement other welfare reform under consideration by Congress, and improve the employment and training features of the Food Stamp Program. However, these proposals raised a number of questions, including:

(1) Whether the welfare reform initiative to which it is attached is the right approach,

(2) The cost of the proposed changes,

(3) Whether States should be allowed additional authorization to experiment with food stamp and other welfare program rule changes, and

(4) Whether the proposed changes actually offered incentives to remain on welfare.

3. Quality Control and Fiscal Sanctions

As do other welfare programs, the Food Stamp Program has a quality control review system. Established by the Food Stamp Act of 1977, it requires States, with Federal oversight, to monitor their programs to identify and measure incorrect food stamp eligibility determinations and issuances. Errors may range from fraud, obtaining insufficient information, or simple arithmetic mistakes. Cases may include issuing too many or too few food stamps or improperly denying eligibility.

Beginning in fiscal year 1981, a system of monetary sanctions was put in place to create a financial incentive for States to improve program administration. Amendments passed by Congress in 1982 required States to progressively reduce their error rates (for overpayments and payments to ineligible households) to avoid sanctions. Beginning in fiscal year 1985, States must keep their error rates at 5 percent or below to avoid sanctions. However, almost all States have failed to meet targets for error reduction and sanctions assessed by the Federal Government have risen precipitously to a total of about $650 million by November 1988. Most recent estimates place the average "error rate" at 8 percent nationwide which would result in more than $800 million in erroneous payments. This is a one-third improvement over the 11.8 percent average error rate of late 1976.

Few of these sanctions have been collected, as they have been challenged by the States through administrative appeals and the Federal courts. States and other critics have found problems with the statistical soundness and other factors that affect the error monitoring system and the amount of assessed sanctions. The Administration, on the other hand, views the current sanction system as too weak, and continuously makes proposals to increase sanctions and hasten collections.

Congress responded to the States' criticisms of the quality control program by mandating two studies of the system in 1985 (P.L. 99–198), one by the Department of Agriculture and the other by the National Academy of Sciences. The same law also put a moratorium on the collection of sanctions through June 1986.

The two studies of the food stamp quality control system were released in the spring of 1987. The Agriculture Department found its system basically sound in its implementation and statistical methodology, but indicated that some improvements might be acceptable. On the other hand, the National Academy of Sciences study found significant problems, recommended a major overhaul of the system, and called for the recalculation and lowering of sanctions already assessed to the States.

Studies of the food stamp quality control system by the General Accounting Office also have been critical of the program. Two 1987

reports focused on an evaluation of the system's treatment of improper eligibility terminations and denials. The study found that the States have not focused closely enough on the part of the quality control system intended to measure effectiveness in assuring that eligible households are not erroneously denied or terminated from food stamp benefits. Some of the States responded that this could be attributed to States being held liable for overpayments but not for improper denials or terminations. The Department of Agriculture has acknowledged that it has emphasized overissuance determinations as opposed to determinations of improper denials or terminations, and has agreed to look into the feasibility of combining error rates and a sanction system for improper denial or termination rates.

As a result of the studies, congressional hearings, and other information, corrective legislative and regulatory action for the food stamp quality control system were undertaken. The major issues addressed were:

(1) Sanctions already assessed but not yet collected,

(2) Revision of the methodology for collecting future sanctions,

(3) Whether the 5 percent tolerance level floor should be changed,

(4) Whether and how statistical methods should be revised,

(5) Whether and how to expand the system to cover other measures of program quality beyond overpayments, and

(6) Whether and how the administrative appeals process might be revised into a speedier process.

Underlying any decisions for improving the quality control program were the broader questions of balancing incentives for accurate and effective State administration versus a realistic appraisal of the States' actual ability to achieve certain performance standards.

(A) THE FOOD SECURITY ACT OF 1985

Title XV of the Food Security Act of 1985 (P.L. 99–198) extends the food stamp appropriations authorization through fiscal year 1990, with appropriations ranging from $13 billion in 1986 to $16 billion in 1990. It also makes changes in the program that are expected to add about $800 million in new food stamp spending over the next 5 years plus nearly $300 million to the current $825-million-a-year nutrition assistance block grant for Puerto Rico.

Substantial changes affecting the elderly included:

(1) Automatic food stamp eligibility for AFDC and SSI households (without the special income limit proposed by the Senate, but not including SSI recipients in California and Wisconsin),

(2) An increase in the liquid assets limitation for single-person elderly households from $1,500 to $3,000 (the existing $3,000 limit for households of two or more with an elderly member is not changed and the limit for nonelderly households is increased from $1,500 to $2,000),

(3) Reinforcement of requirements for food stamp services at Social Security offices,

(4) Expansion of the number of pilot projects allowing the use of simplified application and standardized benefit procedures for AFDC, SSI, and Medicaid recipients, and

(5) Extension of pilot projects for cash payment of food stamp benefits for the elderly.

Also included were new initiatives, benefit increases, and eligibility liberalizations:

(1) A requirement for States to establish employment and training programs for employable recipients with performance standards set by the Federal Government,

(2) A prohibition on the collection of sales taxes on food stamp purchases,

(3) An increase in the earned income deduction from 18 percent to 20 percent along with an increase in the degree to which high shelter expenses and dependent-care costs are taken into account in food stamp benefit computations,

(4) An expansion of the definition of "disabled person,"

(5) More liberal treatment for households with self-employment income,

(6) Liberalization of the rules governing disqualification for failure to meet work requirements,

(7) Liberalization of student eligibility rules,

(8) A 6-month moratorium on collection of fiscal sanctions from States, coupled with a study of the food stamp quality control system and revision of the system based on the study's results, and

(9) Increases in the nutrition assistance block grant for Puerto Rico.

Benefit reductions in the Act are:

(1) Earnings received by on-the-job trainees under Job Training Partnership Act programs will be counted as income for food stamp purposes, except in the case of dependents under 19,

(2) Most rules that disregard the portion of education aid not paid for tuition and mandatory fees (i.e., available for living expenses) will be removed,

(3) Most rules which disregard the portion of cash welfare grants diverted through third parties will be removed, and

(4) In a few cases, those food stamp recipients who also get aid under the Low-Income Home Energy Assistance Act may have limits placed on the extent to which they can use utility expenses to reduce their countable income.

(B) 1986 LEGISLATION

In 1986, Congress made several major changes in food stamp law, liberalizing:

(1) Treatment of student income from Federal programs,

(2) Treatment of Low-Income Home Energy Assistance Program (LIHEAP) payments for food stamp recipients,

(3) Eligibility and rules regarding the use of food stamps by the homeless, and

(4) Greater flexibility for the States for applicants' and recipients' income verification through information from other Government program sources.

Under the Higher Education Act Amendments (P.L. 99-498), certain income received from Federal higher education aid programs is exempt from income used to determine food stamp eligibility and benefits. The new amendments expanded the exempt income category to include allowances for books, supplies, transportation, and miscellaneous personal expenses. Previous law exempted only the portion of any grant or deferred-repayment loan used for tuition and mandatory fees.

The 1986 law reauthorizing the LIHEAP (P.L. 99-425) exempts LIHEAP benefits from food stamp eligibility. All households receiving LIHEAP benefits claim the entire amount of their utility costs as shelter expense regardless of whether LIHEAP assistance covers the expense.

Under the Food Stamp Program, both gross and "countable" income affect eligibility and benefit determinations. Gross income is all cash income to a household, less allowed exclusions. It is used in determining a household's income eligibility. Households without an elderly or disabled member must have gross monthly income below 130 percent of the Federal poverty level to be eligible. LIHEAP benefits are excluded by law and, thus, have no effect on a household's gross income eligibility determination.

Countable income is a household's gross monthly income, less certain deductions for living expenses. It is used for determining a household's income eligibility and food stamp benefit. Because LIHEAP benefits are excluded from the computation of the gross income base, they have no direct effect on countable income. However, because shelter expenses, including utility bills, might qualify a household for an excess shelter expense deduction and thereby reduce countable income, the treatment of utility expenses covered by LIHEAP benefits is important.

Previously, LIHEAP recipients were treated in a number of ways with regard to their utility expenses and food stamp determinations. In a number of States, LIHEAP recipients were allowed to claim, as a shelter expense, the entire amount of their utility bills, regardless of whether the LIHEAP benefit is in the form of a cash payment to the household or a "vendor" payment made to the utility provider. In other States, Federal food stamp regulations generally were followed. These rules allowed LIHEAP recipients receiving their benefit as a cash payment to claim the entire amount of their utility costs as a shelter expense, but allowed those receiving benefits as a vendor payment to the utility provider to claim only the portion of costs that they pay themselves.

Under provisions of the Anti-Drug Abuse Act (P.L. 99-570) enacted in 1986, homeless persons would be allowed to voluntarily use their food stamps for prepared meals served by public or private nonprofit establishments such as shelters and soup kitchens. Exceptions for the use of food stamps in purchasing prepared meals previously had been made for elderly participants in meal service programs, drug addicts and alcoholics in treatment programs, and residents of shelters for battered women and children. Other provisions included requiring the Social Security Administration (SSA)

to make regular visits to homeless facilities to take SSI and food stamp applications and requiring SSA and the Agriculture Department to develop procedures to take SSI and food stamp applications from people about to be discharged from medical, penal, and other institutions.

(C) THE ADMINISTRATION'S PROPOSALS

After having been largely ignored by Congress in previous years, the Administration did not propose any legislative changes in the submission of its budget for fiscal year 1989. Although the Administration estimated costs for the Food Stamp Program for fiscal 1989 to be $13.6 billion, the appropriation requested was only $13.4 which was based on collecting $162 million in fiscal sanctions from certain States.

In its submission of the fiscal year 1988 budget, the Administration had proposed substantial changes in food stamp law intended to produce cost savings of $600 million in fiscal year 1988 based on the $13.1 billion it estimated would be necessary for the program under current law and administrative practices. This would have held costs at about $12.5 billion, about the same amount that was estimated to have been spent in fiscal year 1987 under an appropriation of $12.646 billion.

The proposed revisions advanced by the Administration in 1986 were rejected by Congress. In 1987, these same proposals were again largely ignored by Congress. The majority of the cost-saving measures proposed by the Administration were aimed at collecting money from the States by recovering sanctions imposed for high rates of erroneous benefits rather than by cutting recipient benefits. Sanctions of $233 million for erroneous payments prior to fiscal year 1988 were to be assumed as collected in 1988. Legislation also was recommended to increase sanctions imposed for errors in fiscal year 1988 and beyond, allowing the Federal Government to collect these sanctions in advance, based on estimated State error rates. This was projected to reduce appropriations by another $258 million.

Additional savings were to come from reducing by $67 million food stamp benefits to households participating in the Low-Income Home Energy Assistance and the Job Training Partnership Act programs, holding Puerto Rico's block grant to $825 million rather than $879.75 million and saving $5 million through rules changes for Federal cost-sharing of State and local administrative expenses.

(1) Low-Income Home Energy Assistance Act Recipients

For many persons who receive both LIHEAP benefits and food stamps, the Administration proposal advanced in both 1986 and 1987 would have counted more of their income for food stamp eligibility, resulting in reduced food stamp benefits or elimination from food stamp eligibility. This would have affected more than half of low-income persons participating in the LIHEAP program and resulted in savings of almost $57 million.

LIHEAP benefits always have been excluded as income in the Food Stamp Program, so they do not directly affect food stamp benefits or eligibility. As part of legislation reauthorizing LIHEAP in

1986 (P.L. 99–425), the Food Stamp Program cannot count LIHEAP benefits in determining eligibility or benefits. This means that a household may not count its LIHEAP benefits as income and it requires recipients to claim utility bills covered by LIHEAP benefits as deductible shelter expenses.

The Administration viewed allowing LIHEAP recipients to claim utility bills as a shelter expense as a double benefit which they thought was unfair to those who paid their utility bills from other income. The Administration's proposal would have allowed LIHEAP recipients to claim as a shelter expense deduction only the part of their utility bills they pay themselves, while LIHEAP benefits would continue to be excluded as income.

Proponents of the current law argue that the Administration proposal would dilute the value of LIHEAP benefits which have been subject to recurrent appropriation budget cuts and are estimated to reach less than 30 percent of income-eligible households.

(2) Job Training Partnership Act Recipients

The Administration proposed in 1985, 1986, and 1987 to increase the amount of income that Job Training Partnership Act (JTPA) participants counted for food stamp eligibility. Such a move would have reduced food stamp benefits and made fewer people eligible while saving an estimated $10 million in benefit costs in 1988.

The Food Security Act required that earnings received by on-the-job trainees in JTPA programs be counted as earned income for food stamp purposes, except for dependents under age 19. The Administration's proposal would have also counted all other income received by JTPA participants, such as stipends and incentive allowances.

(3) Puerto Rico

In 1982, Congress changed the Puerto Rico food stamp program to a block grant, through which it was given an annual Federal grant to operate its own program, which, in fiscal year 1988, served approximately 1.4 million persons, with benefits averaging just under $49 per person. The original amount appropriated was $825 million, much less than if the regular Food Stamp Program had been continued. The $825 million level continued until the 1985 Food Security Act set higher levels, increasing in increments to $936.75 million in 1990. The Administration requested only $825 million for the program for fiscal year 1988 and $908 million for fiscal year 1989.

(4) State Administrative Funding

Two changes were proposed for the fiscal year 1988 budget to reduce the Federal 50-percent cost sharing for State administrative expenses. States with average administrative expenses in excess of 125 percent of the national average would receive only a 25-percent Federal match for their administrative expenses above the 125 percent threshold and no assistance for administrative expenses above 150 percent of the national average. Also, matching rates for computerization and antifraud efforts gradually would be reduced from

75 percent to 50 percent beginning in fiscal year 1988. This was estimated to save $5 million in fiscal year 1988 and more in later years.

C. LEGISLATION

1. Fiscal Year 1989 Appropriations

Under the law continuing appropriations for fiscal year 1989, (P.L. 100-460), $13.6 billion was appropriated for the Food Stamp Program, including $908 million in nutrition assistance for Puerto Rico. The House Committee on Appropriations version of the fiscal year 1989 appropriations for the Agriculture Department included $13.4 billion for food stamps (H.R. 4784). The Senate Appropriations Committee, in its version of the fiscal year 1989 Agriculture appropriations measure, included $13.6 billion for the Food Stamp Program. The Congressional Budget Office had projected program costs for 1989 to be $13.7 billion. Spending for food stamp benefits and the Federal share of State administrative costs is protected from sequestration under the Gramm-Rudman-Hollings deficit-reduction bill and was not an issue in discussions on budget reduction alternatives.

The appropriation figure was at the upper level, the same as the Senate committee's recommendation. This was attributed to economic factors which influence participation in the Food Stamp Program and potential costs for the liberalizations in the Hunger Prevention Act.

2. Omnibus Homeless Relief Legislation

Congressional action on food stamps in 1987 began with amendments enacted into law (P.L. 100-77) as part of the Stewart B. McKinney Homeless Assistance Act. Food stamp provisions of both House and Senate bills were included with an expected cost of $54 million in fiscal year 1988 and $65-$69 million annually in subsequent years. Although the homeless are eligible for food stamps, the law incorporated these specific provisions intended to address specific food stamp problems related to homelessness.

The new law increased benefits to those with high shelter costs by increasing the shelter deduction to $164 a month, from $152 a month for new applicants and current recipients as they become recertified for eligibility. The Senate's recommendations for revising procedures to calculate future inflation adjustments for the shelter deduction ceiling and the standard deduction were also included.

From both the House and Senate versions, the measure authorizes States to inform the homeless about food stamps through outreach activities with 50 percent Federal cost-sharing. The Food Stamp Act had previously been amended in 1981 to remove outreach programs as a required State activity with Federal cost-sharing.

House provisions which increased benefits to certain homeless persons living in welfare hotels were included as were measures to achieve cost savings by delaying income eligibility guideline adjustments and increasing penalties for fraud.

Also included from the Senate proposals were amendments to increase benefits by allowing parents of minor children (together with their children) to apply for food stamps separately from any relatives they live with and to require expedited service for the homeless and those with very high shelter costs.

3. Welfare Reform

The Food Stamp Family Welfare Reform Act of 1987 (H.R. 3337), was reported out of the House Committee on Agriculture on October 26, 1987. Its purpose was to change the Food Stamp Program to complement the proposed revisions in the welfare system of the Family Welfare Reform Act (H.R. 1720). The two bills were merged when H.R. 1720 passed the House of Representatives on December 16, 1987. The Congressional Budget Office (CBO) estimated the cost of the provisions of H.R. 3337 as $11 million for fiscal year 1988 and $145–$166 million in later years.

Four areas of modification of food stamp law were proposed. To better coordinate with other Federal laws and programs which affect individuals receiving food stamps, the bill would have:

(1) Made permanent the automatic eligibility for food stamps for AFDC and SSI recipients,

(2) Required that income received as advance payments of earned income tax credits be disregarded in food stamp eligibility,

(3) Required further coordination in concurrent application procedures for AFDC and food stamps, and

(4) Required that the first $50 a month of a family's child support payments be disregarded in eligibility and benefit determination.

Proposed changes in work, training, and education incentives which included increasing the degree of dependent care costs related to work for determining food stamp eligibility and benefits, treating education assistance the same way for all assistance programs and opening food stamp eligibility to certain low-income postsecondary students. Food stamp employment and training programs would have been assisted by allowing States to increase payments for support services with 50 percent Federal cost-sharing.

Demonstration projects would have been allowed for up to 10 States to test changing welfare program rules to better address the problems of poverty and assist families and individuals to become self-sufficient. It also would allow Washington State to implement its "Family Independence Program." Food stamp rules affecting potentially eligible farmers also would be liberalized in relation to crop payments as income, irregular income and farm property. Outreach programs to farm households with 50 percent Federal matching funds also would be authorized.

4. Other Legislation

Measures to place a moratorium on the collection of food stamp sanctions through September 1988, were introduced (S. 1440 and H.R. 3160) in the 100th Congress to delay or modify penalties on the States until after corrective action could be taken on the food stamp quality control system. An amendment to accomplish the

moratorium was adopted by the Senate during consideration of H.J. Res. 395 to continue appropriations for fiscal year 1988. However, the amendment was deleted in conference. Instead, substitute language of intent was included by the conferees in the Continuing Resolution for fiscal year 1988 appropriations conference report which required the Department of Agriculture to have in place new regulations for improving the food stamp quality control system before fiscal year 1989.

It was noted that the current food stamp quality control system did not accurately measure State administrative performance according to statistically acceptable criteria and directed the Secretary to take into consideration the recommendations of the National Academy of Sciences and other outside groups in reviewing and reforming the method for determining State error rates.

Amendments to the Older Americans Act reauthorization passed by Congress in 1987 (P.L. 100-175) also contained a food stamp-related initiative. Programs would be authorized under the Act to expand outreach services to older persons who may be eligible for, but who are not receiving, benefits under the SSI, Medicaid, and Food Stamp programs. Ten million dollars would be authorized for each of fiscal years 1989 and 1990 for grants to States to inform individuals about their potential eligibility and to help them apply for assistance.

5. 1988 Legislation

Because of continuing evidence that hunger persisted among poor Americans, Congress passed the Hunger Prevention Act of 1988 which the President signed into law on September 19, 1988 (P.L. 100-435). According to 1986 census data, 32 million Americans live in poverty, up from 26 million 10 years earlier. Of the 1986 poor, 4.5 million were elderly and 13 million were children. Therefore, the 1988 legislation was targeted to those most in need. Major changes were made in a number of food programs other than food stamps, including the Temporary Emergency Food Assistance Act (TEFAP), commodities for soup kitchens and food banks and child nutrition programs.

This legislation was a compromise between the Emergency Hunger Relief Act which was introduced in March 1988, in both the House and Senate (H.R. 4060; S. 2123) and a later Senate bill, the Hunger Prevention Act of 1988 (S. 2560). The Senate bill called for liberalizations in eligibility and regulations for program access and the House proposed larger benefit increases. CBO estimates of the new spending authority for food stamps were estimated at $114 million in fiscal year 1989, $361 million in fiscal year 1990, $517 million in fiscal year 1991 with increasing amounts in later years. Among the most significant features of the new law were:

(1) Food stamp allotments would increase across-the-board in three stages to reach a total of 3 percent by fiscal year 1991. This would mean an increase of about $3 per person per month in addition to normal inflation adjustments.

(2) Benefit and eligibility rules were liberalized for those with high dependent care costs, the disabled, and families receiving Earned Income Tax Credits. Dependent care expenses

(as a "deduction" from countable income) were increased from $160 per household per month to $160 per dependent per month. Disabled individuals receiving State and local medical assistance or welfare benefits under standards as strict as those for Social Security disability will be eligible for more liberal treatment of their shelter and medical expenses. The Hunger Prevention Act also stipulated that income received as "advance payment" of families' Earned Income Tax Credit be disregarded.

(3) Special eligibility benefits were extended to farm households which included those with irregular business expenses to average their income for food stamp determinations of monthly income. Farm assets would be allowed to be disregarded for up to 1 year after a farmer ceases farming and special training was authorized for food stamp office staff who work with farm households.

(4) Twelve amendments were also added to make it easier to apply for and to get food stamps. These included: (1) Federal matching funds of 50 percent for optional State "outreach" activities to inform low-income persons about food stamps. (2) Encouragement of simplified application forms. (3) Requirement that food stamp applicants be given a clear written explanation of necessary procedures for verification. (4) Transportation or other assistance for rural residents. (5) Optional application procedures to coordinate with cash welfare programs. (6) State option to require monthly reporting of household circumstances. (7) Easier access and contact with food stamp offices. (8) Training for volunteer and nonprofit agency staff for screening food stamp applicants and providing information. (9) Easing of procedures to permit deductions for elderly and disabled with medical expenses. (10) Procedures to require correction of improper denials and terminations. (11) Required "conciliation" of disputes between applicant/recipient households and food stamp offices. (12) If an applicant applies late in the month, 2 months of benefits are to be issued if amount of first month benefit is less than a half-month.

(5) State designed and operated training and employment programs will be allowed to expand to include new programs such as basic education. Criteria for State programs will be based, by 1991, on results, such as job placement, rather than on participation rates. Increased support for participants' child care expenses is also required with 50 percent Federal cost-sharing.

The Hunger Prevention Act also incorporated a restructuring of the food stamp quality control system for sanctions against States beginning with "errors" for fiscal year 1986. The total amount of assessments, $400 million, will drop to $100 million and the sanction collection process will be streamlined and made more enforceable. Sanctions will be placed on underpayment errors as well as overpayments.

The new quality control system, the Payment Accuracy Improvement System (PAIS), is designed to reduce underpayments as well as overpayments and sanction or reward only States with extreme error rates. States will be classified according to their combined un-

derpayment as well as overpayment error rate. "Tier 1 States," with a combined error rate below 6 percent, will receive increased Federal funding for their administrative costs. "Tier 2 States," which includes most of the States, with combined error rates above 6 percent and below the national average, about 10 percent, plus 1 percent, must develop "corrective action plans" for reducing their error rate. "Tier 3 States" will be sanctioned according to a formula based on their erroneous benefits.

Food stamp provisions included in the House-passed Family Welfare Reform Act (H.R. 1720) were not included in the final version of welfare reform passed by Congress in September 1988, the Family Security Act (H.R. 1720), and signed into law on October 13, 1988 (P.L. 100-485). The Senate bill did not have any food stamp provisions and many of the House provisions were included in the Hunger Prevention Act. The high cost of the House package was also a factor in its exclusion from the final welfare reform compromise legislation.

D. REGULATORY AND JUDICIAL ACTION

A U.S. Supreme Court decision in 1988 upheld current law in the case of *United Auto Workers and United Mine Workers* v. *Lyng.* This case challenged the food stamp rule that renders an entire household ineligible for food stamps if the household contains a member who is on strike. USDA challenged a lower court decision which held in favor of the unions. The constitutional issues concern denying strikers equal protection under U.S. labor law as this rule lays a heavier penalty than other food stamp rules on those who don't fulfill work rules because it penalizes the entire household rather than the individual.

E. PROGNOSIS

In the 101st Congress, any significant modifications to the Food Stamp Program will likely be deferred until 1990, when all of the domestic food programs will be reauthorized under the umbrella of a new farm bill. Several outstanding issues may, however, be addressed in 1989. The first concerns the number of studies documenting generally low participation rates, which are lower than the average for the elderly. Congressional attention may return to consideration of more significant legislative changes in the Food Stamp Program to simplify administration and make it easier to apply for and participate in the program. Another issue concerns the $300 million backlog of fiscal sanctions prior to 1986 in the quality control program. If legislative changes are made to reform the quality control program of the Aid to Families with Dependent Children program (AFDC), the Food Stamp Program's sanction backlog could be reduced substantially.

Chapter 7

HEALTH CARE

OVERVIEW

As it did during the first session of the 100th Congress, debate on the Medicare Catastrophic Coverage Act of 1988 largely dominated health care policy discussions in 1988. Because the legislation started out on a fast track in January 1987, it surprised many health care and aging advocates that the bill was not signed into law until July 1, 1988. This culminated 18 months of serious Congressional debate on ways to expand the Medicare Program to meet at least some of the catastrophic health care needs of Medicare beneficiaries. General concerns about the costs of the new benefits and specific concerns about the costs of including a prescription drug benefit within the legislation were the primary reasons for the delay on final actions on arguably the largest overhaul of the Medicare Program since its enactment in 1965.

In the health care arena, the second session of the 100th Congress was as notable for what did not happen as it was for what did. For the first time since President Reagan had taken office, his budget proposal was not considered "dead on arrival." Moreover, the Congress was not forced to pass separate omnibus reconciliation and continuing appropriations resolution measures because, for the first time in 12 years, the Congress passed and the President signed into law all 13 appropriation bills without having to pass a short-term continuing resolution. These events were largely the result of the 2-year budget compromise produced by the fall 1987 budget summit and the fact that a Presidential election year was viewed as an inopportune time for advocating overly controversial budget reduction proposals, particularly proposals that would significantly and negatively affect such an active voting population as older Americans.

One of the greatest unmet challenges to Congress in 1988 continued to be the need to rein in health care costs to help reduce substantial Federal deficits while assuring older Americans access to affordable, high quality health care. The deficit reduction pressures played the central role in assuring that the new catastrophic health care law had to be self-financed by Medicare beneficiaries to obtain sufficient Administration and Congressional support to ensure its passage. Similarly, every other health issue affecting the elderly continued to be framed in terms of its effects on the Federal budget.

Other particularly important health issues raised during the second session of the 100th Congress included additional attention on the need to reform Medicare reimbursement to physicians and

to develop better policy approaches to assuring access to health care in rural areas. The long-awaited release of the Hsiao report on physician payment reform proved at least partly anticlimactic as the report's author acknowledged that his methodology had shortcomings and the Physician Payment Review Commission concluded that any reform package could not be implemented until 1991. A Senate Aging Committee report on rural health care capped off a multi-month committee examination of the numerous problems of and possible solutions to assuring access to quality health care in rural communities. In addition, the importance of assuring the future stability of employer-provided retiree health benefits and maintaining the Federal Government's commitment to geriatric research and training was again a focus of committee and Congressional consideration.

A. MEDICARE

1. Background

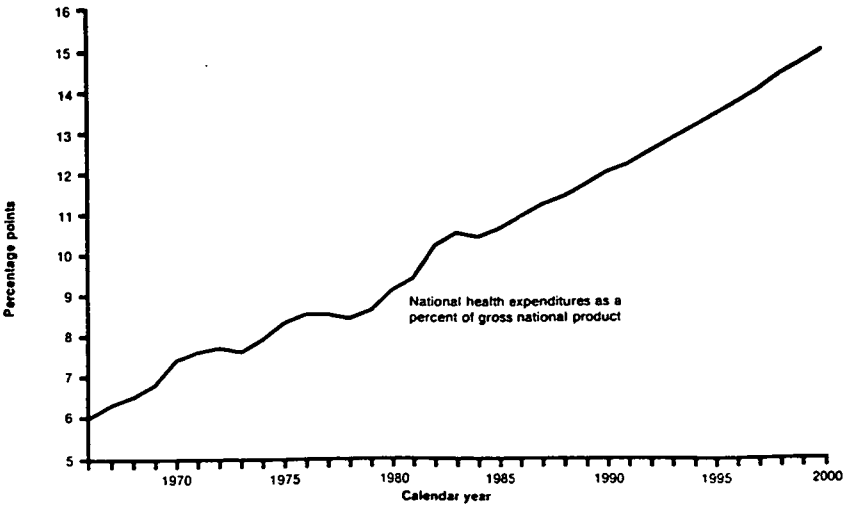
(a) Health care costs

Prior to the mid-1970's, cost of care was not a major issue among health specialists. 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 type of "bang" the Nation was getting for its bucks. Between 1965 and 1987, national health expenditures increased from nearly $41.9 billion (5.9 percent of gross national product) to $500.3 billion (11.1 percent of GNP).[1] (See chart 1.) Even given today's apparent slower rate of increase, health care expenditures are expected to reach $647.3 billion (12 percent of GNP) by 1990, and $1.53 trillion (15 percent of GNP) by the year 2000. (See chart 2.)

[1] U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates. October 1988.

CHART 1

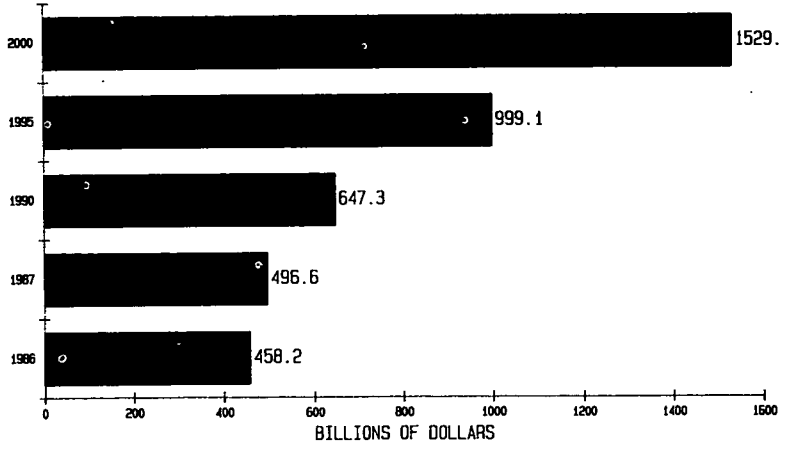
Percent change in national health expenditures as a percent of gross national product: Calendar years 1966-86 and projections 1987-2000



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

CHART 2

NATIONAL HEALTH SPENDING
1986-2000

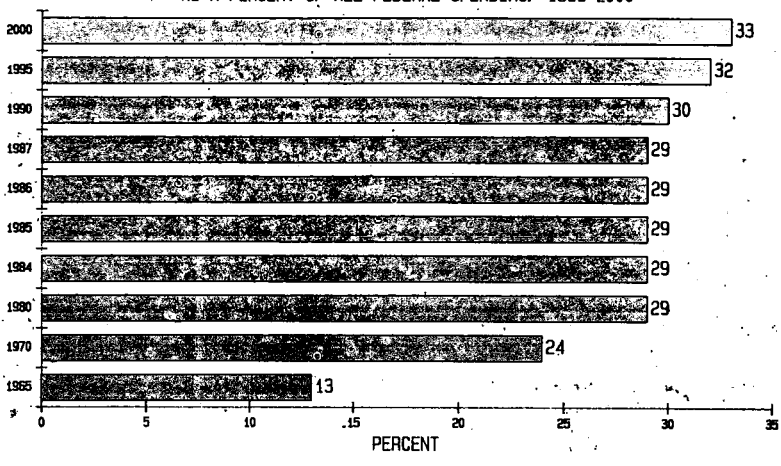


Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

The role of the Federal Government as a payer for health services has grown along with the overall increases in health care costs. In 1965, the Federal Government paid $5.5 billion (13.2 percent) of the Nation's health bill compared with $144.7 billion (28.9 percent) of national health expenditures in 1987. The Federal Government's share of the national health bill is projected to rise to $195—5 billion (30.2 percent) in 1990, $498.6 billion (33 percent) by 2000. (See chart 3.).

CHART 3

FEDERAL SPENDING ON THE NATION'S HEALTH
AS A PERCENT OF ALL FEDERAL SPENDING: 1965-2000

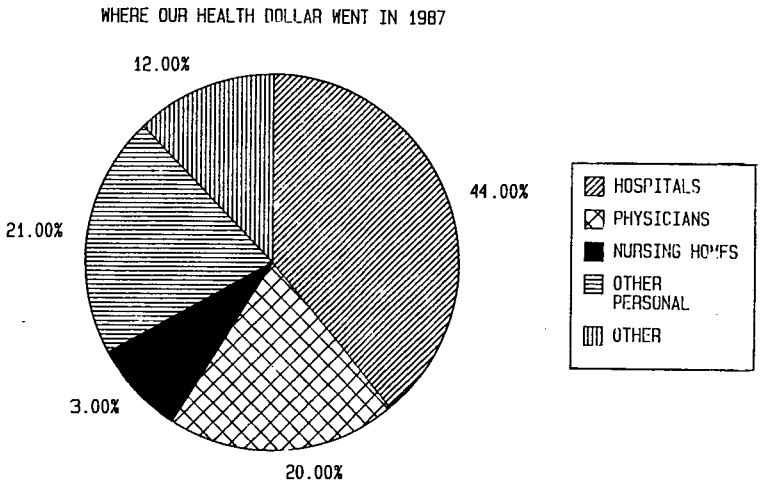


Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

Hospital care costs continue to be the largest component of the Nation's health care bill. In 1987, 44 percent ($194.7 billion) of the $442.6 billion spent on personal health care was paid to hospitals.

During the same year, physicians were paid $102.7 billion or 20 percent of total expenditures for health care. (See chart 4.)

CHART 4



Source: National Health Expenditures, 1986-2000, Health Care Financing Review, Summer, 1987

Throughout the last two decades, the structure and delivery of health care have been plagued by perverse incentives, resulting in the overutilization 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 for Medicare reimbursement of hospitals, at the time the most dramatic change in Medicare since its enactment.

Prospective payment system.—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 473 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.

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. 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, it seems fair to say that the overriding concern influencing the Nation's health care system is cost containment.

Trends in health care inflation.—Looked at in terms of nominal dollars (dollars not adjusted for inflation) the Nation's cost containment efforts seem to be working. In 1987, the total health care expenditures rose 9.8 percent to $500.3 billion from $455.7 billion in 1986, in nominal dollars.[2] This was the fourth consecutive annual increase in the past 20 years, that has been below the 10 percent rate of growth achieved during the economic stabilization program in 1973 when some price increases were constrained artificially.

Most analysts attribute the slowdown in the growth of health care costs to a number of factors—not simply cost containment measures alone. According to DHHS, the slowdown also has resulted from a low rate of inflation in the economy and changing patterns of demand for services, in particular a decline in the use of hospital inpatient services.

The optimistic reports on cost containment efforts aside, however, it may be possible that health care expenditures actually may be escalating faster than in the 1970's. According to Uwe Reinhardt, one of the Nation's leading health economists, Americans have been fooled into thinking that cost hikes are moderating. Reinhardt points to the fact that, "relative to the overall consumer price index, the prices of health services rose much more rapidly after 1980 than they did in the late 1970's." [3] Furthermore, the 9.8 percent increase in total health care expenditures discussed above was the highest increase in the past 4 years, while the lowest was 7.9 percent in 1985. Therefore, while the years following the initiation of PPS may show some immediate cost containment, they may not be an indication of long-term PPS cost containment.

Even more disturbing than the possibility that we have not yet harnessed spiraling health care costs is the fear that existing cost containment initiatives may be exacting a toll in other parts of the health care delivery system. Pressures to reduce costs and make health care delivery more efficient may actually reduce access to and diminish the quality of health care.

This country may, in fact, be faced with a difficult tradeoff. Given an economy struggling under huge budget deficits, the goals

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[2] Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates. October 1988.

[3] Reinhardt, Uwe, How "Money Illusion" May Have Saved the American Health Sector from Starvation (so far), 1986.

of "unlimited access" and "highest possible quality" are becoming more difficult to achieve. This presents Americans with the dilemma of deciding how, in a period of limited national resources, to assure access to the health care system while preserving its quality.

(B) HEALTH CARE UTILIZATION

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 and affects an individual's use of health services. Women over 65 tend to report better health than do men in the same age group.

Chronic diseases are a major threat to the independence of older persons. Arthritis, hypertension, heart conditions, and hearing disorders are leading chronic conditions among the noninstitutionalized elderly. Hospitalization of most older persons is caused by an acute episode of a chronic illness. Visits to the doctor also are most often for treatment of chronic conditions.

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.

(1) Hospital Utilization

Short hospital stays by the elderly increased by more than 57 percent between 1965 and 1986. Since 1985, admissions for elderly patients have decreased. In 1986, a survey of non-Federal short-stay hospitals revealed that 10.7 million elderly patients were discharged from hospitals, comprising 31.3 percent of all short-stay hospital patient stays. Those 75 and older accounted for 16.3 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 8.9 days in 1987.

Older persons tend to stay in the hospital approximately 50 percent longer than and twice as often as the general population. The hospital discharge rate for those 85 and older was 91 percent higher than that for the 65–74 age group. The average hospital stay for persons 65–74 was about 8 days in 1986 compared with 9.2 days for the 85 and older group.

(2) Use of Physicians' Services

Utilization of physicians' services increases with age. Approximately four out of five elderly living in the community had at least

one contact with a physician in 1986. On average, the elderly are more likely than younger persons to make frequent visits to a physician. Persons 65 and older visit a physician six 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.[4]

Approximately three-quarters of physician visits by the elderly are made to a doctor's office. The remaining visits are divided among hospital emergency rooms, outpatient offices, and home and telephone consultations.

The aging of the population will increase the demand for physician care. Projections show that demand will increase by 22 percent from 250 million physician contacts to 305 million contacts by the year 2000 and by 125 percent (more than 562 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 subtantial 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.

(3) Use of Home Health Services

Home health care has been one of the most rapidly growing Medicare benefits. There has been rapid growth in the number of participating agencies (from 3,000 in 1981 to more than 5,700 currently) as well as the volume of visits and services provided. Growth has begun to level off as a result of efforts by the Health Care Financing Administration to curtail growth. (See table 1.)

TABLE 1.—MEDICARE HOME HEALTH SERVICES

	Persons served (thousands)	Number of persons served per 1,000 enrollees	Total reimbursements (millions)	Total visits (millions)	Number of visits per 1,000 enrollees
Year:					
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

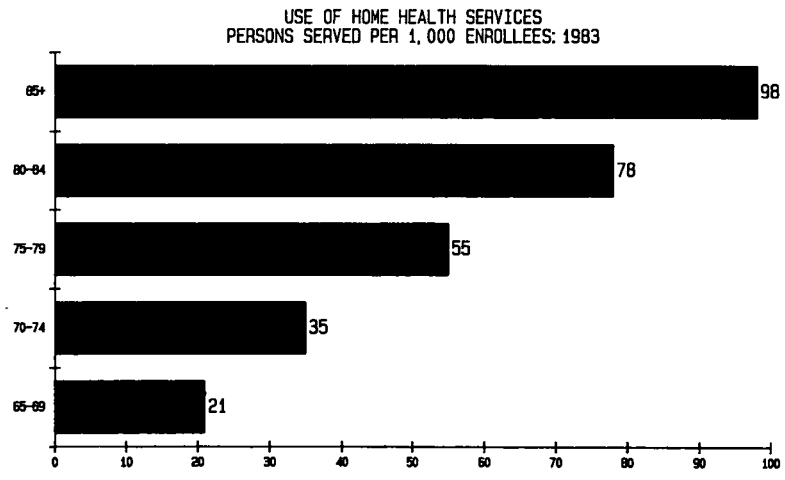
Source: Health Care Financing Administration.

[4] U.S. Senate Special Committee on Aging, America in Transition: An Aging Society. Washington, D.C., U.S. Govt. Print. Off., 1987–88 edition, p. 117.
[5] Ibid.

The increase in home health utilization stems in part from legislative changes adopted in 1980 that removed certain payments, coverage, and participation restrictions from the home health benefit. Additionally, implementation of the prospective payment system in 1983, with its incentives for more efficient management of health care resources, resulted in a significant drop in hospital lengths of stay and prompted a transfer of care from inpatient hospital settings to a variety of outpatient settings, including home health agencies. The decrease in home health utilization since 1985 may be a reflection of more stringent eligibility criteria.

The increasing lifespan, the aging of the elderly population, and the continuing advances in medical technology all suggest that more elderly Americans will suffer chronic conditions that limit their daily activities. Older Americans with chronic conditions will require extensive health care services, including home health care. It should be noted, however, that Medicare will only cover those home health services where a need for skilled nursing care or physical or speech therapy can be demonstrated. Most chronically impaired persons do not need skilled care to remain in their homes. Instead, they require nonmedical supportive care and assistance with basic self-care functions and daily routines that do not require skilled personnel. In 1986, Medicare beneficiaries over 85 were nearly four times more likely to receive home care services than Medicare beneficiaries aged 65–69. As the "old-old" population (those older than 85) increases, home care demand and utilization also will increase significantly. (See chart 5.)

CHART 5



Source: Marian Gornick et. al., "Twenty Years of Medicare and Medicaid," Health Care Financing Review, Annual Supplement

(4) Use of Disease Prevention Services

Utilization of disease-prevention services by the elderly varies by type of service. For example, elderly persons visit dentists less often than the younger population. In 1986, only 43 percent of those over 65 used dental care, while 59 percent of the general population did. Presently, older persons do not receive sufficient preventive or therapeutic dental care. It is estimated that almost one-third of the population is likely to lose some or all of their teeth between the ages of 50 and 70, primarily because of periodontal disease.

In contrast to the low incidence of dental care, 41 percent of the elderly in 1979–80 had one or more eye-care visits compared with 24 percent of those under 65. This percentage almost certainly would be higher if Medicare covered optical services and products.[6]

Many of the chronic conditions of the elderly are strongly associated with personal health habits. In general, there is only fragmented evidence that links changes in the health habits of older persons to reduce risk of disease. The most dramatic example of a behavior change that produces positive effects on health is cessation of cigarette smoking, which is a major risk in cardiovascular diseases and selected cancers. When a person of any age stops smoking, the benefits to the heart and the circulatory system begin right away. The risk of heart attack and stroke drops and circulation to the hands and feet improves. Nonsmokers also have a lower risk of contracting influenza and pneumonia, which sometimes can be life-threatening diseases for older persons.

(5) Health Care Expenditures of the Elderly

Persons 65 and older, 12 percent of the population, account for a third of the Nation's total personal health care expenditures. These expenditures represent total health care investment from all sources exclusive of research. In 1984 (the latest data currently available), total personal health care expenditures for the elderly were $120 billion (tables 2 and 3) and per capita spending reached $4,200. That represented a 13-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.

TABLE 2.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
1984:					
Total per capita	100.00	100.00	100.00	100.00	100.00
Private	32.8	11.4	39.7	51.9	65.3
Consumer	32.4	11.0	39.6	51.2	64.8
Out-of-pocket	25.2	3.1	26.1	50.1	59.9

[6] Ibid., p. 123.

TABLE 2.—PERCENT DISTRIBUTION OF PERSONAL HEALTH CARE EXPENDITURES PER CAPITA FOR PEOPLE 65 YEARS OF AGE OR OVER, BY SOURCE OF FUNDS AND TYPE OF SERVICE: UNITED STATES, 1984—Continued

Year and source of funds	Type of service				
	Total care	Hospital	Physician	Nursing home	Other care
Insurance	7.2	7.9	13.5	1.1	4.9
Other private	.4	.4	.0	.7	.5
Government	67.2	88.6	60.3	48.1	34.7
Medicare	48.8	74.8	57.8	2.1	19.9
Medicare	12.8	4.8	1.9	1.5	11.4
Other government	5.6	9.1	.7	4.4	3.4

TABLE 3.—DISTRIBUTION OF PER CAPITA PERSONAL HEALTH CARE EXPENDITURES FOR PEOPLE 65 YEARS OF AGE OR OVER, BY TYPE OF SERVICE AND SOURCE OF FUNDS: UNITED STATES, 1984

Year and source of funds	Total per capita	Type of service				
		Total care	Hospital	Physician	Nursing home	Other care
1984:						
Total per capita	$4,202	100.0	45.2	20.7	20.9	13.2
Private	1,379	100.0	15.7	25.0	33.1	26.2
Consumer	1,363	100.0	15.3	25.3	33.1	26.3
Out-of-pocket	1,059	100.0	5.6	21.4	41.6	31.3
Insurance	304	100.0	49.2	38.6	3.3	8.9
Other private	16	100.0	42.1	1.9	39.1	17.0
Government	2,823	100.0	59.7	18.6	15.0	6.8
Medicare	2,051	100.0	69.2	24.5	.9	5.4
Medicare	536	100.0	17.0	3.1	68.1	11.8
Other government	236	100.0	73.2	2.4	16.5	7.9

Source: Waldo, Daniel R., Lazenby, Helen C.; Demographic Characteristics and Health Care Use and Expenditures by the Aged in United States: 1977–84, "Health Care Financing Review," vol. 6, No. 1, fall 1984.

(6) Health Care Expenditures by Source

(a) Hospital

Hospital care for the aged was projected to cost $54 billion in 1984; this is an amount equal to $1,900 per capita. Medicare will reimburse about 74 percent of that total while other public funds will pay about 15 percent of the bill. Private health insurance will cover 8 percent of the costs and the remaining 3 percent will be paid out-of-pocket.[7]

(b) Physician services

Spending for physician services to the elderly grew an average of 18 percent per year from 1977 to 1984, reaching a projected level of $24.8 billion for 1984.[8] The growth in patient days spent in the hospital by the elderly (3-percent increase per year during the period 1977–83) largely accounts for the increase in physician services and

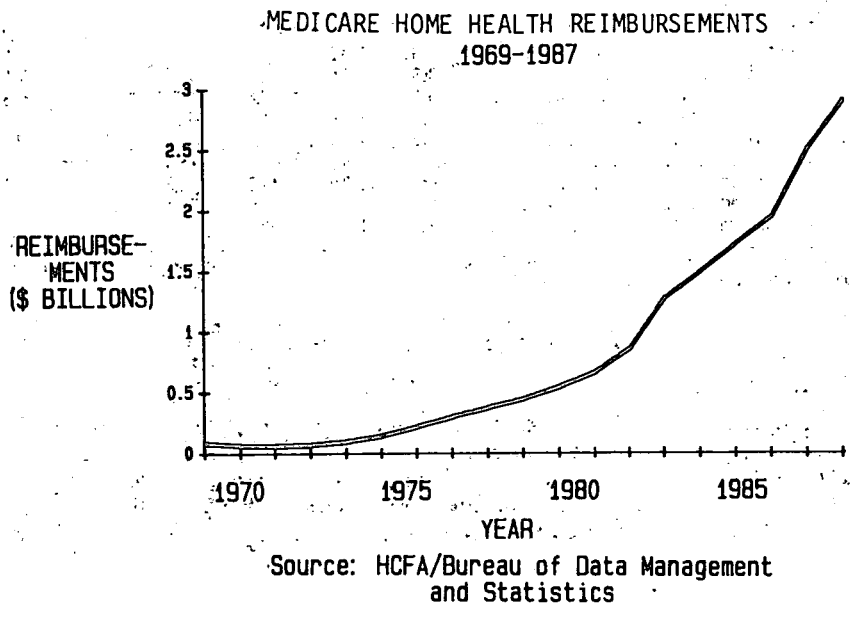
[7] Waldo, Daniel R. and Helen C. Lazenby. Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977–1984. Health Care Financing Review. Vol. 6, No. 1, Fall, 1984, p. 12.
[8] Ibid., p. 13.

costs. More recent increases may be partly attributable to substitutions of ambulatory services for inpatient care. Some people also speculate that physicians have increased the number of services they provide to make up for limitations on Medicare payment increases.[9]

(c) Home health services

As a percentage of total Medicare expenditures, the amount of reimbursement for home health care has been small. According to the Health Care Financing Administration, Medicare payments for home health care comprise a relatively small 3.1 percent of total program outlays. For fiscal year 1988, total reimbursements for Medicare home health services were projected to $2.6 billion. Chart 6 indicates however, that Medicare's home health benefit expenditures are one of the fastest growing components of the Medicare Program.

CHART 6



(C) MEDICARE PROGRAM DESCRIPTION

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 1988, Medi-

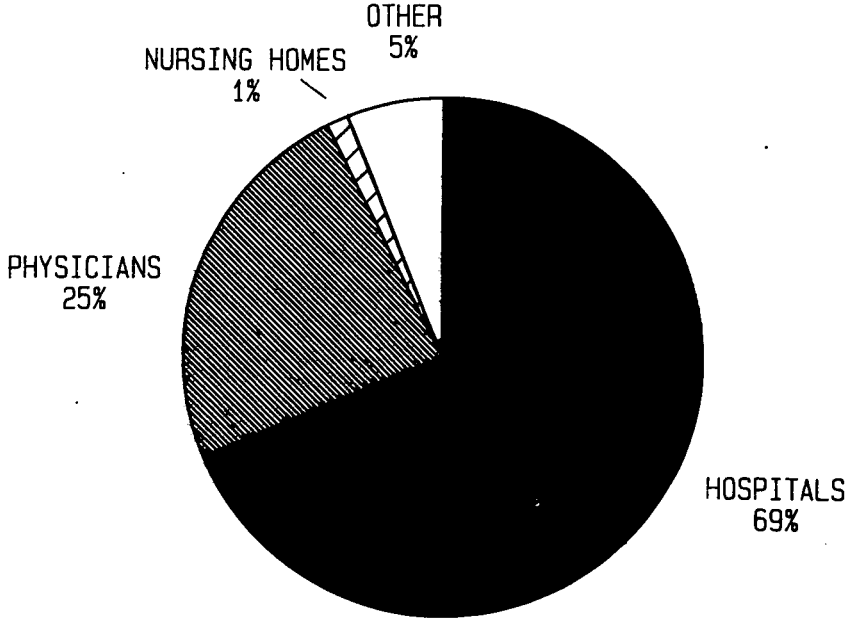
[9] Ibid.

care insured 29 million aged and 3 million disabled individuals. At a fiscal year 1988 estimated cost of $85.6 billion, Medicare is the second most costly Federal domestic program, exceeded only by the Social Security program.

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 (see chart 7). However, until the enactment of catastrophic health care legislation, Medicare did not cover the hospital costs of extended acute illnesses and did not protect beneficiaries against potentially large co-payments or charges above the Medicare payment rate for physician services. These shortcomings in Medicare's coverage of acute illness costs have led two-thirds of older Americans to purchase supplemental private coverage, often referred to as medigap coverage.

CHART 7

WHERE THE MEDICARE DOLLAR GOES: 1985



SOURCE: Health Care Financing Administration, Office of Financial and Actuarial Analysis

Authorized under title XVIII of the Social Security Act, Medicare 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 transplanta-

tion 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).

(1) Hospital Insurance Program (Part A)

Part A is financed principally through a special hospital insurance payroll tax levied on employees, employers, and the self-employed. During 1988, each worker and employer paid a tax of 1.45 percent on the first $43,800 of covered employee earnings. The self-employed pays both the employer and employee shares. In 1989, each worker and employer will pay 1.45 percent on the first $48,000 of covered earnings.

In calendar year 1987, payroll taxes for the HI Trust Fund amounted to $58.6 billion, accounting for 91.5 percent of all HI income. Interest payments equaled 7 percent of all HI income while the remaining 1.5 percent consisted primarily of transfers from the Railroad Retirement Account and the general fund along with premiums paid by voluntary enrollees. Of the $50.3 billion in HI disbursements, $49.5 billion was for benefit payments while the remaining $800 million (1.6 percent) was spent for administrative expenses.

(a) Catastrophic health care provisions

In 1988, the benefits and, to a smaller extent the financing, of the Medicare Program were overhauled. On July 1, 1988, President Reagan signed the Medicare Catastrophic Coverage Act of 1988 into Public Law 100-360. The following are highlights of the major provisions of the Medicare Catastrophic Coverage Act of 1988 as it relates to Part A of the program. (A summary of the new Part B benefits can be found in the next section and an extensive discussion of the development of the catastrophic health care legislation can be found in the Issues and Legislative Actions section of this chapter.)

Effective date.—The new Part A benefits become effective January 1, 1989.

Inpatient hospital services.—Specifies a maximum of one hospital deductible per year ($560 in 1989) and eliminates the day limits, coinsurance charges, and spell of illness provisions.

Skilled nursing facility (SNF) services.—Requires daily coinsurance payments for the first 8 days equal to 20 percent of the national average Medicare reasonable cost for SNF care (estimated at $20.50/day in 1989); eliminates coinsurance charges for 21st–100th days; adds coverage for up to 150 days and eliminates prior hospitalization requirement.

Home health services.—Expands the "intermittent" skilled nursing care definition so that "daily" care is defined as up to 7 days a week for 38 days (instead of 5 days a week for up to 2 or 3 weeks).

Hospice services.—A beneficiary may elect to receive services for two 90-day periods and one subsequent 30-day period during his or her lifetime. Beneficiaries making this election must choose to re-

ceive services through a hospice and give up most other Medicare benefits. This election may be revoked. The Medicare Catastrophic Coverage Act provides for a subsequent extension period beyond the current 210-day limit, if the beneficiary is recertified as terminally ill.

(2) Supplementary Medical Insurance (Part B)

Part B of Medicare, also called supplementary medical insurance, is a voluntary program financed jointly through monthly premium charges ($24.80 in 1988 and $27.90 in 1989—excluding the new catastrophic health care $4 flat premium) on enrollees and Federal general revenues. Under current law, premiums cover 25 percent of program costs and 75 percent are funded from general revenues. Part B (with certain exceptions) pays 80 percent of reasonable charges for the following covered services after the insured meets a $75 annual deductible through costs incurred from physician and other professional services, diagnostic tests, medical devices, outpatient hospital services, and laboratory services.

In 1987, approximately 31.1 million people were covered under Part B. General revenue contributions totaled $23.6 billion, accounting for 74 percent of all income. Another 23.3 percent of all income was derived from premiums paid by participants, with interest payments accounting for the remaining 2.7 percent. Of the $31.7 billion in disbursements, $30.8 billion (97.1 percent) was for benefit payments while the remaining $900 million (2.9 percent) was for administrative expenses.

(a) Physician reimbursement

Medicare pays physicians the "reasonable" or "approved" charge rate for their services, less the deductible and the copayment. The reasonable charge levels for a service have been determined through a method referred to as customary, prevailing, and reasonable (CPR). Under CPR, payment for each service is limited to the lowest of: (1) the physician's actual bill for the service; (2) the physician's customary charge for the service, or (3) the prevailing charge for the service in that community. (Increases in the prevailing charge are limited by the Medicare economic index.) To control ever-increasing Part B program expenditures and 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.

A number of incentives have been implemented to encourage physicians to sign participation agreements. These include higher prevailing charge screens, more rapid claims payment, and widespread distribution of participating physician directories. As of April 1988, 37.3 percent of doctors were participating physicians.

To ensure that limitations on Medicare payments do not result in higher out-of-pocket costs for beneficiaries, the actual charges of nonparticipating physicians are limited during a 4-year period beginning on January 1, 1987. Under the maximum allowable actual charge (MAAC) limits, nonparticipating physicians with actual charges in excess of 115 percent of the prevailing charge are limited to a 1 percent annual increase in their actual charges. Nonparticipating physicians with lower actual charges may increase their charges at a more rapid rate.

(b) Catastrophic health care provisions

The Medicare Catastrophic Coverage Act of 1988 made extensive revisions to the Part B benefit. The benefit changes, as well as the new law's financing mechanism, are summarized below.

Effective date.—The start-up date for implementations of the new benefit is January 1, 1989.

Limitation on out-of-pocket expenses.—Establishes a maximum out-of-pocket limit (the "catastrophic cap") on beneficiary liability for Part B cost-sharing charges after which Medicare will pay 100 percent of the approved amount. The limit is set at $1,370 in 1990; it is indexed so that a constant 7 percent of beneficiaries would be eligible for this catastrophic benefit each year.

Prescription drugs.—Establishes, effective January 1, 1990, a limited prescription drug benefit for home intravenous (IV) drugs and immunosuppressive drugs furnished after the first year following a transplant (they are already covered in the first year). The deductible is $550 in 1990; the coinsurance is 20 percent for home IV drugs and 50 percent for immunosuppressives. Provides coverage, beginning January 1, 1991, for all outpatient prescription drugs, subject to a $600 deductible and 50 percent coinsurance charges. The deductible is slated to go to $652 in 1992 and be indexed in future years so that 16.8 percent of beneficiaries would reach the deductible each year. The coinsurance is slated to be lowered to 40 percent in 1992 and 20 percent in 1993.

Medigap policies.—Amends procedures for Federal certification of medigap policies. Applies the National Association of Insurance Commissioners (NAIC) revision of medigap minimum standards for purposes of Federal certification. Policies sold before enactment, but still in effect on January 1, 1989, will not be deemed to duplicate Medicare's new benefits if they comply with the NAIC model transition rule which provides for refunds, or premium adjustments, when appropriate, for duplicate portions. Requires a one-time notice to be sent to policyholders by January 1, 1989, on the new benefits, how they affect the policy's benefits and premiums, and any adjustments that will be made.

Federal employees.—Requires the Director of the Office of Personnel Management (OPM) to reduce, effective January 1, 1989, the rates charged to medicare-eligible individuals participating in the Federal Employee Health Benefits Program (FEHBP) to reflect the amounts that would have been paid by those plans designed specifically for Medicare-eligible individuals. (See also supplemental premium tax deduction below.)

Maintenance of effort.—Any employer who provides health benefits to an employee or retired former employee (including State and

local employees) that duplicate at least 50 percent of the new or improved Part A and Part B benefits would have to provide additional benefits or refunds that total at least the actuarial value of the duplicative benefits. The provision is effective with respect to Part A benefits in 1989 and Part B benefits in 1990 except that an extension is provided to cover current collective bargaining agreements.

Medicaid.—Mandates States, on a phased-in basis, to pay Medicare premiums, deductibles, and coinsurance for elderly and disabled individuals with incomes below the poverty line. Also, in the case of a couple where one member is institutionalized, the bill provides protection of a portion of the couple's income and resources for maintenance needs of the community spouse.

Respite care.—Provides coverage for in-home care for a chronically dependent individual for up to 80 hours per year. The benefit is only available for persons who meet either the catastrophic cap or the outpatient prescription drug cap.

Mammography screening.—Establishes a new Medicare benefit. Screenings for women over 65 would be covered every other year, subject to a maximum payment per screening of $50 in 1990 (indexed in future years).

(c) Catastrophic coverage financing

The law is financed through a combination of (1) an increase in the monthly Part B premium for all Part B enrollees, and (2) a new supplemental premium that is mandatory for all those entitled to Part A who have Federal tax liability of $150 or more.

Part B premium.—Table 4 shows the new "flat" premiums together with the estimated current law Part B premiums. (The current law provision that prevents a reduction in Social Security benefits as a result of Part B premium increases is retained.)

TABLE 4.—PART B PREMIUM

	1988	1989	1990	1991	1992	1993
New		$4.00	$4.90	$7.40	$9.20	$10.20
Current law	$24.80	27.90	[1] 28.30	[1] 29.70	[1] 31.00	[1] 32.40
Total	24.80	31.90	33.20	37.10	40.20	42.60

[1] Congressional Budget Office estimate, June 1, 1988.

Supplemental premium.—The supplemental premium (collected in conjunction with the Federal income tax) is based on Federal tax liability (i.e., amount of taxes owed). Table 5 shows the rate per $150 of Federal tax liability and the maximum premium amount for the period 1989 through 1993.

TABLE 5.—SUPPLEMENTAL PREMIUM

	1989	1990	1991	1992	1993
Rate per $150 of tax liability	$22.50	$37.50	$39.00	$40.50	$42.00
Maximum annual premium [1]	800	850	900	950	1,050

[1] For married couples filing joint returns, the rate is the same, but the maximum supplemental premium is double the amounts shown above.

The supplemental premium is based on Federal tax liability. The joint tax committee has estimated the premium liability for persons at various income levels. A few examples are shown below in Table 6. It should be noted that the income levels shown include estimated income from all sources, including nontaxable income. (Most Social Security payments are nontaxable.) It should be emphasized that these are only examples. Each person's situation is different. An individual or couple with the same total income, but a different mix of taxed and nontaxed income and/or different deductions, will have a different supplemental premium. The tax committee has estimated the approximate income levels at which the maximum premium amounts would be reached. These are $40,000 for a single return and $65,000—$75,000 for a couple.

TABLE 6.—EXAMPLES OF LIABILITY FOR SUPPLEMENTAL PREMIUM, 1989

Single returns		Joint returns	
Income [1]	Premium	Income [1]	Premium
$3,468	$0	$3,053	$0
$12,455	0	17,341	0
$17,285	78	22,522	66
$22,112	198	27,808	131
$27,228	307	32,360	207
$32,607	371	37,460	311
$37,195	678	42,358	458
$43,286	800	47,400	653
		59,962	1,126
		85,751	1,600

[1] These income amounts are the average within various income ranges.

Source: Joint Committee on Taxation, June 9, 1988.

Adjustment for persons with governmental annuities.—For purposes of calculating the supplemental premium, a special adjustment is made for persons with taxable governmental annuities (including Federal, State, local annuities) and little or no Social Security income. This adjustment is designed to make the supplemental premiums for retirees with taxable governmental annuities more comparable to the premiums of retirees whose annuities are composed primarily of nontaxed Social Security benefits.

The adjustment takes the form of a reduction of the individual's tax liability amount solely for the purpose of calculating the supplemental premium. The reduction is calculated as follows for 1989:

—Take the lesser of (a) $6,000 ($9,000 for a joint return), or (b) the amount of the taxable governmental annuity,
—Subtract any Social Security benefits,
—Multiply the result by 15 percent, and
—Subtract the tax credit for the elderly and the disabled, if taken.

The resulting amount is then subtracted from the individual's tax liability, which forms the basis for the calculation of the supplemental premium. (After 1989, the $6,000 and $9,000 amounts will be increased by the Social Security cost-of-living adjustment.)

For example, in 1989 for a single Medicare beneficiary with a Federal annuity of $14,000, Social Security benefits of $4,000, and who is not eligible for the tax credit for the elderly and the dis-

abled, the reduction to their tax liability for purposes of calculating the supplemental premium would be:

($6,000 - $4,000 = $2,000) × 15 percent = $300

In effect, this $300 reduction would result in a $45 reduction in the supplemental premium in 1989 (i.e., ($300 divided by 150 = 2) × $22.50 = $45).

The maximum amount that could be subtracted from anyone's tax liability to calculate the supplemental premium for 1989 would be $900 for an individual, or $1,350 for a couple (both eligible for Medicare) filing a joint return. These reductions would result in maximum supplemental premium reductions of $135 for an individual, and $202.50 for a joint return.

(4) Peer Review Organizations

Hospitals are required to enter into agreements with peer review organizations (PRO's) as a condition for receiving payments under Medicare's PPS 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 (DHHS) is required to contract with PRO's. Organizations eligible for PRO contracts include physician-sponsored organizations, physician-access organizations, and health benefit payer organizations. PRO's 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 54 PRO contract areas. Each of the 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands are designated as separate PRO areas. Guam, American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands are considered to be in a single PRO area. In these 54 PRO areas, DHHS has contracted with 44 PRO's to review the care provided in those 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 procedure. 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 June 1986 and continues through the present, 2.29 percent of all reviewed discharges were denied on the basis of inappropriate admissions. To help ensure Medicare reimbursement, some States re-

quire physicians to call the PRO for preadmission and extended stay approval.

(5) The Health Maintenance Organization Benefit

During 1982 and 1983, DHHS awarded 26 Medicare demonstration program contracts to develop Medicare Health Maintenance Organizations (HMO's). 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 (CMP's) 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, Medicare pays participating organizations for services rendered. HMO's signing a risk contract agree to provide all defined services at the HMO's risk. In other words, the HMO is responsible for any cost overruns. The beneficiary who enrolls in a risk-contract HMO must receive all medical services except for emergency or urgently needed services from the HMO. This feature is referred to as the "lock-in" provision. Beneficiaries must pay for services received outside of the plan or those services that have not been authorized by the HMO. Neither the HMO's nor Medicare are responsible for payment of out-of-plan services.

The formula used to determine the 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. HMO's receive 95 percent of the AAPCC, thereby saving Medicare 5 percent on each Medicare HMO enrollee. HMO's also are permitted to charge beneficiaries a monthly premium equal to the value of traditional Medicare deductibles and copayments. (In contrast, HMO's, which contract out with Medicare under a "cost" contract, are paid on a prospective basis, and are reimbursed for cost overruns.)

In January 1988, there were 1,169,684 Medicare beneficiaries enrolled in TEFRA risk or cost contracts with HMO's or CMP's. This figure represents about 3.8 percent of the total Medicare population. At that same time, 155 risk contracts and 32 cost contracts were in effect, with another 27 risk contract applications pending. (An additional 566,491 beneficiaries were enrolled in prepaid plans under arrangements other than TEFRA contracts.)

(D) SUPPLEMENTAL HEALTH COVERAGE

At its inception, Medicare was not designed to cover its beneficiaries' total health care expenditures. Several types of services are not covered at all while others are partially covered and require

the beneficiary to pay deductibles, copayments, and coinsurance. Medicare consistently has covered approximately half of the total medical expenses for noninstitutionalized, aged Medicare beneficiaries. Other health care expenditures remain to be covered by Medicaid, private supplemental health insurance, and other sources.

In 1987, 68 percent of the noninstitutionalized Medicare population (including 71 percent of the noninstitutionalized aged) had private insurance to supplement Medicare's coverage.[10] This insurance was either through individually purchased plans, generally referred to as medigap plans, or was provided by or through current or former employers. There are substantial differences in the costs and coverage offered by various plans. The principle protection offered by the majority of Medigap policies is coverage of Medicare's deductible and coinsurance charges. Some policies cover a limited number of additional services, for example prescription drugs. Few policies offer protection against institutional care—potentially the most costly service item.

Approximately 22.6 percent of the noninstitutionalized Medicare population (22 percent of the noninstitutionalized aged) had no other health insurance coverage in 1987. According to an earlier DHHS review, the uncovered population includes a significant portion of poor and near poor elderly not covered by Medicaid.

Private insurance purchased by the elderly generally concentrates its coverage on the uncovered costs, of services such as copayments and deductibles that otherwise are covered by Medicare. For instance, in 1977, 97.6 percent of all privately insured elderly persons with Medicare coverage had supplemental coverage for hospital inpatient services. However, only 40.6 percent had coverage for out-of-hospital prescription drugs.

Section 1882 of the Social Security Act, added by Public Law 96-265, established standards for medigap policies requiring that they provide at least a minimum level of benefits. This was accomplished through the use of loss ratios—minimum expected levels of benefit payouts. Medigap policies sold to individuals must have an anticipated return to policyholders as benefits of at least 60 percent of the premiums collected. This minimum loss ratio was set at 75 percent for policies sold to groups. In addition, section 1882 established Federal criminal penalties for engaging in abusive and duplicative sales and marketing practices for medigap policies.

The statute incorporated the model regulatory program of the National Association of Insurance Commissioners, setting forth two procedures for determining whether insurance policies meet the Federal standards. First, the statute established that if a State had adopted laws or regulations that are at least as stringent as the Association's model and the Federal loss ratio requirement, policies regulated by the State are deemed to meet the Federal requirements. Second, the statute established a voluntary certification program under which insurance companies could market policies as medigap insurance in States that do not have laws or regulations equivalent to the Association's model. (This statute was revised by the Medicare Catastrophic Coverage Act of 1988 to ensure that the

[10] Preliminary Congressional Budget Office (CBO) tabulations for 1987 data from the March 1988 Current Population Survey.

NAIC standards were updated.) Under such a system, insurers can submit policies and supporting documentation to the Secretary of Health and Human Services. If the Secretary determines that a submitted policy meets Federal requirements, it is certified and can be marketed as a medigap plan.

According to a 1986 GAO study of the medigap market,[11] all but four States had adopted medigap insurance regulatory programs at least as stringent as National Association of Insurance Commissioners. This has resulted in more uniform regulation of medigap insurance and increased protection for the elderly against substandard or overpriced policies. Most large commercial insurers, with premiums of $50 million or more, met the loss ratio requirements of section 1882. However, more than 60 percent of the commercial insurance policies with premiums under $50 million had not met those requirements. The aggregate figures for all individual policies studied by the GAO showed that about 60 cents of every premium dollar was returned as benefits or added to reserves.

Of 142 policies studied by the GAO, the loss ratios of most policies were below the section 1882 targets. However, the loss ratios of both Blue Cross/Blue Shield plans and Prudential Life Insurance usually were above the targets. This is important because these policies are the most frequently purchased. In 1984, the Blue Cross/Blue Shield plans had an aggregate loss ratio of 81.1 percent while the Prudential plans had a loss ratio of 77.9 percent.

While the loss ratio is a useful guideline to determine if the benefit level is adequate, it is not a requirement. Therefore, according to DHHS's interpretation of the law, States are not required to monitor loss ratio experience. Furthermore, penalties for medigap sales abuse have been seen as the prerogative of the States because the primarily are responsible for regulating the insurance industry. All States GAO visited had a formal complaint system, within either the State insurance department or the State department of elderly affairs. All States GAO visited also monitored the advertising practices of insurance companies. GAO concluded that section 1882, when combined with State efforts, not only was protecting the elderly against substandard medigap policies, but also was providing them with information on how to select medigap policies. This conclusion has been criticized by some consumer organizations, including Consumers Union, who question the compliance of medigap insurers with the spirit and intent of the law.

2. Issues and Legislative Actions

(A) CATASTROPHIC HEALTH CARE LEGISLATION

The catastrophic health care costs issue so dominated Congressional health policy debate and actions during the 100th Congress that it appeared, at times, that the Congress either was unwilling or unable to confront any other health issue. While other health policy concerns periodically were raised and, in some cases, eventu-

[11] U.S. Government, General Accounting Office, Report to the Subcommittee on Health, House Committee on Ways and Means, Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies. October 1986.

ally addressed, advocates of these concerns had to accept the fact that the 100th Congress—as far as the Congress and the Administration was concerned—would be dedicated to the development of a catastrophic health care law.

(1) Defining Catastrophic Illness

Prior to addressing the shortcomings of public and private health insurance protection against the costs associated with a catastrophic illness, a definition of the term had to be developed. While most agreed that a catastrophic illness could be defined as a major—usually unexpected—financially unmanageable illness, there were varying opinions on what amount of health care expenditure qualifies as a true catastrophic expense. In response, many rather arbitrarily chose a specific figure, for example $2,000, to define a catastrophic health care expenditure. Other health policy analysts advocated the use of a certain percentage of total annual income, for example 10 percent, to obtain a more accurate picture of the number of people who experience catastrophic health care expenses.

Because the percentage approach takes into account the financial means of the ill person, few disputed its superiority. Such an approach helped illustrate that a $2,000 health care bill for someone making $12,000 a year represents a catastrophic expense, while the same bill for someone earning $100,000 a year may not. At the same time, however, few questioned the practical administrative and political difficulties of being able to use the percentage method to set qualifications for a major expansion of the Medicare Program. Therefore, while Members of Congress and the Administration used every measuring method available to guide them in constructing the catastrophic health legislation, they chose to rely upon a minimim base health care expense figure to set eligibility provisions.

(2) Shortcomings of Current Medicare Coverage

In recent years, the fact that there are major gaps in catastrophic health care insurance for millions of Americans of all ages has not been questioned significantly. Even with Medicare, the elderly remain susceptible to catastrophic health care costs. Using varying thresholds and percentages of income figures, DHHS estimated that as many as 2.1 million elderly (8.1 percent) experienced catastrophic health care expenses in 1987.[12]

Although Medicare provided excellent hospital benefits, coverage for long-term hospital stays (more than 60 days) was limited and left elderly patients vulnerable to catastrophic out-of-pocket expenses. In 1988, after day 60 in a hospital, the Medicare beneficiary was liable for a $135 daily copayment. After day 90, the same beneficiary had to pay $270 a day. At these rates, such expenses quickly can become "catastrophic."

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[12] U.S. Library of Congress, Congressional Research Service. Catastrophic Health Insurance: Medicare. Issue Brief No. IB 87106, by Jennifer O'Sullivan, October 30, 1987 (continually updated). Washington, 1987. p. 2 and Department of Health and Human Services, Catastrophic Illness Expenses. Report to the President, Nov. 1986.

Other non-Medicare-covered expenses that either can be or contribute to becoming catastrophic costs are the expenses associated with long-term nursing home care, outpatient prescription drugs, and physician charges above the Medicare assigned rate. 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 $22,000 a year, nursing home expenses dwarf all other non-Medicare-covered services. It has been 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 Medicare assistance only after becoming, for all practical purposes, destitute. (Further discussion of this problem can be found in chapter 8.)

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. An American Association of Retired Persons survey found that, of those elderly who regularly take prescription drugs and do not have private supplemental health insurance that covers these costs, 40 percent spent more than $360 on prescribed drugs in 1986. For low-income elderly on fixed incomes, these high costs can and do represent catastrophic expenses.

Further, because prescription drug prices have increased at a rate two and a half times faster than the rise in consumer prices from 1980 through 1986, many insurers have dropped coverage of prescription drug costs from 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. From 1980 to 1986, beneficiary liability for non-covered physicians costs increased by almost 100 percent, from $1.45 billion to $2.8 billion.[13]

Private insurers offering supplemental insurance (medigap) coverage to the elderly have been hesitant to offer policies that do

[13] Varner, Theresa. Catastrophic Health Care Costs for Older Americans: The Issue and Its Implications for Policy Development. American Association of Retired Persons, Public Policy Institute, June 1987. p. 16.

more than build upon what 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.

Millions of nonelderly Americans are at least as vulnerable to catastrophic health care costs. There are 37 million persons under 65 who have no health insurance and are completely vulnerable to being financially devastated by a catastrophic health incident. Moreover, millions more have inadequate protection against catastrophic health care costs. Using varying thresholds and percentages of income figures, DHHS estimated that as many as 6.2 million (3.2 percent) of the under-65 population were victimized by catastrophic health care expenses in 1987.[14] Finally, as pointed out by a Senate Aging Committee sponsored 2-part report series by the Congressional Research Service, the percentage of the under-65 population who are uninsured increased from 14.6 percent in 1979 to 17.5 percent in 1986. Despite receiving a great deal of attention in the 1986 DHHS catastrophic health care report and in a number of Congressional hearings in 1987 and 1988, the lack of health insurance protection of the under-65 population was not addressed in the Medicare Catastrophic Protection Act of 1988.

(3) Administration's Actions to Address Shortcomings

When President Reagan initially mentioned his desire to find ways to better protect Americans against catastrophic health care costs in his 1986 State of the Union Address, he started the ball rolling toward the almost inevitable passage of legislation that begins to accomplish this goal. Although it was not a new issue (many Members of Congress had introduced legislation in previous sessions), the administration's willingness to move forward on the catastrophic health care front breathed new life into the issue.

(a) Bowen report on catastrophic health care

In the 1986 State of the Union Address, the President announced that he had directed the Secretary of DHHS to study the catastrophic health care issue and develop recommendations to address health insurance shortcomings. Although an encouraging development, many critics were skeptical of what, if anything, would come of this report. However, when the report was released in 1986, most of the critics were pleasantly surprised and praised Secretary Otis Bowen for the scope of the study and the thoughtfulness of the report's recommendations.

The report provided a comprehensive analysis of the shortcomings of current public and private insurance coverage of catastrophic health care legislation. It focused on three vulnerable

[14] U.S. Library of Congress. Congressional Research Service. Catastrophic Health Insurance: Medicare. Issue Brief 87106. p. 2.

groups: The elderly who face large out-of-pocket costs associated with lengthy, non-Medicare covered hospital stays for acute illnesses, older Americans who require long-term care, and the vulnerable uninsured and underinsured under-65 population.

To most health policy analysts, the report's recommendations for addressing the lack of catastrophic protection for the under-65 population and for those elderly needing long-term care were not unexpected. These recommendations placed heavy emphasis on encouraging (through tax incentives) the development of private sector, State and local initiatives.

Specifically, Secretary Bowen's long-term care proposal consisted of recommendations to: (1) Provide tax incentives and other inducements for the private sector to develop and market long-term care insurance more actively, (2) encourage the use of individual medical accounts (IMA's) in a way that individual retirement accounts (IRA's) had been used prior to the Tax Reform Act of 1986, and (3) provide much-needed information to the public about the costs, potential for requiring, and the limitations of Medicare coverage of long-term care.

The Administration made similar recommendations with regard to catastrophic protection for the under-65 population. To encourage employers to provide catastrophic protection for their employees, the Secretary recommended comprehensive tax deductions to those who provided such coverage to their employees. With regard to State involvement, the proposal which received the most attention was a recommendation to encourage States to develop, with guidance from the Federal Government, insurance risk pools for medically uninsurable citizens (those who cannot obtain insurance due to previous major medical conditions and/or lack of income). Risk pools would require that all health insurers in the State contribute to developing and offering a feasible health insurance option for these high-risk populations.

Although the analysis of the numerous problems surrounding the lack of long-term care insurance for older Americans and catastrophic health care protection for the under-65 population was comprehensive, the proposed recommendations to deal with these problems were viewed by many health policy analysts to be inadequate and/or politically unrealistic. The long-term care proposals were criticized on the grounds that their tax incentives might well benefit the relatively wealthy, but would leave large gaps in protection for middle to lower income brackets. In particular, critics argued that IMA's, like IRA's, would be taken advantage of primarily by upper middle to upper income groups. Further, bipartisan criticism pointed to the fact that the IMA recommendation was inconsistent with a provision of the 1986 Tax Reform Act that significantly limited the use of IRA's. The proposals to deal with the underinsured and uninsured under-65 population were given similarly negative reviews, and—like the long-term care proposals—were not incorporated into any catastrophic legislation.

Far and away the most widely heralded—and surprising—recommendation was the Secretary's proposal to restructure the Medicare Program to include a beneficiary-financed, actuarily-sound, acute care catastrophic benefit. This was an unusual departure for an Administration official because it represented one of the first

Reagan Administration health proposals to depart from its customary reliance on the private sector and/or the State to address a critical need.

While Secretary Bowen's acute catastrophic care recommendation received praise from many in the Congress, it also was the recipient of much criticism from conservatives in and outside of the White House. In a New York Times article, Peter J. Ferrara, a former Reagan domestic policy adviser, called the proposal "reverse privatization, blatantly and directly contrary to the President's policies." Despite the criticism and after much debate within the White House, Secretary Bowen's acute care catastrophic proposal eventually was endorsed by the President and served as the basis not only for the legislation the Administration submitted to the Congress, but also for all other catastrophic bills.

(4) Congressional Response

The Congress, weary and frustrated with its role of spending the majority of its time trying to control health care costs rather than address health care needs, heartily welcomed Secretary Bowen's report. After a long respite, the Administration finally had opened its doors to the possibility of a major health initiative. Members quickly recognized that, regardless of whether the President followed the report with an endorsement for legislation, they could use the report and its recommendations as a vehicle for legislative action.

Even prior to the introduction of the Administration's bill, Members of Congress quickly scheduled hearings on the catastrophic health care issue and introduced various versions of the legislation. In fact, the first catastrophic health bill submitted in the 100th Congress was introduced by Senator Kennedy almost 2 months before the Administration submission. This bill, S. 210, was introduced to incorporate the most highly praised recommendation of the Bowen report—the recommendation to restructure Medicare to include an acute care catastrophic benefit.

(a) Hearings

Soon after S. 210's introduction, Senator Melcher called two Special Committee on Aging hearings on the catastrophic health care issue. At the first hearing, held on January 26, 1987, members received testimony from catastrophic health care victims of all ages, health insurers, and consumer advocates. The committee held the hearing to evaluate the extent of private and public catastrophic insurance and to illustrate the need for a Federal response. At the second hearing, a joint Senate/House Aging Committee hearing held 2 days later, one witness was invited to testify—Secretary Otis Bowen. This hearing gave the members of the two Aging Committees an opportunity to ask Secretary Bowen about his report and how President Reagan had received it.

The Aging Committee hearings, and hearings held by the Senate Labor and Human Resources Committee, the Finance Committee, the House Ways and Means Committee, and the Energy and Commerce Committee, and the Energy and Commerce Committee praised Secretary Bowen for his report, but also raised concerns

about its failure to address the lack of protection against costs associated with long-term care, prescription drugs, and the under-65 uninsured issue. With regard to the acute care catastrophic benefit, many members (although impressed with Secretary Bowen's proposal) questioned the validity of the Secretary's estimates regarding the cost of the benefit and how many people it would benefit.

(b) Legislative development

The House of Representatives moved more rapidly than the Senate in developing, introducing, marking up, and passing the catastrophic legislation. However, the primary debate in both Houses of Congress consistently centered around how the benefit would be financed and whether it would cover prescription drugs.

In the House, Representatives Stark and Gradison, Chairman and Ranking Member of the Ways and Means Subcommittee on Health, quickly moved to introduce two bills (H.R. 1280 and H.R. 1281), that would initially serve as the legislative vehicle for House actions on the catastrophic health issue. These bills built on the Bowen proposal by lowering the annual limit on out-of-pocket costs for Medicare covered services, expanding Medicare's skilled nursing home and home health care benefit, increasing mental health coverage, and requiring that States pay the new cost-sharing charges up to the catastrophic limit for very-low-income elderly. Significantly, this legislation did not include a prescription drug benefit.

The Stark/Gradison legislation originally was to be paid for by taxing part of the actuarial value of Medicare's benefits. However, after hearing significant concerns from representatives of labor, aging advocacy groups, and insurers (who feared that such an approach would set the precedent of taxing non-cash benefits), the bill's sponsors agreed to alter their financing approach in favor of a supplemental premium based on the actual income of elderly taxpayers.

Led by Representatives Dingell and Waxman, a coalition of Congressmen was successful in including a prescription drug benefit in the catastrophic bill that emerged from the House Energy and Commerce Committee. To assure that the legislation would make it to the floor and could be supported by key Members of the House and aging advocates, the chairman of the Ways and Means Committee, Representative Rostenkowski and Representative Stark agreed to include a prescription drug benefit (beginning in 1989 with a separate catastrophic $500 deductible) in the final catastrophic bill that was reported to the House floor. The House of Representatives passed the bill on July 22.

The Senate committee with jurisdiction over the Medicare Program, the Finance Committee, held hearings on a bill (S. 1127) that had been introduced by the chairman of the committee, Senator Bentsen. Although the bill's benefits were slightly less liberal than the House version, its financing approach was viewed by many as striking a strong compromise between Secretary Bowen's across-the-board flat premium proposal and the predominant reliance on a supplemental premium approach included in the House version. The Senate bill would reduce the amount of the flat premium that the Administration advocated and would set up a more progressive

supplemental premium than what was included in the House proposal. In addition similar to the early versions of the House bill, the Senate bill originally did not include a significant prescription drug benefit.

During markup of S. 1127, Senator Heinz raised the issue of adding a prescription drug benefit. Of major concern to a number of committee members was the great disparity in projected cost estimates from the Congressional Budget Office (CBO) and the Health Care Financing Administration (HCFA) for such a benefit. The cost of the benefit also was a particular concern to many Members because the elderly would pay, under the financing approach chosen by the Finance Committee, the entire cost through a premium. Chairman Bentsen agreed to hold a hearing on the prescription drug issue and suggested the possibility that more expansive coverage might be considered as an amendment to S. 1127 during Senate floor consideration.

Chairman Melcher authorized two Aging Committee hearings on the issue of prescription drug costs. Both hearings, one of which was chaired by Senator Pryor in Arkansas, highlighted the significant out-of-pocket burden prescription drug costs create for the elderly. Testimony highlighted the fact that seniors, though they constitute only 12 percent of the population, consume approximately 30 percent of all prescription drugs. Poignant personal accounts by elderly witnesses described how difficult it was for many older Americans to afford their prescription drug expenses and, at the same time, pay for other basic essentials such as groceries, utilities, and rent.

Two General Accounting Office reports on catastrophic health cited Public Health Service findings which concluded that 15.5 percent of the elderly who require prescriptions report that they are unable to pay for their drugs.[15] Further, information provided by the Congressional Budget Office indicated that 17 percent of Part B enrollees spend more than $500 annually for their prescription drugs, and therefore, would benefit from the out-patient prescription drug coverage that would be provided by the House bill. With this information, GAO concluded in one of its reports that the $500 deductible would keep this provision from helping some of the elderly who need it the most—the poor, near poor, and those who do not have private supplemental insurance.

Despite the finding that many elderly desperately need protection against prescription drug costs, concern remained high about the cost of a drug benefit. For months, a coalition of Senators placed holds on the catastrophic bill, threatening to filibuster any attempt to bring it to the Senate floor for a vote. Because there were a number of other priority legislative items pending, the Senate leadership did not want to spend unnecessary time on a bill that would be filibustered, and opted to delay action until an acceptable agreement could be forged. Finally, a group of Finance Committee members including Senators Heinz and Mitchell successfully negotiated a compromise with the Administration to clear the way for floor action.

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[15] U.S. General Accounting Office. Medicare: Prescription Drug Issues. Report to the Chairman, Special Committee on Aging, U.S. Senate. PEMD-87-20, July 1987. Washington 1987.

On October 27, 1987, the Senate catastrophic bill was sent to the floor for consideration by the full Senate. Senators Heinz, Mitchell, and others offered the compromise catastrophic drug amendment to the bill. Although much more modest (a benefit with a $600 deductible beginning in 1990, but not completely phased in until 1993) than either the House bill's drug provisions, a number of Senators continued to raise concerns about the potential costs of the amendment.

Despite great initial momentum to sign catastrophic health care protection legislation and despite that separate catastrophic health bills were passed in both Chambers of the Congress in 1987, a compromise between the two bills was not achieved until June 1988. The delay was the result of many factors, including concerns about the prescription drug benefit's costs, the fact that many of the catastrophic health care bill's conferees were participating in the budget summit following the October 1987 stock market crash, and the fact that early delays in the process made it clear that there would not be sufficient time to implement the legislation before 1989. Finally, after 18 months of reports, hearings, legislative proposals, and compromising, the Congress passed and the President signed the Medicare Catastrophic Coverage Act of 1988 into Public Law 100-360 on July 1, 1988.

(B) MEDICARE SOLVENCY AND COST CONTAINMENT

Controlling health expenditures within the Medicare Program and looking for ways to assure the program's solvency well into the next century continue to be among the highest priority issues for both the Congress and the Administration. Total costs for Medicare have steadily increased from $4.6 billion in 1967 (the first full year of the program) to an estimated $82 billion in 1987, and an estimated $89 billion in 1988.[16] By 1990 Medicare outlays are expected to reach more than $111.2 billion.[17]

The rise in Medicare costs has been a concern on two levels. First, Medicare has been consuming an increasing share of the Federal spending. In 1988, outlays for Medicare represented 7.5 percent of the total Federal budget.[18] This compares with a little more than 4 percent in fiscal year 1976. With Federal deficits expected to remain close to $150 billion in fiscal year 1988, there are continuing pressures to curb the growth in Medicare outlays. As the second most expensive domestic program, it provides a major target for deficit reduction efforts. While Part A is funded out of the Trust Fund, Part B is largely funded out of general revenues making it a prime target for annual spending cuts. Under current law, 25 percent of the Part B program is financed by premiums paid by beneficiaries. The bulk of Part B expenditures goes to pay for physician services. Thus, as physician payments increase, so too will pressures on the general treasury to finance Part B—a fact that has underscored the need to bring effective cost containment to physician and other Part B expenditures.

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[16] Table 6, 1987 SMI Trustees' Report, Table 6, Hospital Insurance Trust Fund Report.
[17] Ibid.
[18] Congressional Research Service, Report No. 88-35 EPW, 1989 Budget Perspectives: Federal Spending for the Human Resources Programs, by Gene Falk, April 1988, p. 35.

A second driving force for Medicare cost containment is the need to assure solvency of the Trust Fund. The introduction of the Prospective Payment System, along with other factors slowing inflation in the medical marketplace, has given life to the trust fund. In 1984, the Medicare trustees were estimating that the HI Trust Fund would go bankrupt by 1989 under pessimistic economic assumptions and by 1992 under intermediate economic assumptions. In the 1985 report, the trustees revised their projections, estimating that the HI Trust Fund would remain solvent until 1998 under intermediate economic assumptions, and until 1992 under pessimistic ones. In the 1988 HI trustees report, the trustees again revised their projections, moving forward the date of insolvency under intermediate assumptions to 2005–2008, and 1999 under pessimistic assumptions.[19]

Despite the 1988 projections, there remains a legitimate concern that the present financing schedule for the HI Trust Fund is inadequate to ensure its long-term health. According to the trustees, "in order to bring the hospital insurance program into actuarial balance even for the first 25-year projection period under alternative II–B assumptions (intermediate economic assumptions), either outlays will have to be reduced by 14 percent or income increased by 16 percent (or some combination of these)."[20] Moreover, because of changing demographics, there will be increasingly fewer workers to support each Medicare beneficiary as we move into the next century. Today, four covered workers support each Medicare enrollee. By the middle of the next century, there will be only slightly more than two covered workers supporting 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, there is a growing need to find ways to ensure the same level of benefits to future generations of the elderly.

While there is evidence that indicates the implementation of the prospective payment system has made a contribution to slowing the increases in Medicare inpatient hospital expenditures, the jury is still out on the degree of its success. At a time when health care inflation is still consistently double the general inflation rate, there is little debate that much more needs to be done to prevent the future insolvency of the trust fund. In response, Congress may well have to make further systemwide changes to the Medicare Program.

In 1987, the Senate Finance Committee attempted to address the Medicare insolvency issue by recommending in the reconciliation legislation initially reported out of committee a provision to repeal the Medicare payroll tax exemption for earnings in excess of the statutory wage base. Under current law, the Medicare payroll tax is 1.45 percent for both the employee and the employer up to a maximum level of $45,000 in 1988 and $48,000 in 1989. The Finance Committee proposal would have removed the $45,000 cap and re-

[19] 1987 HI trustees report, p. 55.

[20] U.S. Department of Health and Human Services, Health Care Financing Administration, 1988 Annual Report to the Trustees of the Federal Hospital Insurance Trust Fund. Washington, May 5, 1988, p. 51.

quired the 1.45 percent Medicare payroll tax be paid on all earnings. It was estimated that this proposal would raise $2.2 billion in fiscal year 1988 and $15.4 billion over 3 years. The Finance Committee argued in favor of this proposal for several reasons, including:

(1) It would begin to address the long-term, solvency needs of the Medicare trust fund.

(2) It would eliminate the regressivity of the Medicare payroll tax by making the 1.45 percent rate uniform for all workers. Currently the more a person earns in excess of the wage base, the lower his or her effective rate.

(3) It would apply to only the most highly paid workers—those earning in excess of $45,000 in 1988. There would be no effect on the 92 percent of workers who earn less than that and a two-earner family could earn up to $90,000 without being affected.

(4) It would not repeal the wage base cap on the Social Security payroll tax. Under Medicare, all eligible beneficiaries receive the same coverage, regardless of the amount of the worker's contribution. Unlike Medicare, Social Security benefits are based on the amount of contribution. A dollar cap on the taxable wage base is more appropriate for the Social Security tax because it prevents the benefit formula from generating unduly large benefits.

Despite serious consideration, the proposal to remove the Medicare payroll tax cap was not included in the final reconciliation legislation. During the budget summit following the October stock-market crash, the administration indicated that it would not support this tax increase. Further, many Members of Congress had been looking at this source of funding for, among other items, an expansion of the Medicare long-term benefit. In light of the opposition to this proposal from both sides of the political fence, it was not surprising that the proposal did not reach the President's desk when he signed the Omnibus Budget Reconciliation Act (OBRA) of 1987 into law.

Although not significantly addressed in 1987 or 1988, the need for comprehensive Medicare reform will not disappear. There continues to be no consensus about how reform is to be achieved. However, beyond the 1987 Senate Finance Committee approach, options include tapping new sources of revenue for the trust fund such as additional premiums, dedicated additional excise taxes on tobacco and alcohol, and funds from general tax revenues. Other options propose to transform the basic mode of health care delivery to a delivery system dominated by organizations that manage the provision of health care, such as health maintenance organizations and competitive medical plans. Still others suggest that Medicare costs can be contained by cutting back coverage, by requiring a means test for eligibility, or by altering payment incentives to make providers more efficient. Whether these or other courses of action are selected as the options in the future, it appears clear that Congress and the administration cannot wait too much longer before taking steps toward comprehensive reform of the Medicare Program.

(C) ADMINISTRATION'S FISCAL YEAR 1989 BUDGET PROPOSAL

For the first time in recent memory, the President submitted a budget that was not characterized as dead on arrival. This was an encouraging development as it enabled the Congress to work much more cooperatively with the Administration in crafting a budget compromise.

The President's fiscal year 1989 proposed budget provided $86 billion in outlays for the Medicare Program, approximately $1 billion below the amount needed to maintain the fiscal year 1988 level of services. Over a 5-year period, these proposed cuts totaled an estimated $14.6 billion. The Administration's proposed cuts included additional reductions (not called for in the 1987 bipartisan budget summit) of $980 million in Part A and nearly $240 million in Part B, a total of $1.2 billion. As a rationale for higher than expected cuts, the Administration contended that the Medicare Program savings outlined in the budget summit were not sufficient to meet the terms of that agreement.

(1) Beneficiary Impact

The Administration's fiscal year 1989 budget would have permanently fixed Medicare Part B premiums at 25 percent of the program's costs. Under the current law, premiums are required to fund 25 percent of Part B costs only through 1989, after which, premium amounts will be tied to the Social Security cost-of-living adjustment [COLA]. As program costs are projected to rise at a significantly faster rate than the COLA, this proposal was projected to cost Part B beneficiaries an additional total of $6.9 billion through 1993.

(2) Provider Impact

A number of proposals to reduce reimbursements to providers by $1.4 billion in fiscal year 1989 were included in the Administration's budget. Over a 5-year period, these proposals would amount to $9.6 billion in cuts. Key provisions include:

Physician services.—Proposed to reduce payments to physicians by $53 million in fiscal year 1989 by placing cost controls beyond those recently enacted by Public Law 100–203 for surgical procedures considered to be overpriced. (Under Public Law 100–203, payments for overpriced procedures generally were reduced by 2 percent.) The Administration proposed to cut payments by an additional 5 percent. Five-year savings were estimated at $505 million. In addition, payments to cover radiologist and anesthesiologist fees were proposed to be reduced by 10 percent in fiscal year 1989, resulting in 1-year savings of $156 million and 5-year savings of $1.5 billion.

Medical equipment.—Proposed to reduce payments for durable medical equipment (i.e., wheelchairs, hospital beds, etc.), oxygen supplies, and renal dialysis services by $95 million in fiscal year 1989 and by $855 million over the next 5 years. In addition, proposed to save $55 million in fiscal year 1989 and $585 million through fiscal year 1993 by changing the the way in which suppliers of home dialysis products are paid. Similarly, proposed to save

$20 million in fiscal year 1989 and $120 million over the next 5 years by reducing payments to suppliers of enteral products and equipment (i.e., nutritional products and medical equipment designed for those who are unable to ingest food).

Medical education.—Proposed to reduce payments to hospitals for the direct costs of medical education (namely, residents and teachers salaries and classroom expenses) by $60 million in fiscal year 1989 and $440 million over a 5-year period. Proposed cuts amounting to $900 million in fisal year 1989 and $5.3 billion over a 5-year period for payments for the indirect costs of medical education (the costs of additional tests and procedures prescribed for purposes of learning).

(3) Peer Review Organizations (PRO's)

Funding for PRO's, which monitor utilization and quality of care, would be increased by almost 70 percent, from $131 million to $322 million. The proposed increase would fund implementation of new quality control measures, including substandard care review, preadmission review for certain frequently performed surgical procedures, and review of second surgical opinions.

(4) Other Quality Control Efforts

The 1989 budget submission proposed freezing at $66 million funding for the inspection of skilled nursing facilities and hospices under Medicare and the certification of a number of new facilities.

(5) Coverage of State and Local Employees

As a revenue raising measure, the President's budget proposed mandating Medicare coverage of all State and local employees. Under current law, only employees hired after March 31, 1986, are required to pay the Medicare payroll tax of 1.45 percent. This proposal would have yielded $1.5 billion in fiscal year 1989 and $9.2 billion over the next 5 years in revenues, which would flow to the Medicare trust funds. However, as a result of the increased number of beneficiaries, outlays would rise by an estimated $55 million over this same period.

(6) Fiscal Intermediaries

The President proposed to increase the amount paid to Medicare's fiscal intermediaries is by $100 million above the fiscal year 1988 level. This increase would fund intensified medical reviews, prepayment screens, prepayment quality reviews, and other measures aimed at reducing the volume of services provided by certain physicians.

(7) Catastrophic Care

In anticipation of enactment of the Medicare Catastrophic Coverage Act of 1988, the Administration proposed establishing a contingency fund of $112.4 million for implementation of the measure.

(D) CONGRESSIONAL RESPONSE

Because the Administration's Fiscal Year 1989 budget proposals were generally consistent with the budget summit agreement, the Congress characterized the President's proposal as a reasonable beginning of the budget process. This sentiment, heretofore rarely if ever felt by the majority in the Congress, contributed to assuring that 1988 would be one of the, if not the, most noncontroversial years of the Reagan Administration, in terms of the budget.

To summarize the budget and clarify its potential impact on programs affecting older Americans, the Aging Committee released an information paper entitled, "The President's Fiscal Year 1989 Budget Proposal: How It Would Affect Programs for Older Americans." While acknowledging that the Fiscal Year 1989 budget proposal was much more realistic than previous than previous submissions, the report pointed out that myriad cuts in programs such as Medicare were unnecessary and unacceptably severe.

Congress again concluded that achieving Medicare cuts through cost-shifting could not be done by placing additional financial burdens on the elderly. As a result, the budget reductions that survived the Congressional obstacle course and emerged from the 1987 budget summit were targeted at providers and not beneficiaries. Consistent with OBRA 1987, the Fiscal Year 1989 Medicare cuts to providers amounted to $3.8 billion. The major health policy issues, which were raised and/or addressed both in and outside of the budget process, are outlined in the following section.

(1) Issues Affecting Medicare Beneficiaries Out-of-Pocket Costs

The Congress rejected all the Administration's proposals that would significantly affect Medicare beneficiaries. Because most of the beneficiary measures had been previously advanced by the Administration, it was not surprising that Congress did not give them much serious consideration. The implementation of the catastrophic health care legislation (discussed earlier in the chapter) will have a significant impact on beneficiaries' out-of-pocket costs. In the first session of the 100th Congress, another issue of particular consequence to beneficiaries was prominent: The 1988 Part B premium increase.

When Medicare was established in 1965, the Part B premium was set at an amount that would cover 50 percent of program costs. The Social Security amendments of 1972 modified this requirement to limit increases in premium amounts to the percentage increase that Social Security beneficiaries received in their cost-of-living adjustment (COLA). Because program costs increased well beyond the inflation rate on which COLA's are based, the portion of program costs covered by the premium declined to less than 25 percent by 1982. The Tax Equity and Fiscal Responsibility Act of 1982 set the premium at the level necessary to cover 25 percent of program costs through 1986. This provision subsequently was extended through 1988 by the Deficit Reduction Act of 1984, and extended again until the end of 1989 by OBRA 1987.

In September 1987, the Health Care Financing Administration (HCFA) announced that the Part B monthly premium would be increased an unprecedented 38.5 percent in 1988 from $17.90 to

$24.80 to meet the 25 percent of program costs requirement. HCFA explained that the three factors influencing the increase were: (1) Earlier projections for 1987 expenditures and utilization (primarily related to costs associated with physician services) under Part B were too low; (2) the Part B program is projected to continue its current rate of growth; and (3) due to a surplus in the Part B trust fund, the 1986 and 1987 monthly premiums were, in effect, discounted as a result of the contingency reserve fund being drawn down.

Congressional hearings to examine the issue found that while the increase was justified and somewhat expected, it was nonetheless overly burdensome to many Medicare beneficiaries, particularly those with low incomes. Although the 1989 premium increased only 12.5 percent (to $27.90, not including the $4 monthly catastrophic premium), no changes were made to ensure that the premium will not increase by a large amount again. Medicare beneficiaries are paying 963 percent more in Part B premiums in 1989 ($27.90+$4.00=$31.90/month×12 months=$382.80) than they were in 1966, when the premium was $36 per year. These escalating, seemingly uncontrollable costs are putting increased pressure on Congress and other policymakers to reform the way Medicare pays physicians.

(2) Issues Affecting Home Health Care

During 1987 and into 1988, there was growing concern that the Medicare home care benefit did not provide adequate post-hospital care to many Medicare beneficiaries. This problem had been exacerbated by the efforts of the Health Care Financing Administration (HCFA) to reduce access to the Medicare home care benefit. At the same time, concerns were raised about the quality of home health care and the adequacy of the current oversight and monitoring system to assess quality care.

In 1983, Medicare changed the method for paying hospitals from a pay-as-you-go system to a prospective payment system based on predetermined rates for specific diagnosis-related groups. Since then, 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, HCFA has targeted the home health benefit for continual cutbacks, lower payment levels, and narrower interpretation of the scope of the benefit. As a result, more Medicare beneficiaries need home health care at a time when less care is available.

Large numbers of Medicare patients who are discharged "quicker and sicker" often find post-hospital care unavailable or substandard. The stress on post-hospital services is increasing substantially. In addition, existing hospital discharge planning programs—important mechanisms for assuring that patients are placed in appropriate community settings—are seriously overtaxed under PPS with the result that Medicare patients often received inadequate post-hospital care.

Adding to the problem is the fact that HCFA has sought to reduce nursing home and home health care utilization through administrative denials of reimbursement. Two hearings conducted by the Senate Aging Committee in 1986 found that while increasing

numbers of seriously ill Medicare patients are in need of home health care, home health care denials nearly have tripled since the first quarter of 1983 when PPS was initiated. During this period, the rate of growth in home health services slowed—Medicare-covered visits rose an average of 19 percent from 1980 to 1983, but only rose 8 percent in 1984 and actually declined 2 percent in 1985. The committee concluded that Federal policies to restrain beneficiary protections, combined with vague and confusing guidelines for providers, resulted in reduced access to home health care for older Americans.

Further, HCFA's use of unwritten and unpublished guidelines further limit the Medicare home health care benefit. HCFA repeatedly attempted to eliminate the "waiver of liability" which gave home health agencies critical flexibility in interpreting Medicare rules and regulations so they are not forced to deny access in cases of questionable eligibility. In addition, HCFA placed limits on home health providers' abilities to appeal decisions denying Medicare beneficiaries home health care and has made it difficult for Medicare beneficiaries to appeal decisions themselves.

Finally, little attention from the Federal level focused on the quality of care that home care agencies provide. The evaluation of quality of care by HCFA has focused on the home care agency's organizational form, the facilities and equipment, its staff's credentials, and its fiscal management. These standards tend to measure an agency's capacity to deliver services rather than the quality of the services actually provided.

In response to these concerns, Senators Bradley, Heinz, Pryor, Glenn, Melcher, and others introduced legislation in the first session of the 100th Congress to address these concerns. OBRA 1987 included many of the provisions of this legislation that were aimed at improving the Medicare home care benefit. The key provisions affecting home care included in OBRA 1987 are:

Publication of policies.—HCFA must promulgate regulations on any new policies that change the legal standard governing benefits and eligibility for Medicare coverage. HCFA must ensure that the practices of fiscal intermediaries and carriers are consistent and clearly understood by service providers as well as beneficiaries and the fiscal intermediaries have mechanisms for consultation with representatives of health and skilled nursing home providers and consumers in their region regarding problems of claim review and coverage guidelines.

Denials.—HCFA's fiscal intermediaries must give to the home care provider and beneficiary a written explanation of any denial of a claim for home health or SNF services, including the statutory and regulatory basis for the denial.

Homebound definition.—OBRA 1987 clarifies the homebound definition so that even if a person is able to leave his or her home for short periods of time, he or she is still considered homebound.

Home health prospective payment.—HCFA must conduct a study and demonstration of alternative methods for paying home health agencies under Medicare on a prospective basis, taking into consideration the effects of these methods on access and quality of care.

Tougher survey and certification process.—HCFA must establish a revised certification survey that focuses on the quality of patient care and the effect of that care on the patient. This ensures that the capacity to deliver care actually translated into the provision of high quality care. Rights for home care consumers are clearly delineated and quality monitoring surveys of home care agencies will be conducted annually and unannounced. The inspection process must include actual visits with and interviews of patients. Intermediate sanctions for poor quality also are established, including civil fines and denial of Medicare reimbursement for future Medicare patients. Finally, employees of home care agencies, including home-health aides, would be required to meet approved training standards.

Home health hotline and investigative unit.—All state agencies that certify home health agencies for participation in Medicare must collect certain information on Medicare-certified agencies, including significant deficiencies relating to patient care, corrective actions taken, and sanctions imposed. Agreements must also provide for a toll-free hotline to receive complaints and answer questions with regard to home health agencies and for a unit to investigate these complaints. The unit will have enforcement authority and access to survey reports and consumer medical records.

As of early 1989, HCFA has not taken any regulatory action to implement OBRA 1987, despite the law's requirement that some of its changes be in place by October, 1988. Home health providers and consumers are closely monitoring HCFA policies and actions regarding this issue, as there is concern that OBRA 1987 home health reforms may not be implemented in keeping with the law's intent. Beyond OBRA 1987, the Catastrophic Coverage Act of 1988 contains provisions to expand the number of covered days of daily home health benefits and also clarify the intermittent care requirement (discussed earlier in the chapter). In addition, the Older Americans Act Amendments of 1987 (P.L. 100–175) includes a provision under Title IV authorizing consumer protection demonstration projects for services provided in the home for fiscal years 1989 and 1990. It also added a new program under Title III of the Act for support of nonmedical in-home services for the frail elderly.

As the elderly population increases, so too will the need for quality home care. Because of past problems with HCFA's administration of the Medicare home care benefit, the Aging Committee will continue to monitor the performance of DHHS in this area to make certain this need is met. The April 1988 report from the Aging Committee entitled "Home Care At The Crossroads," outlined the major issues that need to be addressed to improve access to and the quality of home care services for the elderly. While many of these issues were addressed in OBRA 1987, the report details other concerns, such as the fragmentation of services, that OBRA did not address. Many older persons are receiving inadequate home care because various funding sources and differing eligibility requirements, often with restrictive interpretations, beget fragmentation of services. There also is a lack of adequate public and private funding for the kind of supportive, long-term care that many older

persons need. "Homecare at the Crossroads" also discusses the problems concerning home care employees, who are frequently paid very low wages and are undertrained, often resulting in absenteeism and high staff turnover.

(3) Issues Affecting Hospitals

In 1988, 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 fact, 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 hospitals that would be particularly vulnerable to further cuts, and in preserving the largest possible hospital payment update within the tight budget constraints.

(a) 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 (PRO's) with monitoring quality of care as well as utilization outcomes.

Nevertheless, PPS incentives to reduce costs and thus services were strong enough to raise fears that the health or lives of some Medicare beneficiaries might be endangered. After a year of implementation, many physicians and consumer groups representing the elderly began to grow concerned that PPS was posing serious threats to quality of care for Medicare beneficiaries, and might be eroding access to care for the sickest and oldest beneficiaries.

Since implementation of PPS, 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. The findings of former Aging Committee Chairman Heinz led him to develop legislation to ensure better quality care under PPS and to safeguard against unfit health care 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 discharged 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 PRO's review the quality of care provided.

In the final days of the 99th Congress, the House and the Senate attempted to enact additional quality of care and antifraud changes included in S. 837/H.R. 1868, the Medicare and Medicaid Patient and Program Protection Act. However, despite efforts by the bill's sponsors, Senators Heinz and Glenn, the abbreviated election-year legislative session provided insufficient time to complete action on the measure. However, the legislation was reintroduced in 1987 and was signed into Public Law 100–93 on August 18, 1987.

The new law mandatorily excluded from participation in Medicare, Medicaid, the 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 of a criminal offense relating to delivery of a service under Medicare or a State health care program. Among its other provisions, the law specifies a number of circumstances under which the Secretary of DHHS 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, there was continued congressional interest in the PRO system and its objective of ensuring the delivery of quality health care. Of particular concern to the Congress were PRO funding adequacy, contracting procedures, and the denial and provider sanctioning procedures.

OBRA 1987 included a number of changes affecting contracting and other aspects of the PRO system. Specifically, the final legislation extends initial and renewal PRO contract periods from 2 years to 3 years, and allows the Secretary of DHHS 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 new law requires that each PRO offer educational sessions several times each year to hospital staffs regarding review of the hospital's Medicare service, directs PRO's (to the extent possible) to provide initial review of psychiatric and physical rehabilitation services by a physician trained in the appropriate field, and requires PRO's to consider special problems of delivering care in remote rural areas.

Also included in the OBRA 1987 were PRO provisions which require that: (1) PRO's 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 DHHS 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 DHHS provide documentation to each PRO on its performance in relation to other PRO's.

(b) Rural health care

Access to adequate, appropriate health care services in rural areas was one of the major health care issues of 1988. Rural hospitals are perceived by many health policy analysts to have a special set of problems that make them more vulnerable to experiencing significantly greater financial problems. Some of the problems may be related to cost containment and other changes that have come along with the implementation of Medicare's prospective payment system. Other problems have arisen due to adverse economic conditions in rural areas. These problems include fewer hospital admissions, declining lengths of stay, and increasing severity of illness of the patients who are admitted to hospitals. In addition, these hospitals 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. As a result of these differences, many experts believe these hospitals have been more vulnerable to recent Federal health cost containment policies.

There is considerable debate among health policy experts whether steps should be taken by the Federal Government to prevent the closing of rural hospitals, especially those which are the sole providers in their area. While such hospitals may not be economically efficient, they often play a role in the community that goes beyond the provision of inpatient hospital services. They are often the single largest employer in the area and they help to attract primary care physicians who want to be assured that they have access to necessary specialized equipment and staff. In some areas of the United States, the small rural hospital provides the only health care in the area. In these cases, potential patients would be forced to travel long distances to obtain medical care if the local hospital were closed.

To remain financially viable, some rural hospitals are attempting to diversify their services to generate new revenues. A popular strategy is to convert a number of beds to post-acute beds and to offer home care and social services. Other hospitals are entering into multihospital arrangements to help ease their financial strains. These arrangements can include affiliations, shared services, consortium arrangements, contract management, leases, corporate ownership with separate management, and complete ownership. The advantages of joining 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.[21]

There are a number of features of PPS which have been identified as having an effect on rural hospitals, including the urban/rural DRG payment differential, the wage index adjustment, payments for outlier cases, and the special provisions for sole commu-

[21] Rural Hospitals and Medicare's Prospective Payment System, Background Paper, Prepared for the Use of the Members of the Committee on Finance, May 1986.

nity providers, referral centers, and hospitals serving a disproportionate share of the poor patients.

Of primary importance to all hospitals (and particularly rural hospitals) has been the amount of increase Congress authorizes to PPS hospitals. This increase, known as the update factor, is discussed in greater detail in the next section. However, a number of other important provisions were included in the final OBRA 1987 package that addressed congressional concerns with regard to rural hospitals. These provisions include: (1) Developing an Office of Rural Health Policy to coordinate departmental initiatives related to rural health care to assess the impact of department rules on sound health care delivery, and to establish a clearinghouse on information related to rural health care, (2) establishing a grant program for small, rural, private, not-for-profit hospitals to provide assistance in altering their health care delivery practices to respond to changing rural health care needs, (3) expanding the rural swing-bed program to include certain hospitals with up to 100 beds, (4) clarifying eligibility for payment adjustments to compensate for a significant decline in the volume of admission for hospitals which meet the criteria and definition of sole community provider, (5) modifying the rural referral center criteria, (6) revising the standard for including certain rural counties in adjacent urban areas, (7) requiring a Prospective Payment Assessment Commission (ProPAC) study of eliminating or phasing out the separate urban and rural payment rates (as well as of the desirability of maintaining separate rates for large urban and other urban hospitals), (8) requiring the Secretary to DHHS to conduct a survey of and to revise the Medicare hospital wage indices by October 1, 1989, and every 3 years thereafter, and (9) requiring the Secretary of DHHS to set aside at least 10 percent of departmental demonstration funding for projects related to rural health.

In 1988, the Special Committee on Aging held two hearings and issued one report to address concerns about rural health care. One hearing focused on rural hospitals and the other on rural health care personnel specifically. Among the major findings that affect rural hospitals is the 12.3 percent lower Federal Medicare reimbursement rate for rural hospitals than for urban hospitals, and the burden of proof this places on the rural hospitals to demonstrate that their costs are equivalent to those of urban hospitals, rather than on urban hospitals to prove that their costs justify higher payments.

Additionally, the average small rural hospital (fewer than 50 beds) suffered a loss when caring for Medicare patients. The bottom 10 percent of these hospitals had losses of 45 percent or more, and one out of four lost at least 18.5 percent. Medicare reimbursement policies have difficult to meet qualification thresholds for assistance on unusually high cost cases ("outlier" cases), revenue "losers" which are much more difficult for small hospitals to absorb. Furthermore, these policies fail to recognize the vulnerability of low-volume small rural hospitals to a payment system which leaves them at complete risk for fluctuations in admissions and costs.

In 1986 and 1987, rural hospital closures exceeded urban closures, and as many as 600 rural hospitals face the prospect of clo-

sure in the next few years. Also threatening rural hospital viability is the rural hospital's inability to compete with urban hospitals in offering financial bonuses to attract nurses. The Department of Health and Human Services (DHHS) Nursing Commission has estimated that 9 percent of rural hospitals were forced to close beds as a direct result of the nurse shortage. Medicare reimbursement policies inhibit the rural hospital's ability to offer competitive wages because they assume that all rural hospitals in a State have the same wage index, while urban hospitals receive a wage index specific to their area.

The importance of hospitals that are their community's sole source of care or are so-called "frontier" hospitals is strongly suggested by a recent study of rural residents which found that, largely because of limited resources and access to transportation, only 31 percent of those under age 75 crossed a county line to obtain needed medical care; moreover, a mere 18 percent of those over 75 left their home counties for care. DHHS has yet to provide Congress with needed and timely data on what role Medicare and other Federal health care policy decisions have played in terms of maintaining or improving access to medical care in rural areas.

The major recommendations regarding rural hospitals presented in the June hearings address changes in Medicare reimbursement policy and research areas. The policy recommendations include changes that would, (1) eliminate the 12.3 percent differential in urban and rural hospital payments, (2) annually survey hospital wages and develop a more appropriate wage index for rural hospitals without any further delay, (3) simplify and streamline the process by which hospitals qualify for financial assistance when they have experienced large declines in patient volume, and (4) because of the importance of maintaining access to health care for Medicare beneficiaries in underserved areas, develop alternative reimbursement options for sole community hospitals, including removing sole community hospitals from the PPS system and returning them to a cost reimbursement basis.

The major research recommendations presented in the June hearings include the need to establish a PPS research agenda for the Office of Rural Health Policy, HCFA's Office of Research and Development, and the Prospective Payment Commission that will elicit answers to questions regarding the equity of PPS for rural hospitals. The areas of concern for this PPS research agenda include sole community hospital protections, protections for rural hospitals from high cost cases (outliers), the source of higher urban hospital costs, and the effectiveness of volume protection provisions.

Other major recommendations for research were to, (1) provide $10 million to the National Center for Health Services Research to fully fund the rural health services research agenda recommended by the Rural Health Services Research Conference, and (2) establish a Federal clearinghouse for rural health services research under the auspices of the Office of Rural Health Policy. Innovative and successful approaches to health services delivery in rural areas should be documented and catalogued so that other rural communities can emulate them.

(c) Transition to national rates and increasing DRG payments

Prior to PPS, hospitals were reimbursed for services by Medicare based on the costs the individual hospital incurred in the delivery of such services. Under PPS, a set payment rate (based on the physician's diagnosis) is paid to the hospital. During the initial 4-year phase-in period, PPS rates were to be based in part on historical, hospital-specific costs and in part on a Federal prospective rate.

During 1986, transition to a fully phased-in national DRG payment rate was delayed until 1987. Because of delays during 1987 in final disposition of the fiscal year 1988 budget (and under threat of a Gramm-Rudman-Hollings reduction of 2 percent in Medicare payments) the Congress froze hospital PPS rate at the fiscal year 1987 level from October 1, 1987 through November 20, 1987 (under the debt limit extension act, Public Law 100–119). This measure allowed Congress some additional time to act on a budget measure. The legislation also delayed the PPS transition to fully prospective, national rates for 51 days, and required that all Medicare payments to hospitals made on or after November 21, 1987, would be reduced by 2.324 percent (Medicare's share of the Gramm-Rudman-Hollings deficit reduction provisions).

The transition was completed during fiscal year 1988. 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. 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.

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 470 DRG's has been assigned its own weight which reflects the relative costliness of treating a patient in that DRG compared to the average Medicare patient.

Because hospital payments comprise such a large share of the Medicare Program, they were again the major focus of Congressional efforts to trim Medicare in 1988. However, authorizing committees, sensitive to the growing financial concerns of hospitals (particularly rural hospitals), tried to provide as large a PPS update factor as possible for hospital payments. In addition, in an attempt to increase rural hospital reimbursement by Medicare, many Members actively supported efforts to equalize payment increases between urban and rural rates.

The final budget package included a payment update effective for discharges on or after April 1, 1988, of 1.5 percent for hospitals in large urban areas, 3 percent for hospitals in rural areas, 2.7 percent for PPS-exempt hospitals, and 1 percent for other hospitals (those in smaller urban areas of less than 1 million population). Based on regulations published September 30, 1988, the percentage increases for fiscal year 1989 are: 3.9 percent for hospitals in rural areas, 3.4 percent for hospitals in large urban areas, and 2.9 percent for hospitals in other urban areas. The debt limit extension act, Public Law 100–119, also established regional hospital payment floors and required a study (due in 1989) by the Prospective Pay-

ment Assessment Commission (ProPAC) on nonlabor costs and adjustments for variations in input prices among hospitals.

(d) Capital reform

Under current law, hospitals are reimbursed on a retrospective cost basis for their expenditures for equipment and facilities, including rental, interest, insurance, and depreciation costs, and a return on equity. The passthrough of capital costs has encouraged hospitals to make capital investments, whether or not those investments 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 1984, Medicare paid about $3.2 billion for capital-related costs.

During 1986, the appropriate method for folding capital into the PPS rates was a hotly contested issue. The administration advocated a 4-year phase-in period and the use of 1983 cost reporting data. The Congress and ProPAC examined alternative strategies which included a longer phase-in. There was no final resolution to the debate, and the budget measure for fiscal year 1987 postponed disposition of the matter until the next budget cycle. However, OBRA 1986 did include reductions in cost-based capital reimbursement of 3.5 percent in fiscal year 1987, 7 percent in fiscal year 1988, and 10 percent in fiscal year 1989, and prohibited the Secretary of DHHS from making regulatory changes in this area prior to September 1, 1987. On September 1, 1987, DHHS issued a final rule regarding prospective payments for capital which established separate urban and rural rates for fixed and moveable equipment to be phased in over 10 years for fixed capital and 8 years for moveable equipment. The rates would be based on updated capital-related costs for fiscal year 1984. In the early years rates would be heavily weighted toward the hospital-specific portion. The 1987 reduction (3.5 percent) was extended through November 20, 1987 under Public Law 100-119, as was the prohibition against regulatory changes in this area.

The 1987 budget debate brought no greater clarification of the appropriate manner for PPS payment of capital-related costs. OBRA 1987 included further reductions in the cost-based payments for capital: 12 percent for fiscal year 1988 and 15 percent for fiscal year 1989. The legislation also specified requires the Secretary to include capital-related costs in the DRG payment rates beginning in fiscal year 1992.

(e) Periodic interim payment (PIP)/prompt pay issues

Those who provide services to Medicare beneficiaries are reimbursed through fiscal intermediaries and carriers. These entities—usually insurance companies such as Blue Cross and Blue Shield—contract with Medicare to handle claims processing, auditing, payment safeguards, and other such responsibilities. Congress approves an annual budget for HCFA to administer the Medicare Program which includes within it funds for the carriers and fiscal intermediaries. In recent years, the administrative budget has been

tightly controlled as part of efforts to hold down Medicare expenditures.

In response to this situation, Medicare contractors reduced service levels to providers and beneficiaries, claiming that they were receiving inadequate payment to perform the increasing volume and scope of work. Consequently, it is taking more time to process claims and to respond to inquiries.

During 1986, DHHS took steps to institutionalize a slow-down in the processing of Medicare payments with the intention of making significant savings in the health care program. Medicare contractors, providers, and Members of Congress responded with vehement opposition to the proposal and the Department recanted. However, the final budget action for fiscal year 1987 included a provision which set minimum standards for timeliness of claims processing: 95 percent of clean claims in fiscal year 1987 were to be paid in not more than 30 days, reduced to 26, 25, and 24 days in subsequent fiscal years.

Prior to fiscal year 1987, DHHS regulations allowed for biweekly periodic interim payments (PIP) to providers. These payments were based on the providers projected annual costs divided into 26 equal amounts. Hospitals, home health agencies, and skilled nursing facilities meeting certain criteria were entitled to receive payments on this basis. Under legislative action during 1986, PIP was eliminated for all PPS hospitals with the exception of rural hospitals of 100 beds or less and certain disproportionate share hospitals (hospitals that have a disproportionate share of low income patients). PIP was to be continued in cases where a hospital could demonstrate it was experiencing significant cash-flow difficulties resulting from operations of the intermediary or from unusual circumstances of the hospital's operation.

OBRA 1987 included several changes in claims processing. As an alternative to achieving deficit reduction savings through lengthening the Medicare claim payment process (as recommended by House budget action), the law instead set a "payment floor"—an initial processing period during which claims must be held without payment (a proposal forwarded by the Senate). The payment floor was set at 10 days for the 3-month period beginning July 1, 1988, and 14 days for 1 year beginning October 1, 1988. The legislation prohibits the Secretary of DHHS from taking other steps with the specific goal of slowing claims processing or delaying claims payments.

In another attempt to reduce the deficit, the Senate proposed elimination of PIP for disproportionate share hospitals. However, this proposal was dropped in the joint Senate/House conference and not included in the OBRA 1987.

(f) Medical education

Since its enactment in 1965, Medicare has reimbursed hospitals for its share of 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.[22] 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 than 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 by the end of the decade. However, while in the aggregate there may be an excessive amount 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.

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. 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. Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Congress established a PPS for the direct costs of medical education. Payment is based on each hospital's average cost per resident and on the number of years of training provided to residents. COBRA also reduced the indirect medical education adjustment factor to approximately 8.1 percent from May 1, 1986, to October 1, 1988. This adjustment is applied on a curvilinear basis, meaning the payment would not necessarily increase in direct proportion to the ratio of interns and residents to bed size. The Congress also provided for a temporary adjustment for hospitals with large percentages of low-income Medicare and Medicaid patients. This adjustment was financed by the reduction in the teaching adjustment.

DHHS has not yet issued regulations implementing the COBRA payment changes for graduate medical education costs, and has continued to reimburse hospitals on the basis of reasonable costs. Once the regulations are issued in final form, DHHS will retroactively adjust payments to conform to the COBRA changes.

A development in OBRA 1986 was a provision which reimbursed under Medicare all time a resident spends in patient care activi-

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[22] 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.

ties, regardless of the setting. This change encourages training in primary and long-term care, and eliminates the disincentive to train in certain outpatient settings.

To further control costs and reduce the Federal deficit, OBRA 1987 reduced the indirect medical education adjustment to approximately 7.7 percent. This reduction took effect on October 1, 1988. Although the Senate recommended further reductions in direct education payments for Foreign Medical Graduates, this provision was dropped in the Joint Senate/House conference and the final budget legislation did not include this change. OBRA 1987 also extended the disproportionate share adjustment to October 1, 1990.

The fiscal year 1989 budget proposed to reduce the adjustment factor from 7.7 percent to 4.05 percent calculated on the same curvilinear basis. DHHS argued that this amount, more accurately reflects the estimated effect of teaching programs on a hospital's costs. Estimates by DHHS and ProPAC show that teaching hospitals have experienced higher than average profits under the PPS, which may be due, in part, to being overpaid at the current level. The reduced factor would be used indefinitely, and the Secretary would continue a disproportionate share payment on the size and cost of the hospital's intern and residency program, and how dependent it is on Medicare's indirect medical education payment to support its activities.

(g) Uncompensated care

Traditionally, the public-private patchwork of health insurance coverage has afforded basic protection to a majority of Americans. However, today there are 37 million Americans who find themselves without health insurance. Approximately 17.1 percent of the population under 65 is uninsured. Of these, 5.5 million are 45–54 and 2.9 million are 55–64. Surprisingly, even 389,000 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.[23]

The number and proportion of the uninsured is increasing substantially. The number of uninsured non-aged persons, the only group for which trend data are currently available, increased by 20.4 percent from 1979 to 1983.

Prior to the last recession, the problem of the uninsured was viewed as a problem of the very poor, and those individuals who had seasonal, part-time or low-skilled jobs, in which employers generally did not provide health insurance coverage. Most working Americans received health insurance through their or their spouse's employer. Other were protected by public insurance programs or their costs were picked up by health care providers who subsidized nonpay patients by shifting the costs for these "bad debts" and "uncompensated care" patients to other payers.

During the last recession, 10.7 million Americans lost their health insurance. These people lost this vital protection when they or their family's head of household lost their jobs. Since that time, the system of health care protection has changed radically. Cut-

[23] 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.

backs in Medicaid and other public programs have reduced some of the sources of funding which formerly helped to subsidize health care for America's uninsured. In addition, the changing nature of the better care market, with reforms in reimbursement, heightened competition and the growth of for-profit medicine, is making it increasingly difficult for the uninsured and the underinsured to obtain even emergency access to health care.

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 threatened ratcheting down 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.—Legislation addressing disproportionate share hospitals (DSH's) was first enacted as a provision in the Tax Equity and Fiscal Responsibility Act of 1982. The Secretary of DHHS was required to provide for exemption from, and adjustments to, the cost limits then in effect for Medicare reimbursement to hospitals. HCFA did no implement the provision because, as was indicated in regulations, it did not have the data to determine the extent to which special consideration for such hospitals was warranted or the type of provision that might be appropriate. A similar provision for DSH's was included in the Social Security Act Amendments of 1983. Under this act, the Secretary was charged with developing a methodology for a DSH adjustment to the DRG's. Again, HCFA indicated in regulations that it would not implement the provision in fiscal year 1984 or fiscal year 1985 because it did not believe that it had the evidence to justify the adjustment. In Public Law 98–369 (the Deficit Reduction Act of 1984), Congress required the Secretary to develop a definition of disproportionate share hospitals and to identify such hospitals by the end of 1984, which it failed to do.

The special needs of DSH's 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, 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 results 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.[24]

In 1985, ProPAC recommended that a DSH provision be included in fiscal year 1986 PPS rates.[25] Armed with this recommendation, and frustrated by HCFA's inaction, the House Ways and Means Committee decided to develop its own adjustment, and included a provision in its deficit reduction package. In response to a court order from the U.S. District Court for the Northern District of California, resulting from the lawsuit of a small California rural hospital, HCFA published proposed rules implementing the DSH provision on July 1, 1985. However, HCFA made clear that it would award such an adjustment only in extraordinary cases and only after a case-by-case review.

The 1985 budget reconciliation package (OBRA) required that the disproportionate share adjustment be applied to the Federal portion of the DRG rate for hospitals with a relatively high percentage of low-income patients. Urban hospitals with at least 100 beds receive a graduated adjustment from 2.5 to 15 percent, if their disproportionate patient percentage is at least 15 percent. Smaller urban hospitals receive an adjustment of 5 percent if their disproportionate patient percentage is at least 40 percent. Rural hospitals receive an adjustment of 4 percent if their disproportionate patient percentage is at least 45 percent. The adjustment applies to all discharges after April 30, 1986, and before October 1, 1988. Under OBRA 1987 (P.L. 99-509), the adjustment was extended to all discharges before October 1, 1990.

During the 1987 budget debate, members of authorizing committees of Congress once again expressed concern about DHHS delays in implementing the DSH adjustment for hospitals receiving more than 30 percent of net patient revenues from State and local government programs, and increased the limit on the disproportionate share adjustment for these hospitals meeting the State and local indigent care revenue test from 15 percent to 25 percent. This change provides increased revenues to those hospitals serving the mose significant low-income Medicare populations, providing them more equitable DSH payments.

The President's fiscal year 1989 budget included a proposal to continue disproportionate share payments indefinitely and to make a continuing reduction in the partially overlapping payments for indirect medical education. Public Law 100-647, the Technical and Miscellaneous Revenue Act of 1988 continues disproportionate share payments through September 30, 1985, but does not change current law on indirect medical education payments.

(h) 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 payment reflect differences in wages from area to area. To compute the initial wage index, HCFA used

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[24] 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, DC, July 1985.

[25] U.S. Dept. of Health and Human Services, Prospective Payment Assessment Commission, Report and Recommendations to the Secretary. Washington, DC, April 1, 1985.

hospital wage and employment data maintained by the Bureau of Labor Statistics (BLS) of the Department of Labor. However, it is generally recognized that this data base does not accurately reflect differences among hospitals. The principal limitation of the BLS data—their inability to recognize local differences in the number of part-time workers—was cited by a large number of hospitals, particularly rural midwestern facilities.[26] Under the Deficit Reduction Act of 1984, HCFA was required to report to Congress on a refined wage index which was to be implemented retroactive to October 1983. In 1984, HCFA attempted to obtain better data on wage differences through a survey of hospitals, but the survey was hampered by a low response rate and questionable data quality.

The required report,[27] which was released to Congress in 1985, proposed two alternatives. One wage index was derived from total gross hospital wages, which included salaries and wages for contracted labor, interns and residents, personnel employed in nonhospital cost centers and hospital-based physicians. The other index excluded several variables from its calculation and was referred to as the adjusted gross index. Later that year, HCFA implemented a new wage index for discharges based on the gross wage data from HCFA's 1984 survey. The rule also provided that the retroactivity required by current law would not come into effect until 1986. This was done to allow time for Congress to reverse the retroactive provision and for HCFA to develop a method to identify retroactive amounts.

In 1986, HCFA implemented a revised wage index, based on 1982 HCFA data which reflected the total hours of employment rather than the number of employees. This wage index was continued into 1987 with minor changes.

In 1987, ProPAC recommended that the Secretary of DHHS 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.[28] In September 1987, the HCFA published final rules for the Medicare inpatient hospital prospective payment system for fiscal year 1988 which changed the method of computing the national average wage level for use in determining the area wage index. In addition, the regulations adopt a blended wage index which uses a combination of 1982 and 1984 data. These changes resulted in a lower wage index value for all areas relative to the national rate; however, the payment rates were adjusted so that the new index would have no effect on total PPS payments.

(4) Issues Affecting Physicians

(a) Physician expenditures under Medicare

Part B Supplemental Medical Insurance (SMI) of the Medicare Program has experienced tremendous growth since its inception, in

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[26] Department of Health and Human Services, Health Care Financing Administration, Report to Congress on the Hospital Wage Index as required by Section 2316(a) of Public Law 98-369, Washington, DC. March 28, 1986.

[27] Ibid.

[28] Prospective Payment Assessment Commission, Report and Recommendations to the Secretary, U.S. Department of Health and Human Services, April 1, 1987.

terms of both services delivered and program expenditures. During Medicare's first full calendar year of operation (1967), total SMI exdenditures were $1.3 billion; in 1986, they were $26 billion. Over this 19-year interval, SMI expenditures grew at 17.5 percent per year. 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.[29]

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.[30] 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. This suggests to some policymakers that physicians may be increasing the volume of procedures and visits provided to Medicare beneficiaries to make up for the loss of income that they may have experienced as a result of the fee freeze.

OBRA 1987 (P.L. 100-203) contained several provisions to limit physician expenditures under Part B of the Medicare Program. For the 3-month period ending March 31, 1988, prevailing and customary charge levels were maintained at the levels in effect during 1987. A 2.3 percent reduction in Medicare payments to physicians that was initially put into place through the Gramm-Rudman-Hollings sequestration process was extended through March 31, 1988. Effective April 1, 1988, the increase in the medical economic index (MEI) for participating physicians became 3.6 percent for primary care services (e.g., home and office visits, emergency department services) and 1 percent for other physician services. Nonparticipating physicians received an increase of 3.1 percent for primary care services and 0.5 percent for other services. In 1989, the percentage increase in the MEI for participating physicians will be 3 percent for primary care services and 1 percent for other services. The MEI increase for nonparticipating physicians will be 2.5 percent and 0.5 percent, respectively. By January 1, 1989, the prevailing charge differential between participating and nonparticipating physicians was increased from 4 to 5 percent.

The Secretary of DHHS was authorized to monitor the actual charges of each nonparticipating physician for services provided after March 31, 1988. When a physician knowingly and willfully bills for a service on a repeated basis an actual charge in excess of the maximum allowable actual charge (MAAC), the Secretary will be authorized to apply sanctions.

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[29] Physician Payment Review Commission. Medicare Physician Payment: An Agenda for Reform. Washington, U.S. Govt. Print. Office, 1987, p. 13.

[30] Anderson, Gerald F. and Jane E. Erickson. National Medical Care Spending. Health Affairs, v. 6, no. 3, Fall, 1987. p. 101.

(b) Physician payment reform options

Neither the fee freeze nor the participating physicians program (discussed earlier in the chapter) are considered to be long-term solutions to controlling expenditures in the Part B program. Although the development of the fee schedules discussed below for pathologists and radiologists represent an attempt by Congress to get a handle on escalating costs, those services are only a small part of physician expenditures under Medicare. Serious consideration of more fundamental reforms has been hampered by several factors. These include major gaps in the data on what the program is currently paying for, opposition by physician groups to a major alteration in the fee-for-service and voluntary assignment approach, and the uncertainty of the impact of the major reform options on both the program and its beneficiaries. Yet, with the increasing need to curb costs and the vast innovation and change occurring in the organization of physician practice, pressures for comprehensive reform are likely to mount.

The major alternatives being considered include fee schedules, paying for physician's inpatient services on the basis of DRG's, or paying for services on a capitation basis. Studies of a number of options currently are being conducted by HCFA and other public and private entities. COBRA 1985 provided for the establishment of an independent Physicians Payment Assessment Commission (PPRC) whose mission and on-going duties are to make recommendations regarding Medicare physician payments. PPRC's first report to Congress was released in 1987 and focused primarily on reforms within the present fee-for-service payment system, although future reports likely will concentrate on more long-term reforms. In 1986, the Office of Technology Assessment (OTA) released its study on physician payment options which,[31] along with the work of PPRC and others, has helped form the debate as Congress continues to review possibilities for comprehensive reform. Options under consideration include:

Fee Schedules.—The current de facto fee schedules based on local prevailing charging patterns would be replaced by a uniform fee schedule for all physicians services. One method would be to use a relative value scale (RVS), which is a method of valuing individual services in relationship to each other. Each service is assigned an abstract index or weight and other services are assigned higher or lower numbers to indicate their value relative to that service. The use of a RVS could make the payment system more sensitive to a physicians' time, skill, overhead costs and the complexity of the service. A RVS is not a fee schedule. However, it is translated into a fee schedule by use of a predetermined conversion factor. One drawback to a RVS is that it may be so complex that a workable system would be difficult to develop.

The discussion surrounding the resource-based relative value scale (RBRVS) has centered on that developed by Professor William Hsaio and others at the School of Public Health at Harvard University. Their congressionally mandated report was released to

[31] U.S Congress, Office of Technology Assessment, Payment for Physician Services: Strategies for Medicare, Washington, DC, U.S. Government Printing Office, February, 1986.

HCFA on September 29, 1988. The Harvard researchers found that the current reimbursement system pays too much for surgical services and too little for cognitive services. Preliminary assessment of the income redistribution that would result under this RBRVS revealed that Medicare revenues for family physicians could increase as much as 60 to 70 percent, while thoracic surgeons and ophthalmologists could see their Medicare revenues decrease 40 to 50 percent.

With funding from HCFA, the Harvard researchers surveyed 180 physicians in each of 12 specialties that have high numbers of physicians and consume a large portion of Medicare physician expenditures. These specialties were: anesthesiology, family practice, internal medicine, obstetrics/gynecology, ophthalmology, orthopedic surgery, otolaryngology, pathology, radiology, general surgery, thoracic/cardiovascular surgery, and urology. Researchers selected procedures and then ranked them according to mental effort required to perform the service; technical skill; physical effort; psychological stress due to uncertainty; and potential risk to patient or physician. It was their intent to assign a worth, or value, to the intensity of effort associated with each service. Although the researchers were not able to evaluate variations in physician competence and patient characteristics, they believe their margin of error to be only 5 percent to 10 percent.

The results of the Hsaio study will likely meet with mixed reactions from various physician specialty groups. For example, the study supports previous findings that Medicare overpays cataract surgery by about 63 percent. On the other hand, the study found that family practitioners and internists are being underpaid by Medicare. The American Medical Association (AMA) supports the Harvard project as a way "to establish some sort of benchmark." However, the AMA also states that "in no way should it be considered a fixed, mandatory reimbursement policy." [32]

HCFA is required by law to develop and report to Congress on a RVS by July 1, 1989, and PPRC faces a difficult task in translating the Harvard RBRVS—or any RVS—into a workable Medicare fee schedule. Among the stumbling blocks they must overcome is adjusting rates to reflect geographic variation in practice costs, the development of a conversion factor to transform the RVS into a fee scale in dollars, and recognition of some specialty differentials.

PPRC will release its annual report to Congress by April 1989; they hope to present Congress with a blueprint for physician payment reform. Congress will likely decide whether to put a new payment system in place by the early 1990's. In the interim, PPRC recommends that Congress move toward a more equitable system of paying for primary care services (such as office visits, nursing home visits, emergency room, and home visits) by putting a floor equal to a fixed percentage of the national mean under them. The Commission believes this would increase beneficiaries' access to primary care services in those areas where primary care physicians are underpaid.

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[32] Milt Freudenheim, "Which Treatment is More Valuable? New Fee System to Rank Specialties," New York Times, April 21, 1988.

HCFA warns that the Harvard RVS should not be considered the "magic bullet" capable of solving the Medicare physician payment conundrum.[33] While the RVS will likely correct some of the inequities in the current reimbursement system, it does not address the issue of volume intensity. There is some concern that a RVS could exacerbate that problem if physicians respond to reduced fees by increasing volume and intensity.

Physician DRG's.—Under the Social Security Act Amendments of 1983, DHHS was required to report to Congress in 1985 on the feasibility of paying for physicians' services provided to hospital inpatients on the basis of DRG's. However, DHHS has not yet given Congress the report.

It is expected that a physician DRG payment scheme for inpatient services would involve the establishment of a predetermined payment for each of the 471 DRG's used under the PPS system. The major advantage of this scheme is that it would establish a specified payment amount for all services provided during an inpatient stay. There are, however, numerous questions about the practicality and appropriateness of a DRG scheme for physicians. The existing DRG coding system is based on resource use in hospitals; it may not be an accurate measure of physicians' input costs. Another question is who is going to receive the payment—the hospital, the attending physician, or the medical staff? One consideration in making this determination is the degree of financial risk imposed on the various parties involved. For example, an individual physician's caseload may consist of a higher proportion of sicker patients requiring more intensive care than the average for a particular DRG. Placing an individual physician at risk could potentially encourage the provision of less care than was medically appropriate or the avoidance of more severe cases.

Another issue is the potentially dangerous alignment between hospital and physicians incentives under a DRG payment scheme. Under the existing system, the physician is the last remaining check on quality. If he or she is given the same incentives as the hospital to reduce care, then quality may deteriorate. Other issues involve potential gaming—multiple admissions to maximize reimbursement, shifting care to the outpatient setting, and similar manipulations of the system.

Capitation.—Medicare would contract with an entity such as a carrier, which would serve as an at-risk insurer in a defined geographical area. Medicare would essentially purchase a specified package of services for a specified per-person price. The entity would be responsible for determining payment amounts and payment units. To assure beneficiary access to care at predictable levels of out-of-pocket costs, an entity could be required to obtain physician participation agreements from a certain percentage of physicians in the geographic area. The Federal Government would be required to determine the per-person payment. The system could be designed to be mandatory for all beneficiaries or optional.

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[33] William L. Roper, M.D., Administrator, Health Care Financing Administration, statement before the Subcommittee on Health, House Ways and Means Committee, House of Representatives, May 24, 1988.

The Reagan Administration, while it supported capitation as a long-term solution, has four short-term approaches they believed would help control Part B costs under the present fee-for-service system. These approaches included limiting payment fees on certain overpriced procedures, and intensive claims review to validate medical necessity and appropriateness of the level of care. The administration also supported bundling payments (providing one or a small number of payments for a particular diagnosis) to increase incentives to provide only medically necessary and appropriate services. Finally, the administration would encourage Medicare beneficiaries to use preferred provider networks. Providers participating in the networks would be those identified by HCFA as providing high quality care at affordable prices. Intensive utilization review and financial incentives would be used to encourage more appropriate volume and level of intensity of services by providers participating in the networks.

It is not clear at this time what position the Bush Administration will take on physician payment reform, although it is expected to be similar to that of the Reagan Administration. There are many questions about the effects of the aforementioned proposals, and they are likely to be heavily scrutinized by Congress and organizations representing the elderly. Initial concerns regarding the preferred provider networks and the capitation plan include whether beneficiaries will have the information and knowledge to make rational selections among the various plans. There is also a question of skimming and adverse risk. For example, the healthier beneficiaries may opt for the capitated scheme leaving the basic Medicare Program to absorb the high cost, heavy care patients. Finally, there is a concern that the Administration will be driven by budget concerns to hold the capitation payments low and to pare down the required benefit package.

(c) Inherent reasonableness

Payment for physicians' services is determined on the basis of customary, prevailing, and reasonable (CPR) charges. Under this system, charges for new procedures may be initially priced high because of the new technologies involved. Once a procedure has become established and frequently used, these initial payment levels may be artificially maintained under the CPR system despite technological or productivity advances. For example, improved medical technology resulting in lower costs, or reduction in the time required to perform certain procedures due to increased medical proficiency, should result in lower charges. In the past, this generally has not occurred.

Medicare carriers have the authority to use factors other than CPR in determining whether a charge for a specific service is inherently reasonable. In addition, under OBRA of 1985 the Secretary of DHHS is required to promulgate regulations specifying explicitly the criteria of "inherent reasonableness" that are to be used for determining Medicare payments. In 1986, DHHS focused through regulation on cataract procedures and payments for anesthesiologists who stand by and monitor the general care of a patient during a surgical procedure when the surgeon administers the local anesthesia. Each of these regulations were superceded by

OBRA 1986 (Public Law 99-509). Congress specified an approach to inherent reasonableness, specified limits on actual charges when allowable charges are limited through inherent reasonableness, and set inherently reasonable limits on allowable charges and limits on actual charges for cataract surgery and associated anesthesia services. This law reduced by 10 percent the prevailing charges for cataract surgery procedures performed in 1987, and by 2 percent in 1988.

OBRA 1987 specifies that the following 12 physicians' services will be subject to "reasonable charge reductions: Bronchoscopy, carpal tunnel repair, cataract surgery, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatectomy, transuretheral resection of the prostate, and upper gastrointestinal endoscopy.

OBRA 1987 reduced the 1987 prevailing charge levels by 2 percent, and further reductions of up to 15 percent will be implemented pursuant to a sliding fee scale. Prevailing charge levels that are at or above 150 percent of the weighted national average of prevailing charges for the procedure in all localities in the United States for 1987 will be reduced by 15 percent. When the physician's prevailing charge level for the service does not exceed 85 percent of the weighted national average, there will be no reduction beyond the 2 percent previously mentioned. When prevailing charge levels are between 85 percent and 150 percent of the weighted national average, the percentage reduction will be based on a straight line sliding fee scale equal to three-thirteenths of a percentage point for each percent by which the prevailing charge exceeds 85 percent of the weighted national average. In setting the new prevailing charge levels for these services, the Secretary's determinations will not be subject to administrative or judicial review.

(d) Other physician payment issues

OBRA 1987 contained several other provisions that effect physicians and physician reimbursement under Medicare. A provision to give incentive payments to physicians providing services in rural and/or medically underserved areas is of particular importance to Medicare beneficiaries experiencing problems with access to health care. An additional payment equal to 5 percent of the allowed amount for services will be made starting January 1, 1989, for services provided in a rural health manpower shortage area, and on January 1, 1991, for services provided in a nonrural health manpower shortage area.

The Administration's fiscal year 1988 budget proposal would have modified the fee-for-service reimbursement system for radiology, anesthesiology, and pathology (RAP) services provided for hospital inpatients. Under this proposal, Medicare would have paid an average rate per discharge for all RAP services, similar to DRG's. Congress rejected the administration's plan although certain provisions for OBRA 1987 address these issues. The law reduces payments for anesthesiologists supervising certified registered nurse anesthetists, and requires the Secretary of DHHS to develop a relative value scale (RVS) to serve as the basis of payment for physician radiology and pathology services. The Secretary is to use the

RVS and appropriate conversion factors in developing proposed fee schedules. Medicare payments will be based on fee schedules effective January 1, 1989, for radiology services, and by January 1, 1990, for pathology services.

On the whole, 1988 was a year of limited activity with regard to the Medicare physician payment system. In May 1988, Senator Heinz chaired a field hearing in Philadelphia to examine kickbacks and induced referrals between optometrists and ophthalmologists for cataract surgery for Medicare beneficiaries. Testimony at the hearing revealed that the current reimbursement methodology for cataract surgery has a great number of loopholes that enable "gaming" of the system, and pointed to a need for stricter oversight on reimbursement. The Aging Committee also released a report in 1988 entitled "Medicare Physician Payment Reform: Issues and Options." This report provides an overview of the current system, as well as options for change to physician payment under Medicare. While several of the provisions in OBRA 1987 (the most recent legislation affecting physician payment) that address the issue of physician payment reform are somewhat short-term or limited in nature, it nonetheless represents a movement toward more fundamental change. Because there is almost universal agreement that Medicare's current physician payment methodology is unsatisfactory, reform will occur in one form or another. Unfortunately, there is little agreement as to what reforms are necessary, so finding and implementing solutions will be a source of continued—and heated—debate.

(5) Issues Affecting Medicare Health Maintenance Organizations

The participation of health maintenance organizations (HMO's) in the Medicare Program represents yet another attempt by the Federal Government to stem rising health care costs. Like all health cost containment strategies, the challenge facing the Medicare HMO program is to achieve this objective without compromising health care quality. In 1988, Congress rewrote legislation originally enacted in 1973 and produced the Health Maintenance Organization Amendments of 1988 (P.L. 100–517). OBRA 1987 also contained provisions addressing problems related to post-contract protection of Medicare beneficiaries against non-Medicare covered health costs, quality of care, and HMO capitation rates.

(a) The Health Maintenance Organization Amendments of 1988

Congress spent 2 years rewriting the 1973 HMO Act to ease restrictions on HMO's and on employers who purchase HMO coverage. Prior to the passage of this law, HMO's were required to use the community rating to set their prices. Under the new HMO amendments, plans can calculate their premiums according to expected utilization, or a modified experience rating. However, if the projection of expected utilization proves incorrect, no adjustments will be allowed. HMO's must also make publicly available the data they use in determining premiums.

The HMO amendments repeal the requirement that employers make equal contributions to HMO's and traditional indemnity insurance plans when they offer their employees a choice of insur-

ance options. Instead, firms are barred from financially discriminating against one type of insurance coverage. Premiums charged for indemnity coverage cannot exceed HMO premiums by more than 10 percent where the number of workers involved is less than 100. Finally, as of October 1, 1995, employers will no longer be required to offer employees a choice of HMO or indemnity coverage.

(b) Post-contract protection

An attractive feature of many HMO's 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 HMO's as an alternative to traditional medigap policies. However, if an HMO closes or ceases participation in the Medicare Program, a beneficiary may be left facing unanticipated, uncovered health costs. This is particularly the case for the beneficiary who cannot find an alternative medigap policy for the HMO coverage that does not exclude, as most such policies do, existing medical conditions for a period of several months. As a result, a participant of an HMO which has closed may be left totally vulnerable to non-Medicare covered health care costs.

In 1987, two events highlighted this potential problem. First, the Florida-based International Medical Corporation, Inc. (IMC), one of the nation's largest HMO's with about 150,000 Medicare beneficiaries, declared bankruptcy. Second, 29 Medicare HMO's—18 percent of the total—pulled out of the Medicare HMO Program.

In the case of IMC, another health care corporation 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.

Nevertheless, both of these events drove 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 HMO's to ensure that Medicare enrollees are provided with supplemental coverage in the event the HMO ceases to serve such beneficiaries. Additional provisions required HMO's to inform Medicare enrollees of the possibility that its Medicare contract may be cancelled at some future time.

The coming year follows a record 44 HMO pullouts from Medicare in 1988 and will, therefore, test the adequacy of the OBRA 1987 provisions. This pullout affects 92,234 beneficiaries, which is approximately the same number of beneficiaries affected by the 29 HMO pullouts from Medicare in 1987.[34]

(c) Quality of care

Following a year-long Senate Special Committee on Aging investigation, Senator Heinz released a report in 1987 on HMO's with Medicare risk contracts. It found cases of questionable marketing

[34] "Medicare loses 44 HMO Contractors," *Medicine and Health*, McGraw-Hill, Inc., Volume 42, Number 44, November 7, 1988, p. 1.

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, the report, groups representing the HMO industry criticized the report for focusing only on grievances within a limited number of HMO's, thereby unfairly and inaccurately magnifying the problems within the Medicare HMO program.

To prevent wrongful practices among HMO's, Congress included provisions in OBRA 1987 to broaden and increase monetary sanctions against HMO's 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.

The 1987 reconciliation legislation also delayed by 1 year the effective date of the prohibition against so-called incentive payments. HMO management often provides such payments to physicians as a way to reduce utilization. Out of concern that the unrestricted use of incentive payments could reduce access to health care, Congress originally had barred such practices beginning in April 1989, and mandated a DHHS report on acceptable incentive payment systems. The extension to April 1980 was needed to provide time to fully consider any recommendations in the DHHS report.

(d) HMO-capitation rates

A continuing controversy in the Medicare HMO program surrounds the capitation rates used to determine the prospective payments a risk-contract HMO receives. The formula for such rates, referred to as the average adjusted per capita cost (AAPCC), accounts for a number of variables, including beneficiary age and sex and the location of the HMO. Rates can vary dramatically, and HMO's can receive widely differing payments. This and other related problems have led many to criticize the AAPCC.

To develop a better payment system, Congress included provisions in OBRA 1987 which authorized the Secretary of DHHS 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.

OBRA 1987 also authorized the Secretary of DHHS to enter into a limited number of contracts with employers and unions to provide Medicare benefits to retirees. This authority carries with it a limitation on the amount of profit the project's sponsor may retain and a number of requirements designed to protect the rights of beneficiaries.

In light of the urgent need to hold down Medicare costs, the Medicare HMO program holds the promise of providing cost-effective, quality health care. Congress can be expected to continue to adjust the program to assure that cost-effectiveness is not achieved at the expense of Medicare beneficiaries.

3. Prognosis

Consistent with the terms outlined by the 1987 Budget Summit, 1988 saw $3.8 billion cut from the Medicare program in fiscal year 1989 budget. Early in 1989, President Bush submitted his Fiscal Year 1990 budget. In it, he proposed a $5.2 billion cut in the Medicare program, most of it coming from the Medicare health care provider side of the ledger. By the end of February 1988, many Members of Congress had voiced their opinion that such a large cut was unreasonable and would be impossible to achieve. Aging advocates raised concerns that large cuts in the provider side might well affect the quality of services delivered to beneficiaries.

As a result of the 38.5 percent increase in the 1988 Part B premium, the Congress and aging advocates will be closely monitoring expenditures out of the Supplemental Medical Insurance (SMI) Trust Fund. Should Medicare Part B expenditures for physicians services continue to skyrocket, pressure for physician reimbursement reform will proportionately increase. Although it appears unlikely that comprehensive reform in this area be enacted by the 100th Congress, there may well be overwhelming pressures for implementation of temporary stop-gap measures, such as reducing beneficiary liability for Part B program costs. In addition, selected physician services and specialties likely will be targeted for further reductions in reimbursement.

Hospitals may receive more favorable treatment than physicians. In early 1988, studies released by both the DHHS' Inspector General's office and the Prospective Payment Assessment Commission (ProPAC) reported that hospital profits on Medicare inpatients had dropped. The DHHS study, largely corroborated by the ProPAC study, found that: (1) Hospital profits on Medicare inpatients dropped from about 14 percent of revenue in 1984 and 1985 to 9.6 percent in 1986, (2) one-third of all hospitals operated at a net loss on Medicare, and (3) rural hospitals as a group suffered a net loss. Further, preliminary estimates by the ProPAC study determined that fiscal year 1987 hospital profits were 2 percent. The reports concluded that reduction in profits were largely attributable to rising hospital costs which are outstripping inflation, declining admissions, and the fact that the Federal Government has slowed the amount of annual increases in the hospital reimbursement rate. Hospitals can be expected to use these findings to bolster their argument that they should not be targeted for further Medicare cuts.

With the findings of the DHHS and ProPAC study in hand, some Members of Congress, concerned that reduced reimbursement may threaten access to and quality of health care, will hesitate from supporting significant hospital reimbursement reductions. In contrast, Congressman Pete Stark, Chairman of the House Ways and Means Subcommittee on Health, can be expected to maintain his past position that hospital managers should not be rewarded for failing to control rising hospital costs.

As Congress and the Administration continue to look for ways to reduce the Federal deficit, hospitals (as the largest recipient of Medicare payments) will continue to receive close scrutiny during budget negotiations. To strike a compromise to the varying reimbursement approaches being discussed, Congress can be expected to

continue to give favorable treatment to financially vulnerable hospitals, such as those in rural settings. However, Congress will continue to try to find as much savings as possible from hospitals that are perceived to be faring very well under the prospective payment system.

If an agreement on a budget cannot be achieved, much more severe cuts from the Gramm-Rudman-Hollings budget sequester mechanisms would take place. Although Medicare is shielded from the full force of Gramm-Rudman-Hollings, it nevertheless would be a recipient of major cuts if a sequester was ordered. Whichever budget reduction process is pursued, however, Medicare and its over 31 million beneficiaries will be directly or indirectly affected by the process of belt-tightening and program retrenchment.

Beyond completing the long process of formulating a Federal budget, the first order of health policy business for the Congress in 1989 will be to ensure that anticipated serious deficit reduction measures do not cripple the health care delivery system and the beneficiaries it serves. In an environment in which deficit reduction continues to take priority on the national policy agenda, the Medicare Program faces difficult times ahead. With budget cuts slowing down reimbursement rates for providers, pressures will increase to deliver care at the lowest cost possible. 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 shortcomings of the Medicare Catastrophic Coverage Act of 1988 will likely be highlighted during its implementation in 1989 and beyond. An expected major focus of the aging and health policy debate will include the lack of protection against long-term care expenses (detailed in the next chapter), the need for addressing the issue of the 37 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.

The long-term care and insurance for the uninsured debate will be carried on in the halls of the Congress, but also will have a stage on the U.S. Bipartisan Commission on Health, mandated by the catastrophic health care legislation. The issue of increasing physicians' costs and ongoing pressures on the Part B program are expected to also receive significant attention during the continuing discussions on how to reform Medicare reimbursement to physicians. However, without question, the highest priority issue facing the Congress appears to be the Federal deficit. And, in that context, health care cost containment issues will remain the focal point of Congressional consideration.

The success of health care cost containment reforms rides on the willingness of patients, providers, and regulators to get the most out of 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.

B. HEALTH BENEFITS FOR RETIREES OF PRIVATE-SECTOR EMPLOYERS

1. Overview

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 65 and older. Since that time, retiree health benefits have become a common provision of private employer plans and a major source of Medicare supplemental insurance among many retirees.

At present, approximately two-thirds of the Nation's large firms offer retiree health benefits, and more than one-half promise a contribution to the costs of such coverage. Because these benefits commonly lack an adequate funding mechanism, however, retiree health plans represent large unfunded liabilities for the employer. The absence of benefit security has lead to a growing concern over whether employers can meet these obligations. Such concerns are compounded by the rising costs of health care, which continue to drive up employer liabilities in this area. Should employers cut back or cancel their retiree health plans in response to these factors, many retirees stand to lose an important source of privately sponsored health insurance.

2. Background

Many employers sponsor group health insurance plans that supplement Medicare benefits for retirees 65 and older and provide coverage for retirees not yet eligible for Medicare. Medicare, which covers more than 32 million Americans, provides fundamental health insurance for nearly all Americans 65 or older. However, Medicare neither meets all of the health care needs of these retirees, nor covers those who retire before age 65. As a result, employer-sponsored retiree health plans represent an extremely important source of health insurance protection for the Nation's retirees.

Although privately sponsored retiree health plans are far from universal, they nevertheless are included in the benefit packages offered by many employers. According to the Employee Benefit Research Institute (EBRI), 76 percent of the full-time health plan participants in 1986 had coverage continued after early retirement. Of those, 90 percent received such coverage after reaching age 65.

The availability of retiree health coverage appears to increase with the size of a company. According to survey data collected by the Washington Business Group on Health, approximately 8 out of 10 large employers provide postretirement health coverage. In 1987, data from several surveys revealed that 42 percent of employers with 50 to 99 employees provide health benefits, and 46 percent of employers with 100 to 149 employees have such plans. These figures increase steadily with the size of the employer to 62 percent for firms with 500 to 999 employees, 77 percent for those employing 1,000 to 4,999 persons, 89 percent for firms with 5,000 to 9,999 em-

ployees, and 94 percent for firms employing more than 10,000 workers.

However, when measured against the total number of older Americans, the extent of retiree health coverage is less impressive. According to Department of Labor reports, only 1 out of every 6 Americans 65 or older in 1983 was receiving a portion of his or her health coverage from an employer or union. In that year, approximately 6.9 million retirees were covered by private employer or union-sponsored health plans, with 4.3 million of these retirees 65 or older and 2.6 million under 65. According to other reports, approximately 25 million of the Nation's workers—representing 34 percent of the national labor force—are employed by companies that sponsor retiree health benefit plans.

For those who have employer-provided coverage, retiree health benefits are very important. Just the opportunity to continue participating in the employer's group plan after retirement can represent a significant savings for a retired worker as the cost of purchasing an individual policy following retirement often is prohibitive. As a result of lower administrative costs and employer contributions, group insurance plans typically offer beneficiaries a higher range of benefits at a lower costs than are available under individual policies. For retirees under age 65, an individual plan can be extremely costly, and for those 65 or older with a pre-existing medical condition it also may be very difficult to find.

Those 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. Under these plans, one of 3 approaches may be used: A "carve-out," "Medicare supplement," or "coordination of benefits" plan.

Most commonly offered to retirees is the carve-out plan. This type of health care approach provides for continued retiree coverage under a group plan, but does not cover services for which Medicare pays, thus avoiding duplicate coverage. Because retirees share their costs through copayments and deductibles, carve-out plans tend to be the least costly for employers.

Under a variation of the carve-out approach, the so-called coordination of benefits plan pays what it would in the absence of Medicare, but limits payments to 100 percent of the cost actually incurred. As this type of plan pays for services not covered by Medicare, its costs are affected by changes in Medicare coverage.

Unlike the coordination of benefits plan, a Medicare supplement type of retiree health care plan is insulated from changes in Medicare coverage by specifying exactly what costs are covered. The plan can tailor benefits to the needs of the retiree and also may result in a change in benefits when an early retiree reaches age 65. Although the costs of a Medicare supplement can be more easily controlled, this approach requires the design and administration of a separate plan.

3. Issues

(A) PROTECTION FOR RETIREES

Traditionally, employers have not prefunded health benefits, preferring instead to handle these obligations on a pay-as-you-go basis. In fact, many employers still do not appear to fully recognize the potential financial implications of their health benefit plans. Estimates of current unfunded liabilities for employee health benefits range from $85 billion, according to EBRI, to $2 trillion, according to a 1986 report released by the House Select Committee on Aging.

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 the vulnerability of retiree health benefits. As part of the company's bankruptcy, LTV moved to terminate the health and life insurance benefits or more than 78,000 of its retirees. In moving to meet this crisis, the Congress was confronted with the larger and more difficulty issue of whether the Nation's other companies would provide the health care coverage promised to their retirees or simply terminate their plans in the event of a similar financial crisis.

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. In addition Congress 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. However, this incident also spurred the Congress to enact legislation aimed at protecting other retirees who found themselves in similar straits. Included were (1) provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272, requiring the 18-month continuation of the provision of health benefits to retirees who otherwise would lose their health coverage upon retirement; (2) provisions in the Omnibus Budget Reconciliation Act of 1986 (OBRA), Public Law 99-509, requiring that companies entering Chapter 11 bankruptcy after July 1, 1986, continue health coverage for their retiring or retired employees for life, as well as coverage for their spouse and dependent children for 3 additional years in the event of their death; and, (3) provisions in the continuing appropriations resolution for fiscal year 1986 (P.L. 99-591), requiring that the health and life benefits being paid by companies in Chapter 11 bankruptcy as of October 2, 1986, continue to be paid until May 15, 1987. Under provisions in Public Law 100-334, the last provisions were extended.

Reflecting Congressional concern in this area, on August 7, 1986, the Senate Special Committee on Aging held a hearing on the difficulty of securing health benefits for retirees whose employers enter bankruptcy. Witnesses testified that while Congress could require vesting of health benefits at retirement, it would discourage employers from providing these benefits for current workers and even lead to a reduction of retiree health benefit coverage. In addition, while vesting would protect the health benefits of retirees of exist-

ing companies, it would not adequately protect the retirees of bankrupt companies. They would still lose their coverage and have only an unsecured claim for the value of the benefits. To survive bankruptcy, retiree health benefits would have to be funded and guaranteed in much the same way as are pension benefits, according to witnesses. However, they added that it was unlikely that even the most aggresssive efforts would result in the adequate funding of retiree health benefits in the near future.

Nonetheless, retirees have found some measure of protection for their employer sponsored health benefits through the Federal courts, which increasingly has been forcing employers to honor what previously was regarded as an informal obligation. In *Eardman* v. *Bethlehem Steel Corporation* [607 F. Supp. 196 (1984)], 16,000 nonunion retirees objected to changes in their medical plans which were instituted by Bethlehem Steel to contain costs. A U.S. district court, reviewing the terms of these plans, held that where the employer did not clearly retain the right to reduce or cancel retiree benefits, these benefits could not be reduced. After filing an appeal, Bethlehem agreed to provide a permanent health program for the retirees by combining features of the original and modified medical plan.

A Tennessee case, *Musto* v. *American General Corporation* [615 F. Supp. 1483 (1985)], went even further. While *Bethlehem Steel* had implied that employers were free to modify retiree benefits if those retirees had been informed of the possibility prior to leaving their job, *Musto* prohibits modification by the employer regardless of what employees or retirees have been told. *Musto* holds that employer health benefits vest upon retirement and are unchangeable thereafter regardless of the reservation clauses employers may have incorporated into plan documents.

While some hail the *Musto* decision as a far-reaching development in the protection of retirees' rights, others question whether its line of reasoning will do more harm than good. The Washington Business Group on Health (WBGH) has raised the concern that a prohibition against any change in retiree health plans would prevent employers from adopting plan modifications which would help to contain escalating health care costs and increase the quality of care provided. The WBGH has warned that depriving employers of the ability to modify plans in any way will have the effect of locking in plans which are outmoded and wasteful, and will impose the entire burden of cost containment on future retirees.

The lower court decision in *Musto* has been overshadowed by the 6th U.S. Circuit Court of Appeals decision in another case: *Hansen* v. *White Farm Equipment Co.*[1] In this case, the company cancelled retiree medical coverage when it filed for Chapter 11 reorganization. A U.S. district court reversed a bankruptcy court decision and held that the company had to continue coverage because retirees had a vested right to their health benefits at retirement and the clause the employers had included in the plan to reserve the right to terminate benefits had not been sufficiently clear.[2] On appeal,

[1] 23 Bankruptcy Reporter 85 (1982).
[2] 42 Bankruptcy Reporter 1005 (1984).

the appeals court reversed the district court, ruling that although retirees do have contractual rights in post-employment benefits, they are not automatically vested upon retirement, but subject to the terms of the contract.[3] The court held that only the Congress, not the Federal courts, has the power to declare retiree medical benefits vested. The case was remanded to the bankruptcy court for a determination as to whether the information conveyed to the retirees clearly and expressly reserved the right of the company to terminate benefits.

The 6th Circuit decision in *White Farm* directly contradicts the *Musto* ruling by a lower court in the same circuit of vested benefits under Federal common law.

(B) FUNDING OF RETIREE BENEFIT PLANS

As a result of increasing pressure on employers to guarantee the health benefits they have promised to their retirees, employer concerns over the financial burden such benefits represent have mounted. A major factor has been the growing cost of health care. Rapidly rising health care costs have forced employers to recognize that more and more financial resources will be needed to provide health benefits to retirees in the future, particularly for companies with a high ratio of retirees to employees.

Employers also are concerned that the Federal Government, in its efforts to contain costs under Medicare, will make changes in Medicare policy that shift more health care costs to employers. The unpredictability of future Medicare policy is of particular concern in light of various court decisions that have held employers liable for the delivery of promised health benefits.

A third factor in this area is the growing recognition among 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 the health care benefits promised to their future retirees. However, in 1984, the Financial Accounting Standards Board (FASB), an independent, nongovernment group which develops standards for financial reporting, for the first time required disclosure of plan liabilities, effective 1985. More specifically, employers were required to disclose in a footnote how, or whether their health benefits plans were prefunded. As part of this effort, in January 1989, the FASB released for comment a set of more comprehensive draft rules that would require that companies report both current and accrued expenses associated with retiree health benefits.

By focusing on the adequacy of employer prefunding of such benefits, FASB's proposed reporting requirements may significantly affect the financial standing of companies with large unfunded liabilities. Previously, investors paid scant attention to a company's current and future liabilities of their retiree health plans. Under the draft rules, however, companies would have to reveal these li-

[3] *Hansen* v. *White Motor*, 788 F.2d 1186 (6th Cir. 1986).

abilities, possibly diminishing their attractiveness to potential investors as a result. Particularly for companies that already are financially strained, this reporting requirement could further weaken their position in financial markets.

These factors have led some employers to consider prefunding their retiree health benefit plans. Relatively few employers currently prefund their plans and, to date, no consensus exists as to whether prefunding is desirable. Some employers feel that they are legally obligated to provide promised retiree health benefits and therefore should prefund their plans. Others, however, resist accepting these obligations and the notion of prefunding.

At any rate, refunding will remain an unattractive option for employers until tax incentives are provided that offer favorable treatment for setting aside funds to finance future health benefits—similar to the favorable tax treatment that pension contributions currently receive. At present, however, 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.

Indeed, as a result of provisions in the Deficit Reduction Amendments of 1984 (DEFRA), one tax mechanism for prefunding of employer sponsored health benefits was significantly scaled back, effective January 1986. Previously, that law had allowed employers to establish a voluntary employee benefit association (VEBA) into which they could set aside unlimited funds to provide for retiree health benefits. To receive a tax deduction for these funds, the employer only had to certify that the funds would be used to pay for benefits. However, the Treasury Department persuaded the Congress that although the VEBA mechanism was not widely used, unlimited deductions were not appropriate for "contributions" which faced neither reporting and disclosure requirements, nor limitations on total funding.

In effect, the DEFRA provisions put the burden of justifying the need for a tax-favored funding mechanism for retiree health benefits on the employer. Also, the law placed a cap on the amount of funds that an employer could set aside for tax purposes, thus decreasing the value of VEBA's as a prefunding mechanism. At present, no more can be set aside than the total of a company's current expenditure for a particular benefit, plus 75 percent of that amount to account for future uncertainties. The 75 percent limit, according to benefit consultants, is far below the amounts needed to account for increases in the size of the retiree population and the rapidly escalating costs of health care.

4. Legislation

In the first session of the 100th Congress, legislation enacted to address problems in the area of securing retiree health benefits was largely crisis driven, resulting in short-term, stop-gap measures aimed at helping retirees of companies that filed for Chapter 11 bankruptcy. In response to LTV's attempt to terminate its retirees' health plan, two bills were signed into law in 1987 requiring the continuation of health benefits for the corporation's retirees.

Legislation to protect retirees in a similar situation was subsequently enacted.

However, in 1988, the Congress developed a broader response to problems in this area. The enactment of the Retiree Bankruptcy Protection Act of 1988, signed into law on June 16, 1988, as Public Law 100-334, prevented employers from unilaterally canceling or reducing retiree health benefits when filing for bankruptcy under Chapter 11 and extended creditor status to retirees. Also, the law required the continuation of retiree health benefits pending agreement to modify benefits by the retirees' representative or to reduce or terminate benefits by a bankruptcy court.

5. Prognosis

In the 101st Congress, retiree health benefits will remain a major concern. To date, Federal legislation has sought to protect retirees in the event of a company's filing for bankruptcy under Chapter 11. In 1989 and beyond, however, Congressional activity likely will stem from the impact of the expected ruling by the FASB to require employers to count unfunded retiree health benefit liabilities against company earnings. At present, the final ruling is expected to take effect by 1992.

This anticipated change in accounting practices will place great pressure on employers to fund retiree health plans. Amid such pressures, employers may seek tax incentives from the Congress to help offset the costs of funding retiree health plans, possibly by easing up on the limitations that currently apply in this area. However, should employers also attempt to cut back retiree health care benefits to lessen the liability of such plans, the Congress also may look to ways to prevent abuses in this area.

C. HEALTH RESEARCH AND TRAINING

1. Background

Biomedical research is one of the most fundamental, yet often overlooked, ways to reduce health care costs and the need for long-term care. The Federal Government's substantial investment in biomedical research for nearly four decades has resulted in America's outstanding advances in science and health. However, the Federal Government's investment in medical research is only about 1.2 percent of total spending on health care in the United States.

Although the National Institutes of Health (NIH) is the major biomedical research arm of the Federal Government, the Alcohol, Drug Abuse, and Mental Health Administration, particularly the National Institute of Mental Health (NIMH), also is involved in considerable research activity relating to the elderly.

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. For example, the incidence of Alzheimer's disease and related dementias is projected to double before the end of the century and quadruple by 2040, if biomedical researchers haven't identified the cause and developed effective treatments.

The lack of a cohesive biomedical aging research policy was addressed by the Senate Special Committee on Aging in a hearing on May 11, 1988. Entitled "Advances in Aging Research," prominent researchers in the field of aging addressed significant scientific findings and the complex and technical issues of the goal of modern aging research—an extended "health span," not just lifespan.

Currently, it is estimated that one-third of all health costs in the United States are spent on the 12 percent of the population which is over age 65. With the projected rapid expansion of the aging population, it is expected that by the year 2000, one-half of the health cost dollar will be spent on older Americans. Hearing witnesses suggested that if 1 percent of the cost of care were spent on research, major advances could be made in finding the cause, cure, prevention or postponement of the major diseases of aging, such as Alzheimer's disease and osteoporosis.

In many parts of the United States, the health care system is unable to deal with the current needs of elderly patients suffering from dementia and other diseases. To meet those needs, the Federal Government is expanding the scope of its research activity regarding services to meet the more immediate needs of Alzheimer's disease patients and their families. Specialized professional training for health care providers working with geriatric patients is another emerging, significant, and severely undermet need that Congress is beginning to address.

(A) THE NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health (NIH), which celebrated its centennial in 1987, seeks to improve the health of Americans by increasing understanding of the processes underlying disease, disability, and health and by helping to prevent, detect, diagnose, and treat disease. It supports behavioral and biomedical research through grants to facilities, 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 into both of these areas increasingly challenge health providers to seek causes, treatment, and prevention of the many ailments of 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 of disorders and diseases also facilitates progress in health promotion, medical education, and health policy and planning.

(1) History of NIH

NIH traces its beginning as a health research organization of the Federal Government to the establishment of the Laboratory of Hygiene for research on cholera and other infectious diseases in 1887 as part of the Marine Hospital Service at Staten Island, NY. The Marine Hospital Service was a forerunner of the present Public Health Service. In 1930, Congress passed the Ransdell Act, which renamed the Laboratory of Hygiene and created the National Insti-

tute of Health. The Ransdell Act also authorized a system of fellowships and the construction of two buildings "for study, investigation, and research into the fundamental problems of the diseases of man."

With the passage of the Social Security Act in 1935, up to $2 million annually was authorized for the "investigation of disease and problems of sanitation," but appropriations ranged from $375,000 in fiscal year 1936 to $707,000 in fiscal year 1940. Congress authorized the creation of the National Cancer Institute in 1937 as a division of the Public Health Service. The Public Health Service was revised and consolidated in 1944, giving NIH its postwar legislative basis establishing permanent, general authority to conduct research.

The National Heart Act, passed in 1948, established the National Heart Institute and changed the name of the National Institute of Health to the National Institutes of Health. Since then, many more institutes have been established and the NIH budget has grown from $8 million to almost $6.7 billion.

(2) Health Research Extension Acts of 1983 and 1985

These bills, to amend the Public Health Service Act relating to the National Institutes of Health, became a point of confrontation between the White House and the Congress. The Health Research Extension Act of 1983 was passed by Congress and then pocket vetoed by the President in 1984 after Congress adjourned. It was reintroduced in 1985, again passed by Congress, and, once again, was vetoed by the President. This time, however, the veto was overridden by 380–32 in the House and 89–7 in the Senate.

The Administration's objections focused on the creation of a new nursing research center, the imposition of a uniform set of authorities on all research institutes, and additional administrative and program requirements. However, in 1985, the President, in his veto message, acknowledged the need to establish a National Institute of Arthritis, a point on which he had vetoed the Health Research Extension Act in 1984.

The new legislation also reauthorized the National Cancer Institute and the National Heart, Lung, and Blood Institutes, established a Biomedical Ethics Advisory Board, increased emphasis on the humane care of laboratory animals, and provided explicit statutory authority for each of the institutes while retaining the authority of the Secretary of the Department of Health and Human Services to support research and reorganize the institutes.

(3) The Institutes

Much of the research into particular diseases, disorders and conditions at NIH is collaborative, with different institutes investigating pathological aspects related to their specialized approach. At least 10 of the NIH research institutes 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 Disease,
National Institute of Neurological and Communicative Disorders and Stroke,
National Institute of Allergy and Infectious Diseases,
National Eye Institute,
National Institute of Arthritis and Musculoskeletal and Skin Diseases, and
National Center for Nursing Research.

(a) National Institute on Aging

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

NIA areas of biomedical and clinical research include Alzheimer's disease, molecular genetics to understand the basic mechanisms of aging, the effects of infections and toxins on the aging nervous system, the ability of transplanted brain cells to enhance memory and reverse learning deficits in animals, brain metabolism, function and biochemical diagnostic tests as related to dementia and aging, burden-of-care, and osteoporosis, hip fractures and falls.

(b) National Cancer Institute

The National Cancer Institute (NCI) conducts and sponsors basic and clinical research relating to the cause, prevention, detection, and treatment of cancer. 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.

Although the rate of cancer survival has increased to 50 percent from the 30 percent of the 1950's due to advancements in surgery, radiation, and chemotherapy treatment, the rate of overall cancer incidence and mortality has been increasing, particularly in those 55 and older.

In addition to basic and clinical, diagnostic and treatment research, NCI supports a prevention and control program emphasizing such programs as assistance to stop smoking programs.

(c) National Heart, Lung, and Blood Institute

The National Heart, Lung, and Blood Institute (NHL&BI) 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 NHL&BI. In 1985, more than 1 million deaths were reported from all of the diseases under the purview of the Institute with associated health care costs exceeding $143 billion. Nearly 40 percent of all elderly suffer from hypertension, 25 percent from a chronic heart condition, and 8 percent from arteriosclerosis.

Current research efforts include cholesterol-lowering drugs, DNA technology, and genetic engineering techniques for treatment of emphysema, basic molecular biology research in cardiovascular, pulmonary, and related hematologic research, and regression of arteriosclerosis.

The Institute 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 death and 40 percent decline in heart disease over the past 20 years.

(d) National Institute of Dental Research

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

In a national study in 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 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 and promotion and disease prevention project.

(e) National Institute of Diabetes and Digestive and Kidney Disease

The National Institute of Diabetes and Digestive and Kidney Disease (NIDDKD) 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 11 million Americans at an annual cost of $14 billion. Nearly 10 percent of the elderly are believed to be diabetic.

(f) National Institute of Neurological and Communicative Disorders and Stroke

The National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) supports and conducts research and research training on the cause, prevention, diagnosis, and treatment of hundreds of neurological and communicative disorders. This involves basic research to understand the mechanisms of the brain and nervous system and clinical research.

Most of the disorders studied by NINCDS result in long-term disabilities and involves the nervous system (including the brain, spinal cord, and peripheral nerves), muscles, hearing and hearing communication. Of particular concern to the elderly is research on stroke, Huntington's disease, Parkinson's disease, amyotrophic lat-

eral sclerosis and the dementias, including Alzheimer's disease. NINCDS research is also focusing on neuroimaging technology and molecular genetics to determine the etiology of Alzhemier's disease.

Stroke, the Nation's third-leading cause of death and most widespread neurological problem, primarily affects the elderly. New drugs to improve the outlook for stroke victims and surgical techniques to decrease the risk of stroke currently are being studied.

(g) National Institute of Allergy and Infectious Diseases

The National Institute of Allergy and Infectious Diseases (NIAID) with basic and clinical applications, 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 improved vaccines for high-risk individuals from influenza. Since older persons also are particularly vulnerable to hospital-associated infections, NIAID research is leading to a vaccine for protection against one of the most common, difficult to control, and often fatal infections, P. aeruginosa.

(h) National Eye Institute

The National Eye Institute (NEI) conducts and supports research and research training about the prevention, diagnosis, treatment, and pathology of diseases and disorders of the eye and visual system. 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 basis for future outreach and educational programs aimed at those at highest risk of developing glaucoma.

(i) National Institute of Arthritis and Musculoskeletal and Skin Diseases

The 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. In 1988, the Institute announced its support for the formation of nine specialized centers of research for in-depth research on rheumatoid arthritis, osteoarthritis, and osteoporosis. The research centers, funded by Congress in 1987, will receive NIAMS funding for 5 years.

NIAMS hopes to make contributions to the national research effort for these diseases, which it says are among the Nation's most critical health problems. Affecting over 40 million Americans, these diseases are among the more debilitating of the more than 100 types of arthritis and related disorders. They primarily affect individuals over 50 years of age. 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.

Among topics of research on the cause and treatment of rheumatoid arthritis, a chronic inflammatory disease of unknown cause, are: The study of 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, includes a focus on changes in the network of surrounding cartilage cells in the joint.

For osteoporosis, which causes loss of bone mass, researchers are studying the effects of estrogen replacement therapy and the effects of disuse, age, and hormones on osteons, the building blocks of bones.

(j) 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 related to the elderly includes 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 decision making.

(B) NATIONAL INSTITUTE OF MENTAL HEALTH

As one of three institutes of the Alcohol, Drug Abuse, and Mental Health Administration, 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 develop a comprehensive approach to the neurochemical aspects of the disease. NIHM research has discovered a protein specific to Alzheimer's which shows promise of being a positive diagnostic marker for the disease. Research into amnesia is increasing knowledge about Alzheimer's and other dementia, and on the extent of structural change in the brain as well as the neurochemical aspects of the disease.

(C) GERIATRIC TRAINING

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 was relatively unrestricted and unfocused, aimed at increasing the numbers of all types of health care professionals.

By the mid-1970's, this generalized effort had proven successful and Congress then focused on particular problem areas in the supply of health care professionals, such as geographic and specialty shortages. For example, special trainee and residency programs were established for preventive, family, and general internal medicine, physician assistants and minority health education.

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 which 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 program under the Public Health Service Act for traineeships and fellowships to initiate in-depth training of faculty in geriatrics for training of future health care providers in geriatrics.

2. Issues and Legislation

(A) ALZHEIMER'S DISEASE

For the last several years, Congress has become increasingly concerned about the serious and growing problems of Alzheimer's disease and related dementias. This progressive and irreversible degenerative brain disease is the fourth-leading killer in the United States, affecting an estimated 2.5 to 3 million persons, about two-thirds of the all of the cases of dementia and about 8 percent of the elderly population. The cost of care and treatment for Alzheimer's patients is estimated at $80 billion annually. This includes $40 billion for direct costs and $40 billion for indirect costs.

For the most rapidly expanding segment of the elderly population, those over age 85, the chance of developing dementia is estimated to be 20–30 percent, compared to 7 percent for those age 75–84, and 1 percent for those age 65–74. As the prevalence of dementia escalates in the coming decades, so, too, will the costs—financial, physiological, psychological, emotional, and personal.

Congressional consideration of Alzheimer's disease has focused on increased funding for research on the causes, diagnosis, and treatment of the disease. However, no dramatic fix is expected for dementia in the near future, so concern now also is centering on the cost and ways of providing care for its victims.

Most of the federally funded research into Alzheimer's disease is being carried out by the National Institute on Aging, National Institute of Neurological and Communicative Disorders and Strokes, 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. Recent studies on the molecular genetics of Alzheimer's disease indicate a linkage between chromosome 21 and the familial or early onset form 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 yet have 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. One of these drugs is THA, tetrahydroaminoacridine. Preliminary results of a study of THA, sponsored by the National Institute on Aging, the Alzheimer's Disease and Related Disorders Association, and Warner Lambert, are expected in the spring or summer of 1989. The study, begun in 1987, was temporarily halted 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.

The Alzheimer's Disease Research Centers, established by Congress in 1984, 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 special units for clinical and basic research as well as behavioral studies of Alzheimer's and related disorders. Based mostly 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 and Communicative Disorders and Stroke and the National Institute of Allergy and Infectious Diseases.

In 1986, Congress passed the Alzheimer's Disease and Related Dementias Services Research Act of 1986 as part of the Omnibus Health bill (Public Law 99-487). Many consider this to be a landmark piece of legislation in that it directs researchers to develop the services needed by individuals with Alzheimer's disease and related dementias and their families. It also established within the Department of Health and Human Services (DHHS) 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 1987 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. These services must meet the specific needs of Alzheimer's patients and may include case management, adult day care, mental health services, outpatient drug therapy, respite care, and other home-and community-based services.

(B) OSTEOPOROSIS

Osteoporosis is another major debilitating health problem for an estimated 24 million Americans—half of all women over age 45 and 90 percent of all women over age 75. The disease, 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 $10 billion annually, will increase significantly as the population ages and incidence increases.

Every year, osteoporosis is responsible for 1.3 million bone fractures in those over age 45, or about 70 percent of all bone fractures in that age group. Most of the approximately 245,000 hip fractures suffered by individuals over 45 in 1985 were attributable to osteoporosis. This fracture is one of the most catastrophic of all because it requires a longer hospital stay, may involve a hip replacement, and may result in increased risk of death.

Treatment for osteoporosis is aimed at stopping further loss of bone mass through use of estrogen or calcium supplements. Therapies for restoring or simulating lost bone mass are not yet well-established.

Medical experts agree that osteoporosis is highly preventable through early screening, balanced diet, regular exercise, limited intake of alcohol, and not smoking tobacco.

The National Osteoporosis Foundation stresses, however, that if the rate of osteoporosis is to be slowed, Federal appropriations for research must be significantly increased.

Potential research topics include studies of basic bone biology and bone remodeling related to osteoporosis; improved therapies to increase bone mass; better screening methods to measure bone density; estrogen therapy; bone homeostasis and calcium intake, absorption, and excretion; and the effect of exercise on bone.

The latest scientific consensus on osteoporosis recognizes estrogen and calcium deficiencies as the major causes of postmenopausal osteoporosis while certain drugs could be precipatory agents. It has recently been discovered that bone cells contain receptors for estrogen and that estrogen treatment in postmenopausal women can protect against hip fractures as they age. Scientists also agree that calcium cannot substitute for estrogen in preventing the accelerated bone loss that occurs in the 8–10 years following menopause.

Other possible research subjects include concurrent estrogen and progesterone therapy, calcium and fluoride compounds, the use of calcitonin from salmon, and studies of calcium loss among astronauts.

(C) GERIATRIC TRAINING AND EDUCATION

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 65 and older are increasing at an unprecedented rate. In a 1987 report, Personnel for Health Needs of the Elderly through Year 2020, the National Institute on Aging (NIA) said that projections of potential

use of services by the elderly population by 2020 show an expansion of more than twice the 1980 volume.

NIA predicted that older adults will compose up to two-thirds of the practices of most physicians and other health caregivers. 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 requirements for personnel specifically 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, it said.

Yet most health professions education programs give relatively little emphasis to issues relating to geriatrics and aging, NIA said, and shortages of faculty members and other leaders with adequate preparation in aging and geriatrics pose a serious constraint on education and training needs.

The most serious shortage is in the number of faculty members and other leaders that have specialized backgrounds in aging and geriatrics 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. Therefore, the report strongly recommended that the first priority must be to greatly expand the number of faculty members and other leaders to plan, develop, guide and provide the training, consultation and research needed for geriatric education and training.

The report also recommended that education and service programs should give special attention to high priority services such as home, community-based, and nursing home services, rehabilitative care and health promotion and disease prevention activities. Special attention was also recommended for high-risk groups such as Alzheimer's disease patients and the very frail elderly.

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, NIA said. 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 ranges 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 problematic issues 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, OWL said in its 1988 report, "Chronic Care Workers: Crisis Among Paid Caregivers of the Elderly."

OWL reported that chronic care workers are in extremely short supply in some areas, most notably in the northeastern States. Among the many reasons for high turnover rates among these workers are low wages and few benefits; inadequate training, orientation, and supervision; and no pay for classroom training, OWL said.

The NIA report found that the most effective way of providing multidisciplinary geriatric training was through collaborative arrangements between academic institutions and providers. Financing has come from many sources, including State, local, and private funds and Federal programs. The report recommended that financing of geriatric education and training programs continue to come from multiple sources and be targeted on strengthening proven approaches. It also recommended that Medicare and other health care financing programs emphasize alternative training approaches such as in-service training and continuing education in geriatrics.

Finally, the study found many gaps in the information that is available about the health services the elderly receive and the status of related training and education programs. It was recommended that ongoing studies be continued to develop additional data for future analyses and more specific recommendations.

(D) LEGISLATION

Although a number of bills involving Alzheimer's disease were introduced in the 100th Congress, the only legislative items approved in the second session were an appropriation bill and a resolution designating November 1988 (P.L. 100-620) as "National Alzheimer's Disease Month."

Reauthorization of a number of programs relating to the National Institutes of Health was included in S. 2889, the "Health Omnibus Programs Extension of 1988" which was passed in the closing days of the 100th Congress and signed into law on November 4, 1988 (P.L. 100-607). A new Institute is created under this law, the "National Institute on Deafness and Other Communication Disorders," which is concerned with disorders of hearing and other communications processes, including diseases affecting hearing, balance, voice, speech, language, taste, and smell. It is estimated that 22 million Americans have partial or total loss of hearing and another 2.3 million persons suffer from communication disorders. About half of these persons are over 65 years of age.

The two largest institutes, the National Cancer Institute and the National Heart, Lung, and Blood Institute, were reauthorized for 3 years. The law also established a National Center for Biotechnology Information for the design and development of automated computer systems to be used for research concerning human molecular biology, biochemistry, and genetics.

(1) NIH Appropriations

The President's fiscal year 1989 budget proposal reverses previous Administration positions on the Federal commitment to biomedical research by funding NIH at $7.12 billion—$456 million above appropriations for fiscal year 1988.

Congress' continued support for biomedical research is reflected in the conference report for H.R. 4783 for Labor, Health and Human Services, and Education appropriations (P.L. 100–460), which provides funding for NIH at a level of almost $7.15 billion, an increase of about $666 million over 1988 and the largest budget in the history of the NIH. Of this amount, $607 million is designated for AIDS research.

Both the House and Senate appropriation committees emphasized in their reports (H.R. 4783, H. Rept. 689, S. Rept. 399) the need for an expanded effort and the inclusion of increased funding for Alzheimer's research. The Senate report, in designating $44 million in additional funding to help find the cause, cure, and better treatment methods for Alzheimer's disease, stipulated that this increase intended that a significantly higher priority be placed on Alzheimer's.

(2) NIMH Appropriations

The National Institute of Mental Health's appropriation for mental health research for fiscal year 1989 is $297 million, up from $254 million in fiscal year 1988. The conference report said that this increase would fund important expansions into the neurosciences as recommended by the "Decade of the Brain" report, and into schizophrenia and Alzheimer's disease. The House Appropriations Committee indicated in its report that NIMH should increase its research efforts in the important areas of aging disorders because of the fast-growing incidence of dementia.

(3) Geriatric Training

The Health Omnibus Programs Extension of 1988 (P.L. 100–607), also included the Health Professions Reauthorization Act of 1988 which reauthorized the program that provides grants and contracts to geriatric education centers (GEC's) and for geriatric training projects to train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. $7 million was authorized for each program for fiscal year 1989, up to $13 million in fiscal year 1991. Under the GEC provisions, grants and contracts can be provided to health professions schools, including schools of allied health, related to the treatment of health problems of the elderly. Other provisions included new affiliations with nursing homes, ambulatory care centers, and senior centers to provide students with clinical training in geriatric medicine.

The appropriations bill for fiscal year 1989 also provided $13.5 million for geriatric training programs, an increase of only $1 million over fiscal year 1988. Of this, funding was provided to establish up to two GEC's for geriatric research and training.

3. Prognosis

Within the past 50 years, there has been an outstanding improvement in the health and well-being of the American people. 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

efforts of our Nation's medical and research community which has been possible because of the Federal Government's longstanding commitment to the support of biomedical research.

Now, as Congress grapples with the persistent Federal budget deficit, the Nation is also confronted with the current and impending costs of caring for rapidly increasing numbers of persons afflicted with two deadly and devastating diseases—Alzheimer's and AIDS. Congress has responded with increased resources but consistent and sufficient Federal support is essential in order to follow promising research to unravel the cause, develop treatments, and possible prevention of these and many other costly diseases, such as cancer and diabetes, which have so far been incurable.

Also, with the projected phenomenal increases in our country's over age 85 population, study after study has called for tremendous increases in the number of health professionals trained in geriatric care. While Congress has recognized and initiated programs to meet this need, the Federal commitment for funding has been very limited and may continue to be in the face of budget constraints.

The Administration is expected to sustain its reversal of earlier positions of cutting budgets and to support increased funding for biomedical and clinical research. As in the past, Congress is anticipated to continue its commitment to health research—with close scrutiny of progress and promise; and sustained and increased Federal financial support.

Chapter 8

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 medigap insurance. Many elderly persons and their families pay the full costs out-of-pocket, making long-term care the single greatest threat to the financial security of older Americans and many of their families.

Neither significant public nor private improvements in long-term care financing and delivery have occurred within the last several years. The reluctance to implement new long-term care initiatives can be attributed to three major factors. First, the 6 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. Second, 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 growing budget deficits and competing interests. Third, no consensus exists on the best way to finance long-term care.

However, as the need for increasing access to and affordability of long-term care grows more pressing, there is evidence of heightened Congressional interest in this issue. In 1988, several Senators and Congressmen introduced bills to provide comprehensive coverage of a range of long-term care services. While these bills had varying cost-sharing and eligibility requirements, as well as different approaches to financing, they represent the first serious efforts by Members of Congress to address the financing and delivery of long-term care.

1988 also saw the final passage of the Medicare Catastrophic Loss Prevention Act of 1988 (P.L. 100-360). Although the benefits provided focus on services associated with acute catastrophic illness, rather than long-term coverage of chronic illnesses, there are provisions in the law that begin to address the Federal role in the financing and delivery of long-term care services.

Many see the solution to the long-term care problem in the form of a public-private partnership. However, private initiatives alone are unlikely to solve more than a small portion of the problem. The experience of private insurers to date has been disappointing. Long-term care insurance policies have not been popular with the American public, especially among those young enough to purchase insurance when it is more affordable. Employers, too, have shown a

reluctance to offer a new long-term care benefit, though there are now available several group plans offered by insurance companies.

A. BACKGROUND

1. Types of Long-Term Care

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 encourages 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. According to the 1982 National Long-Term Care Survey, nearly 90 percent of disabled older people who were not in nursing homes received assistance from relatives and friends, sometimes supplemented by paid care.

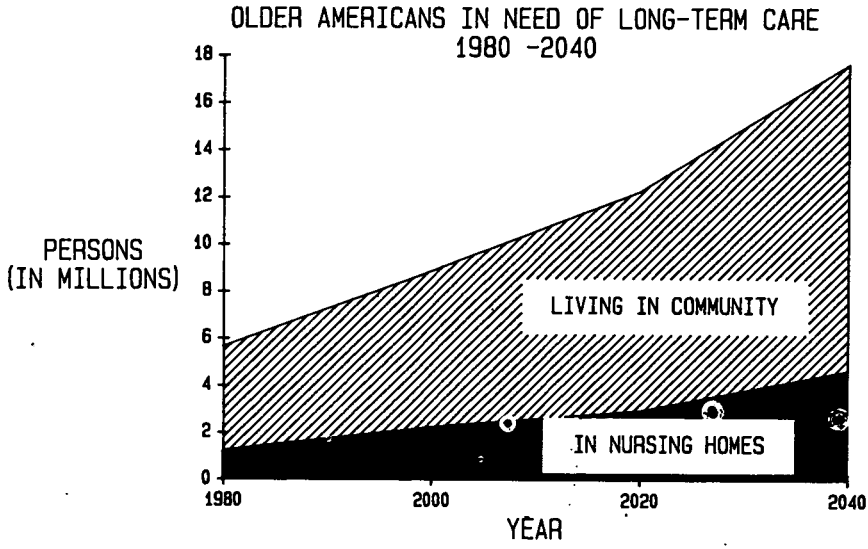
Long-term care services provide for the needs of those individuals who are not able to completely care for themselves as a result of chronic illness or physical or mental conditions which result in both functional impairment and physical dependence on others for an extended period of time. Those groups 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.

Although chronic conditions can occur at any age, their incidence, particularly as they result in disability, increases with age. Moreover, their prevalence rises with advancing age; in 1985, about 14 percent of people age 65–74 were disabled compared to 58 percent for those age 85 and older. However, the presence of a chronic illness or condition alone does not necessarily result on a need for long-term care, and most older persons are able to live independently in spite of these conditions.

It is when these chronic conditions manifest themselves in functional or activity limitations called limitations in "activities of daily living" (ADL's) that assistance may be required. Examples of ADL's include bathing, dressing, eating, getting in and out of bed, etc. A second set of measures, called limitations in instrumental activities of daily living (IADL's), reflect a lower level of disability such as difficulties with shopping, cooking, cleaning, and taking medicine.

CHART 1



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

2. Numbers of People Receiving Long-Term Care

(A) NURSING HOME CARE

Of the 28.6 million people age 65 and older in the United States in 1985, less than 25 percent (6.3 million) were disabled. Of this group, about 2.6 million were severely disabled; that is, needing assistance with three or more ADL's. However, only about 21 percent (1.3 million) of the disabled elderly were residing in nursing homes. Those with severe disabilities were more likely to be in nursing homes, although more than half of the severely disabled were residing in the community.[1]

Because the elderly population, particularly those age 85 and older, is growing, nursing homes will be increasingly burdened in the years ahead. With current utilization, the National Center for Health Statistics estimates that the number of elderly persons residing in nursing homes will increase by 58 percent from 1978 to 2003 if constant mortality is assumed, and by more than 115 percent if declining mortality is assumed.[2] Not only will utilization in-

[1] 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.

[2] Changing Mortality Patterns. Health Services Utilization and Health Care Expenditures: United States 1978–2003, Analytical and Epidemiological Studies Series 3, no. 23, National Center for Health Statistics, Department of Health and Human Services, Pub. No. (PHS) 83-1407, September, 1983. p. 20.

crease, 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.[3]

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, that likelihood increases with age. The old-old (those 85 and older) show much higher nursing home utilization rates than their younger counterparts. For women 85 years and older, their rate of nursing home use per 1,000 population is 251.2, compared to 15.9 for women 65–74 and 80.6 for women 75–84.[4] A similar pattern exists for men, although their utilization rates are much lower.

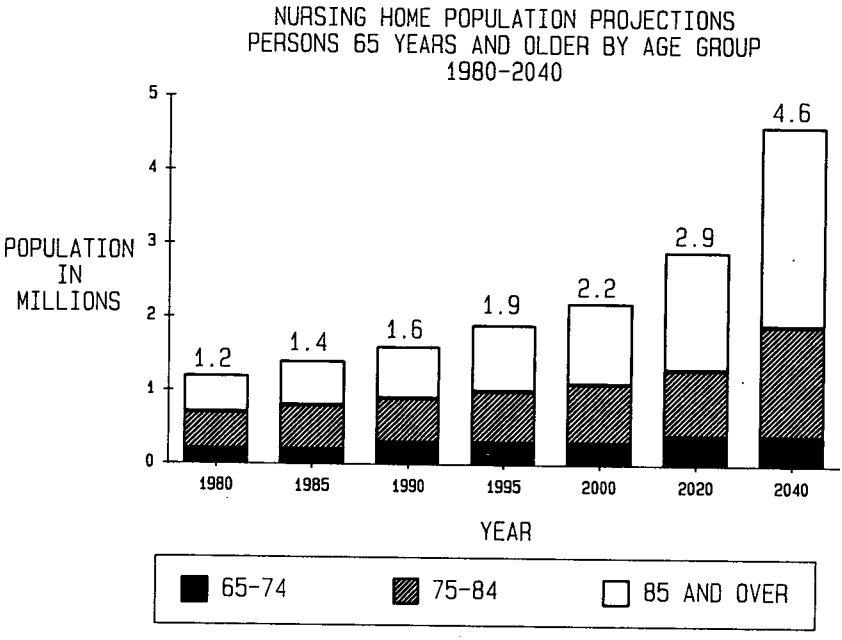
Approximately 425,000 of the noninstitutionalized elderly usually stay in bed all or most of the time because of a chronic health problem.[5] For some of these very dependent people, the nonavailability of beds is a factor preventing their placement in nursing homes. While there are no firm nationwide estimates of the potential needed supply of nursing home beds, experts agree that there are serious shortages of beds throughout the country, with estimates ranging into the hundreds of thousands. Certain localities report a short supply of beds as measured by the numbers of long-term care patients backlogged in acute care hospitals awaiting discharge to a nursing home.

[3] Rivlin and Wiener, p. 11.

[4] Rice, Dorothy, and Jacob J. Feldman. Living Longer in the United States: Demographic Changes and Health Needs of the Elderly. Milbank Memorial Fund Quarterly/Health Society, v. 61, no. 3, 1983. p. 376.

[5] National Center for Health Statistics, 1977 National Nursing Home Survey.

CHART 2



SOURCE: Manton and Soldo, "Dynamics of Health Changes in the Oldest Old: New Perspectives and Evidence," Milbank Memorial Fund Quarterly, Vol. 63, No. 2, Spring 1985 and unpublished tabulations from the author

(B) HOME AND COMMUNITY-BASED CARE

For every person 65 and older residing in a nursing home, there are nearly four 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, which is about 18 percent of the over-65 population, that had limitations in ADL's and IADL's. About two-thirds of the 4.6 million disabled elderly were moderately impaired (less than three ADL limitations or only IADL limitations).[6] About 850,000 elderly individuals were residing in the community with severe limitations (five or six ADL's).

Of the noninstitutionalized disabled elderly, more than 70 percent relied exclusively on unpaid sources of home and community health care. Almost 1 million received at least some paid care and only 240,000 used paid care only. Of those who received both paid and unpaid care, nearly 41 percent were sole payers for this care. Medicare covered the cost of community care for 8.4 percent of this group and Medicaid paid for about 6 percent. Private insurance pays only about 1 percent of the Nation's long-term care bill.

[6] Rivlin and Wiener, p. 6.

These figures illustrate the extent to which informal, family caregiving provide 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.[7] 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—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 associated 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 rather than first.

There is some disagreement as to 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 than 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 adjusting the level of care needed by the patient.[8]

3. 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.

Data on total national spending for long-term care, from both private and public sources for institutional and noninstitutional care, is difficult to collect and quantify. Data recently released by the Congressional Budget Office (CBO) represents the most recent attempt to estimate expenditures for long-term care. According to CBO's preliminary estimates, total national spending on long-term care for all age groups was $44.9 billion in fiscal year 1985. Of this

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[7] 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.

[8] Brain Burwell, "Home and Community-Based Care Options Under Medicaid," in *Affording Access to Quality Care*, ed. Richard Curtis and Ian Hill (Washington, D.C.: National Governors Association, 1986).

amount, $35.8 billion was for nursing home care, and $9.1 billion was for home health services (defined as nursing care, home health aides, medical social services, and speech, physical and occupational therapy). Direct, out-of-pocket payments paid for 45 percent of the costs of nursing home care ($16.2 billion) and 40 percent of the costs of home health care ($3.7 billion). Private long-term care insurance paid only eight-tenths of one percent of the costs of nursing home care, and 4 percent of the costs of home health care.

CBO estimates that about 54 percent of nursing home expenditures were financed by Federal, State, and local governments. The remainder is financed primarily out-of-pocket. By far the largest portion of public expenditures for nursing home care is financed by the Medicaid Program. In fiscal year 1985, CBO estimates that Federal and State Medicaid expenditures for nursing home care amounted to an estimated $17.2 billion—representing approximately 48 percent of total national spending for nursing homes and 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. According to CBO, Medicare's fiscal year 1985 expenditures amounted to $590 million and represented less than 2 percent of national spending and 3.1 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 the elderly will be better off financially in the coming years, there will also be increased numbers of them requiring some form of long-term care. The real incomes of those age 65–74 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 quite so bright. Their income is expected to increase only 17 percent in the same time period. This group is already 50 years of age or older and therefore will not benefit from higher pension benefits or the increased participation of women in the workforce.

Further, because long-term care costs are expected to rise more rapidly than the incomes of the old-old, 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, compared to 4 percent general inflation, spending on nursing home care will triple—from $33 billion in 1986–90 to $98 billion in 2016–20.[9]

Following is a discussion of the five 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 provides 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 requirements, while the Medicare Program does not. Many advocates for the el-

[9] Rivlin and Wiener, p. 12.

derly contend that these differences reflect the fragmented and uncoordinated nature of the long-term care system in this country.

(A) MEDICAID

(1) Coverage

The Medicaid Program, which provides medical assistance for certain low-income persons, excludes most older Americans. Medicaid nonetheless has become the primary source of public funds for nursing home care. Approximately 90 percent of all public expenditures for nursing home care is paid by Medicaid and 48 percent of all nursing home residents are Medicaid beneficiaries. Each State administers its own program and, subject to Federal guidelines, determines the Medicaid income eligibility standard.

State Medicaid programs are required by Federal law to cover the categorically needy; that is, all persons receiving assistance under the Aid to Families with Dependent Children (AFDC) program and most people receiving assistance under the Supplemental Security Income (SSI) program. States also may cover persons who would be eligible for cash assistance, except when they are residents in medical institutions, such as skilled nursing facilities (SNF's) or intermediate care facilities (ICF's).

In addition, States may, at their discretion, cover the medically needy. 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 can mean persons with identical circumstances may be eligible to receive Medicaid benefits in one State, but not in another.

To control costs and to provide a range of community-based services to the Medicaid-eligible population, many States have applied to the Department of Health and Human Services (DHHS) for Section 2176 Medicaid waivers. Congress established these waivers in 1981, giving DHHS 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 an ICF. Services covered under the 2176 waiver include case management, homemaker, home health aide, personal care, adult day care, rehabilitation, respite, and others. While this new waiver option has been enthusiastically received by the States, there is concern about the administration's support for the 2176 waiver program, as is discussed later in this chapter.

(2) Expenditures

Medicaid expenditures for nursing home care in 1985 are estimated to have been approximately $17.2 billion.[10] Medicaid financed 87 percent of Federal spending on nursing homes, and 48 percent of total nursing home expenditures.

To illustrate the extent to which Medicaid finances nursing home care, in fiscal year 1985, 21.8 million people received Medic-

[10] Congressional Budget Office.

aid benefits. Of that number, 2.5 percent received SNF care, and 3.8 percent received ICF services. Yet, of fiscal year 1985 vendor payments, 13.5 percent were for SNF care and 17.4 percent were for ICF services.[11]

Medicaid expenditures have been growing rapidly since 1972, and expenditures for nursing home care are the largest and fastest growing component. (See Chart 3.) Increasing numbers of elderly nursing home residents account for a portion of this growth, but the costs of nursing home care have grown at twice the rate of beneficiary growth. For example, the number of ICF residents (non-mentally-retarded) grew by 3.9 percent between fiscal year 1984 and 1985, while the cost per resident grew by 7.7 percent, nearly twice the growth rate.[12] The growth in costs for SNF benefits is even more dramatic: The number of recipients actually declined by 2.2 percent during this period while costs per resident rose by 7.7 percent.

In contrast, expenditures for home care under Medicaid represent a small and static percentage of total program outlays. In 1985, Federal Medicaid expenditures for home health care were $1.02 billion, accounting for less than 11 percent of total national spending on home health care.[13] In 1982, home health benefits constituted more than 1 percent of total Medicaid expenditures in only 9 States. One State, New York, spent 78 percent of all Medicaid home health dollars.[14]

Because Medicaid expenditures consume 10–15 percent of State budgets, many States are seeking to control the growth of their nursing home population and their obligated Medicaid expenditures. As many as 26 States made changes in nursing home reimbursement policies to reduce costs in 1981 and 1982, and most States now use a form of prospective reimbursement. Other initiatives used to contain Medicaid nursing home expenditures include limits on the number of Medicaid-licensed beds, pre-admission screening programs, and a greater emphasis on home and community-based care.

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[11] Health Care Financing Administration, *Health Care Financing Review,* Summer, 1987, p. 13.

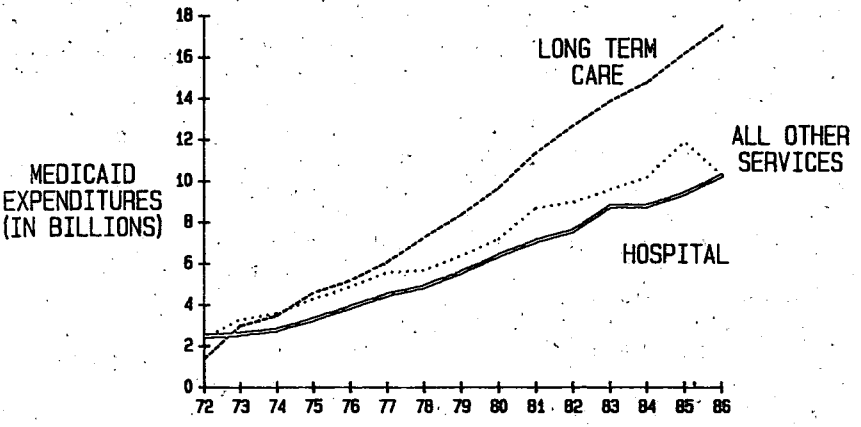
[12] Congressional Budget Office, 1987.

[13] Congressional Budget Office.

[14] Health Care Financing Administration, Medicaid Statistics Branch, 1986.

CHART 3

GROWTH IN MEDICAID EXPENDITURES
1972-1986



Source: U.S. Health Care Financing Administration, 2082 Medical Care Statistical Report, January 14, 1987

(B) MEDICARE

(1) Coverage

The Medicare Program, which insures almost 98 percent of all older Americans without regard to income or assets, does not cover either long-term or custodial care. Primarily, it provides acute care coverage for those 65 and older, particularly hospital and surgical care and accompanying periods of recovery. For example, Medicare now provides up to 150 days of SNF care per year. The recently enacted catastrophic insurance bill expanded this coverage from 100 days, and eliminated the prior hospitalization requirement. The SNF benefit is subject to a 20 percent of the national average per diem SNF rate for the first 8 days of care ($20.50/day, and a maximum copayment of $164 in 1989). This replaces a charge levied for days 21 through 100 of a SNF stay ($67.50/day, for a maximum copayment of $5,400 in 1988).

In order to receive reimbursement under the Medicare SNF benefit, the patient 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. For those persons receiving SNF benefits, Medicare covered an average of 27 days of care in 1984.

Even though Medicare coverage of home health care is only for short periods of care and only for treatment of an acute care condition or for post-acute care, the Medicare home health benefit is the

fastest growing component of the Medicare Program. Below is a brief description of Medicare's home health benefit; developments with regard to this program are discussed in greater detail in Chapter 7.

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 part time or 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. The catastrophic insurance legislation redefined the home care benefit to include up to 38 consecutive days of care instead of the previous 14-to-21 days of care in 5-days-per-week segments. Furthermore, a new 11-member advisory committee will be appointed by HCFA to study the recent increase in Medicare home health care claim denials.

In addition to these changes to the SNF and home health care benefits, the catastrophic law adds coverage of respite care to the Medicare Program. Beginning in 1990, Medicare will provide families caring for chronically ill beneficiaries (i.e., those with two or more ADL's) with up to 80 hours of respite care per year. Eligibility will be limited to those whose out-of-pocket costs exceed either the annual Part B cap ($1,370 in 1990) or the annual outpatient drug deductible ($600 in 1991, when the benefit begins).

Medicare also covers a range of long-term care services, and especially 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, therapy services, medical social services, home health aide services, physician services, counseling, and short term inpatient care. Medicare paid $15 million in benefit payments for hospice care for fiscal year 1985, and $35 million in fiscal year 1986. The previous 210-day limit was eliminated by the catastrophic health care legislation.

While Medicare coverage of long-term care services is restrictive and limited, older Americans apparently believe it includes basic long-term care services. In fact, a 1984 survey by the American Association of Retired Persons (AARP) found that of older persons surveyed, 79 percent believed that Medicare would pay for part, if

not the entire cost, of their nursing home care.[15] These findings are disturbing in that this mistaken belief provides little incentive to older Americans to provide for their future long-term care needs.

(2) Expenditures

Medicare expenditures for long-term care generally have been small. In fiscal year 1985, Medicare's contribution to SNF care was only $590 million, less than 2 percent of total public and private spending for nursing home care and less than 1 percent of total Medicare spending.

Medicare payments for home health care comprise less than 3.3 percent of total program outlays. In fiscal year 1985, total spending on the Medicare home health benefit was $2.34 billion, which is about 25 percent of total spending on home health care.

(C) TITLE XX

(1) Coverage

Title XX of the Social Security Act authorized reimbursement to States for social services, now distributed via 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 not appropriate.

Although 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 Department of Health and Human Services analysis of the States' fiscal year 1986 pre-expenditure reports, home care services, which may include homemaker, chore, and home management services, were to be provided to adults and children by virtually all States.

(2) Expenditures

States receive allotments of SSBG funds on the basis of the State's population, within a Federal expenditure ceiling. There are no requirements for use of Title XX funds—States are provided relative freedom to spend Federal Social Sevice Block Grant funds on State-identified service needs. Legislation in the 98th Congress permanently increased the annual ceiling for all Title XX activities to $2.7 billion, effective in fiscal year 1984. In fiscal years 1985, 1986,

[15] American Association of Retired Persons, "Long-Term Care Research Study," p. 3.

and 1987, the appropriation level was again $2.7 billion; the 1988 appropriation was raised slightly to $2.75 billion. Appropriations in 1989 are $2.7 billion.

(D) THE OLDER AMERICANS ACT

(1) Coverage

The Older Americans Act (OAA) carries a broad mandate to improve the lives of older persons in the areas of income, emotional and physical well-being, housing, employment, civic, cultural, and recreational opportunities, and social services. While the OAA funds a wide range of supportive services, in-home services such as homemaker and home health aide, visiting and telephone reassurance, and chore maintenance have been given explicit priority by Congress. Each OAA area agency on aging is required to spend a portion of its supportive services allotment on home care services.

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, are provided without the restrictions called for by Medicare and without the income tests called for by Medicaid. In some cases, OAA funds may be used to assist persons whose Medicare and Medicaid benefits have been exhausted or who are ineligible for Medicaid.

In-home services represent an expenditure priority for the Title III program. Accordingly to a 1984 National Data Base on Aging survey of 121 area agencies on aging, about one-quarter of their funds were directed at in-home services. While a substantial portion of these funds were spent on the home-delivered meals component (which receives a separate appropriation under the Act), an almost equal portion of the total spent on in-home services was devoted to housekeeping, personal care, and chore services.

(2) 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, for congregate nutrition services and for home-delivered nutrition services. States receive allotments of these funds according to the number of older persons in the State as compared to all States. The law gives States and area agencies on aging some flexibility to define the supportive services to be provided and to transfer funds among the 3 service categories. Total fiscal year 1989 appropriations for Title III are $858.0 million, of which $356.7 million is for congregate nutrition services, $275.7 million for supportive services and senior centers, $78.5 million for to home-delivered nutrition services, $141.3 million for USDA commodities, $4.8 million for in-home services for the frail elderly, and $998,000 for the long-term care ombudsman program.

(E) PRIVATE INSURANCE

(1) Medigap

In 1984, between 64 percent and 75 percent of the noninstitutionalized elderly had some type of supplemental medical insurance coverage. Although these policies vary, individual and group medigap insurance was the most common type of coverage. According to a 1985 AARP Gallup survey, former employers paid some, if not all supplemental insurance premiums for about 40 percent of all retirees. These policies are typically designed to supplement Medicare's coverage of acute care costs, not long-term care costs.

To illustrate, most policies provide comprehensive coverage for Medicare copayments, but very few provide coverage for needed services and products that Medicare does not cover. Some medigap policies cover the daily copayment for an approved stay in a Medicare SNF.

Others provide coverage for skilled care (as defined by Medicare) in a certified facility for stays of 100–356 days, or longer. The value of medigap coverage for long-term care, however, is very limited. These policies generally cover a very small fraction of total nursing home costs and an even smaller portion of home health or custodial care costs. Premiums for medigap coverage vary greatly within States and across the country. For example, premiums in New York State in 1986 ranged from $119 to $1,003; in Wisconsin, they ranged from $152 to $1,578.

A 1982 survey conducted by the Health Care Financing Administration and SRI International, a private research firm, found that people who need supplemental coverage the most because they cannot afford the costs of major illnesses are the least likely to have it. Therefore, while medigap policies provide some needed protection for many of our Nation's elderly, those who have the greatest need of coverage often go without it.

(2) Long-Term Care Insurance Policies

In mid-1986, only about 200,000 people held private long-term care insurance. Assuming most policyholders are over 65, this represents less than 1 percent of the Nation's elderly. This method of financing long-term care has been receiving a great deal of attention recently 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.

In 1987, the General Accounting Office (GAO) released a report on the private long-term care insurance market. GAO reviewed 33 policies offered by 25 insurers, accounting for a sizable portion of the policies sold nationwide. There was considerable variation among the policies—the indemnity benefit amounts (fixed dollar amount paid per eligible day of coverage) ranged from less than $10 to $120 per day. Premiums charged varied from $20 to $7,000 per year, offering varying levels of coverage at different ages. Duration of benefits differed widely, too—from 6 months to 6 years of nursing home care and 10 days to 6 years for home health services. GAO found that in general, premiums increased with age, and insurers offered indemnity benefits that were not indexed to keep

pace with inflation. Most of the policies GAO reviewed contained restrictive clauses (such as requirements that policyholders be admitted to nursing homes within 30 days of hospital discharge) and limitations (such as exclusions from certain diseases) that might prevent some policyholders from collecting benefits.

However, GAO also found that more insurers offer custodial care benefits, and nearly half of the policies reviewed provide benefits for all levels of nursing home care and home care benefits. Most of the policies let consumers choose the length of the waiting period and daily indemnity amounts from among several options. Finally, most of the policies guarantee renewability. However, since the insurers who guarantee renewability reserve the right to raise premiums for a class of insured, some elderly policyholders on fixed incomes could be priced out of the market.

In 1985, at congressional request, the Department of Health and Human Services (DHHS) established a Task Force on Long-Term Health Care Policies. In 1987, the task force released its report to Congress and the Secretary of DHHS. The report contained recommendations for encouraging the development of a broad-based market for affordable long-term care policies while providing reasonable protection for consumers. Recommendations included expansion of the market through employer-sponsored long-term care insurance, the creation of tax incentives to encourage participation by both employers and insurance companies, long-term care financing through vested pension funds, the development of new approaches to eligibility requirements for long-term care insurance benefits, and efforts to educate the public on its need for this type of coverage.

Unfortunately, many of the policies that are available have numerous shortcomings. The Washington, DC-based United Seniors Health Cooperative released a study in 1988 that examined the coverage provided by 77 private long-term care insurance policies. The study found that most plans have restrictions, such as prior hospitalization or prior skilled care, that severely limit the beneficiary's ability to collect any benefits. The average probability of not collecting benefits from a policy was 61 percent, if the beneficiary were admitted to a nursing home.[16] Furthermore, two-thirds of the plans did not offer benefits that increased with inflation. The most common type of nursing home coverage was a $50 per day indemnity benefit, an amount which the study found to be "grossly inadequate" to meet the expected costs of care in the future.[17]

The researchers also found shortcomings in those plans that offered home health care coverage, particularly the requirement for a prior stay in a nursing home. According to the study, this requirement in effect prevents most policyholders from collecting any benefits. Because eligibility for home care benefits is contingent on one's chances of both entering a nursing home and then returning home, as well as meeting a deductible and often a minimum stay

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[16] Firman, James P., William G. Weissert, and Catherine E. Wilson, *Private Long-Term Care Insurance: How Well Is It Meeting Consumer Needs and Public Policy Concerns?*, (Washington, DC: United Seniors Health Cooperative, 1988), p. 24.

[17] Firman, Weissert, and Wilson, p. 30.

requirement, most policyholders have about a 5 percent probability of collecting benefits.[18]

A number of barriers have been cited as impediments to the development of long-term care insurance policies. Many insurers are concerned about adverse selection, in which only persons more likely to need long-term care will buy insurance for it. Induced demand—beneficiaries using more services because they have insurance and/or shifting from unpaid to paid providers for their care—is another concern. Further, many 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.

Despite the problems inherent in this area, many believe that significant market development may occur in the next several years. Not only is there growing interest on the part of some insurance companies, but many States, faced with mounting Medicaid nursing home expenditures, have expressed interest in having such coverage made more widely available.

(F) 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.

Older persons and their families pay for nearly one-half of the costs of nursing home care directly out of their pockets. In 1985, 45 percent of the costs of nursing home care (about $16 billion out of a total of $35.7 billion) were paid out-of-pocket.[19] Further, the proportion of total nursing home costs paid out-of-pocket has increased by about 20 percent from 1975 to 1985. During that same period, the portion of nursing home costs paid by Medicaid has actually decreased, although it was still 48 percent of the total in 1985. As mentioned above, while the amount that Medicaid pays for nursing home care has been increasing (306 percent between 1975 and 1985), so has the amount paid out-of-pocket—an even higher 420 percent between 1975 and 1985.

The vast majority of the chronically ill and disabled elderly population rely exclusively on informal support. Between 70 percent and 80 percent of the elderly persons living in the community who need long-term care receive all of the care they need from family and friends. The remaining 20–30 percent pay for their care themselves, or have some or all of their care paid for by private insurers, Medicare or Medicaid, and family members.[20] Of the total $9.1 billion spent on home health care in the United States in 1985, $3.7 billion, or 40 percent, was paid out-of-pocket.[21] Homes care is generally a less expensive option for the elderly, but 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.[22] These out-of-

[18] Ibid, p. 38.
[19] Congressional Budget Office, 1988.
[20] Callahan et al., 1980; Christianson and Stephens, 1984; Liu et al., 1986; as cited in Stone, Cafferata, Sangl, Caregivers of the Frail Elderly: A National Profile.
[21] Congressional Budget Office, 1988.
[22] 1982 National Long-Term Care Survey.

pocket costs are only for home health care; they 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 in comparison with the cost of nursing home care. The price of a year in a nursing home ranges from $12,000 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 spend their entire savings and become eligible for Medicaid soon after they enter a nursing home. Currently, between one-quarter and two-thirds of the patients who enter nursing homes as private paying patients subsequently spend down their resources and become eligible for Medicaid. 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 the single older American.

B. ISSUES AND LEGISLATION

1. Nursing Home Care

The demand for nursing home services is expected to increase based on projections of growth of the population of older Americans. The 65 and older age group is expected to increase from the present level of 25 million to 36 million by the year 2000. More notably, the 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 interest in the years to come. Following is a discussion of several of the pertinent nursing home issues of the 100th Congress, including: Nursing home quality of care, Medicaid coverage for the impoverished aged, including Medicaid spend-down and spousal impoverishment; the personal needs allowance for Medicaid nursing home residents; and the long-term care ombudsman program under the Older Americans Act.

(a) Nursing Home Quality of Care

Quality of care in nursing homes has been an item of great concern to the elderly and their advocates for a number of years. Several investigations and studies, including a 2-year investigation (completed in 1986) by the Senate Special Committee on Aging, a report by the Institute of Medicine, and most recently a report commissioned from the General Accounting Office by Senator John Heinz, have found that thousands of frail elderly citizens live in nursing homes which fail to provide care adequate to meet even their most basic health and safety needs. Legislation finally was passed in 1987 to implement many of the recommendations of the various studies and aging advocacy organizations. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) contains extensive nursing home quality care provisions that will take effect over 2½

years. This legislation will be outlined in greater detail below, following a discussion of the findings that led to its passage.

In 1982, in response to congressional concern about controversial nursing home regulations proposed by the Heath Care Financing Administration (HCFA), HCFA commissioned a study from the Institute of Medicine (IoM) of the National Academy of Sciences. According to the contract, this study was to "serve as a basis for adjusting Federal (and State) policies and regulations governing the certification of nursing homes so as to make those policies and regulations as appropriate and effective as possible." The study was begun in October 1983 and released in 1986. It 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 the 1987 law. These recommendations include the elimination of the distinction between SNF's and ICF's, the use of intermediate sanctions to enforce compliance with regulations, and the strengthening of residents' rights.

Both the aforementioned GAO report and the Special Committee on Aging's investigation found many of the same problems. For example, the Aging Committee disclosed that nursing home inspection reports from HCFA revealed that in 1984, more than one-third (3,036) of the Nation's 8,852 certified SNF's failed to comply with the most essential health, safety, and quality standards of the Federal Government. About 1,000 (11 percent) of the SNF's violated 3 or more of these standards. GAO found that 41 percent of SNF's and 34 percent of ICF's nationwide were out of compliance during 3 consecutive inspections with one or more of the 126 skilled or 72 intermediate care facility requirements considered by experts to be most likely to affect patient health and safety. Penalties or sanctions to enforce compliance were found to be severely lacking.

In 1987, Senator Mitchell and Representatives Dingell, Waxman, and Stark introduced comprehensive nursing home reform legislation, components of which were included in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). The OBRA 1987 reforms were the result of a tremendous 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. Earlier in 1987, HCFA had proposed new rules to address nursing home quality concerns in what some believe was an attempt to illustrate that legislation was not needed.

Among the provisions of the law are:

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 every day activities as bathing, dressing, eating, and walking. Results 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. All nursing facilities with more than 120 beds must employ at least one full-time social worker.

Training for Nurse Aides.—All nurse aides 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 will have appeal rights). This is effective January 1, 1989.

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 onsite, 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 DHHS must take immediate action to correct the deficiencies through the appointment of tempo-

rary 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 DHHS may impose one or more intermediate sanctions, terminate the facility's participation, or both. Intermediate sanctions include denial of payment for new Medicare or Medicaid admissions, civil penalties for each day of noncompliance, 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.

Since the passage of OBRA, the biggest stumbling block that groups representing nursing home residents and providers have encountered is HCFA's implementation of the law. On February 2, 1989, HCFA published in the *Federal Register* "Medicare and Medicaid Requirements for Long-Term Care Facilities: Final Rule with Request for Comments." According to HCFA, these final rules "reflect . . . the comments on the NPRM [the proposed rules published by HCFA in October 1987, prior to the passage of OBRA 1987] and the requirements of OBRA 1987." The aforementioned NPRM have been a point of contention between HCFA and various aging advocacy groups from the beginning, as many believe they were developed in opposition to anticipated OBRA reforms. Final passage of OBRA occurred after the comment period on the NPRM expired, and critics contend that because OBRA so fundamentally changed HCFA's regulatory mandate, they should reopen the rulemaking process. HCFA, however, disregarded this criticism, and stated that these new requirements, many of them effective August 1, 1989, are a "bridge to the new requirements of OBRA '87 that are effective in 1990."

Most advocacy groups disagree, believing many of the new conditions are at best weak interpretations of OBRA and at worst contrary to the law's intent. For example, OBRA required all nursing facilities to have 24-hour licensed nursing care. This requirement could be waived only the most extreme circumstances when the facility could prove that it had exhausted all possibilities of finding a nurse, and that residents would not be harmed by the absence of a nurse on a particular shift. The new regulations would grant waivers to ICF's that would permit them to either waive the 24-hour nursing requirement or the daily R.N. requirement (but not both); SNF's could waive the requriement for 24-hour R.N. coverage to only requiring R.N. coverage more than 40 hours per week. The new regulations offer little or no criteria for granting the waivers. Many groups also note that despite the fact that HCFA has missed eight deadlines set by OBRA 1987 since March 1988, they issued regulations that will require States to implement a new inspection system 18 months before it is required by OBRA, and do not provide any guidance.

Other problems with implementation exist. Regulations governing nursing home surveys and certification mandated by OBRA 1987 are currently being drafted by HCFA. There is concern that these, too, may not be completely in line with the intentions of the law. For example, HCFA will likely reduce the importance of some of the new enforcement requirement by labeling them as standards instead of conditions. Violation of a condition would not warrant enforcement action against the nursing home.

Finally, on January 1, 1989, a provision of OBRA 1987 that requires the screening of mentally ill and mentally retarded nursing home applicants went into effect. The law states that with the exception of those suffering from Alzheimer's disease, nursing homes must refuse admission to the mentally disabled unless a need for round-the-clock nursing care can be demonstrated. Prospective applicants must be screened beginning January 1, 1989; 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.

This provision was intended to ensure that the mentally ill and retarded get the specialized treatment that they need. It was the hope of those developing the legislation to foster the growth of community-based centers such as groups homes and halfway houses that States have been slow to encourage. Unfortunately, it is causing a great deal of consternation among State regulatory agencies as well as among industry and consumer groups for a variety of reasons. While there is agreement that nursing homes are not the most appropriate placement for the mentally disabled, Medicaid has always paid for their care there. It traditionally does not cover care in other, more suitable settings, such as the aforementioned group homes and halfway houses. The problem is often a result of a lack of funding for this type of care at the State and local levels. However, even if sufficient funding can be found, there are fears that States will not be able to provide services for all those who will need assistance in the alloted time frame (i.e., by April 1, 1990, at the latest). Another significant problem is the absence of any guidelines from HCFA on the screening process. OBRA 1987 required HCFA to develop the Preadmission Screening and Annual Resident Review (PASARR) criteria by October 1988. PASARR would provide, among other things, a definition of mental illness and mental retardation. Although HCFA states that a heavy workload prevented their getting the regulations out on time, they plan to have draft regulations available by spring 1989, and final regulations by early 1990. In the interim, HCFA says that States must do the best they can until then, as they do not have the authority to delay the implementation date. As of this writing, Idaho has won a temporary restraining order against the law's implementation, and several other States are expected follow suit.

(B) MEDICAID COVERAGE FOR IMPOVERISHED AGED

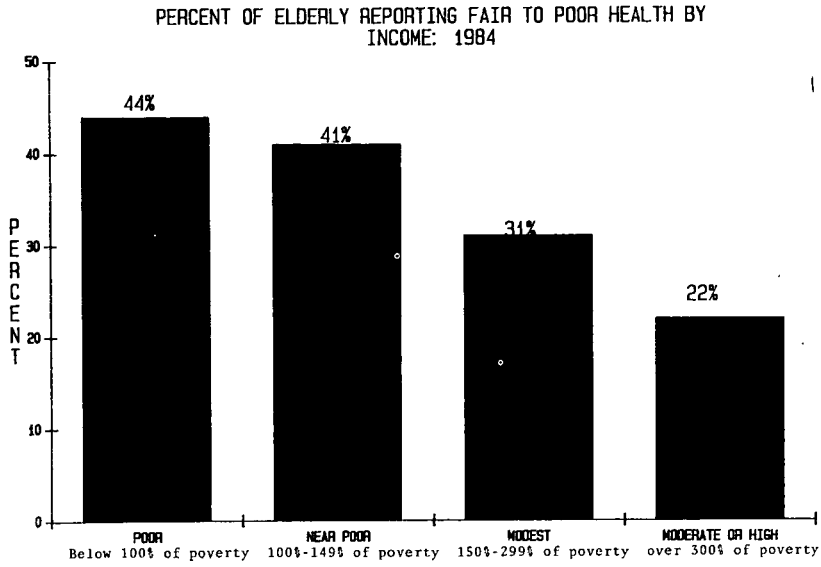
Medicaid was created as the health care safety net for the Nation's poor. There are, however, 2.2 million elderly persons whose incomes are a few dollars too high to allow them to qualify for

Medicaid under traditional income tests, but far too low to allow them to afford the health care they need. Medicaid currently covers only 36 percent of America's aged poor.

There are only two ways to qualify for Medicaid. Categorical eligibility includes all cash recipients of the Aid to Families with Dependent Children (AFDC), certain other AFDC groups, most recipients of the Supplemental Security Income (SSI) program and other SSI-related groups. "Medically needy" eligibility is determined by a spending down through medical costs to 133 percent of the AFDC level. It is intended to assist those who meet all the criteria for categorically needy assistance except for income and who have relatively high medical bills. Through the spend-down provision, individuals or families can become eligible for Medicaid if they have income above the 133 percent level but have high medical expenses which reduce income below the medically needy maximum. Medically needy eligibility is an optional eligibility category, and 35 States currently have medically needy programs. Unfortunately, in both cases the individual's income must be far below poverty. For example, the SSI income eligibility limit is $111 less than poverty ($336) per month for a single person and $199 less than poverty ($504) per month for a couple.

Medicaid coverage for this population group is especially important since the elderly and disabled poor have large health care needs. Death rates among the elderly poor are 50 percent higher than for other Medicare beneficiaries. Despite their greater health needs, they receive 35 percent fewer physician visits, use 29 percent fewer prescription drugs, and are 18 percent less likely to be admitted to a hospital.

CHART 4



Source: National Health Interview Survey and Supplement on Aging, 1984

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's 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—must impoverish themselves before they become eligible for Medicaid coverage. According to the Department of Health and Human Services, about one-half of the persons receiving Medicaid coverage for their nursing home care became eligible after they entered the nursing home.

A recent report from the House Select Committee on Aging revealed that 7 in 10 elderly persons living alone (and 9 million of the 27 million noninstitutionalized elderly in this country live alone) are impoverished after 13 weeks in a nursing home.[23] Within 1 year of entering a nursing home, more than 90 percent of these elderly are impoverished. Based on income, a person older than 65, living alone, with an annual income between $9,700 and $15,000 (between 200 percent and 300 percent of the poverty level) would be impoverished after only 17 weeks, on average, in a nursing home. The same older person with an income between $6,000 and $10,000 (between 125 percent and 200 percent of the poverty level) would be impoverished, on average, after only 6 weeks in a nursing home.

[23] U.S. Congress, House Select Committee on Aging, "Long Term Care and Personal Impoverishment: Seven in Ten Elderly Living Alone Are At Risk," Committee Print, 100th Congress, 1st Session, Washington, D.C., U.S. Government Printing Office, 1987.

While the picture is somewhat brighter for elderly couples, more than one-half of the couples are impoverished after one spouse has spent only one-half year in a nursing home. Most often, it is the wife who remains in the community, and she often is left with little or no money with which to meet her own health care and other needs.

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 is considered his for the purpose of determining Medicaid eligibility. 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 other than their husband's.

The attribution of resources such as certificates of deposit and savings accounts is done similarly. If the resources are held solely by the institutionalized spouse, they are attributed to him or her for purposes of determining Medicaid eligibility. If they are in both spouses' names, they are still attributed to the institutionalized spouse. Medicaid eligibility can be denied to individuals who transferred resources for less than fair market value within 2 years of applying for Medicaid.

Once an institutionalized spouse has been determined Medicaid-eligible, some of his monthly income is reserved for the use of his spouse. When combined with the community spouse's income (if one exists) it allows a maintenance needs level. Under current regulations, the maintenance needs level may 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 vary 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 is equal to $150, the contribution from the institutionalized spouse would be $200.

The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) included a provision that offers protection to the at-home spouses of Medicaid-eligible nursing home residents. As of September 30, 1989, States must allow the community-based spouse to keep at least $786 per month in income, or 122 percent of the Federal poverty level. This allowance would increase to 133 percent on July 1, 1991, and 150 percent on July 1, 1992. However, the maximum allowance will not exceed $1,500 per month. It 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 $12,000, whichever is higher, to the spouse, up to $60,000. For example, if the couple has assets worth $20,000, the institutionalized person may transfer $12,000 to the spouse. If they have assets worth $130,000, the institutionalized person may transfer $60,000 to the spouse. If the spouse's share of their assets exceeds $60,000, the excess is attributed to the institutionalized persons.

(C) PERSONAL NEEDS ALLOWANCE FOR MEDICAID NURSING HOME RESIDENTS

Nearly 800,000 Medicaid nursing home residents depend on their personal needs allowance (PNA) each month to cover a wide range of expenses not paid for by Medicaid. The current amount of the personal needs allowance is $30 a month—or $1.00 per day. With the passage of the Omnibus Budget Reconciliation Act of 1987, the PNA was increased from $25 to $30 per month, effective July 1, 1988. Prior to this, the PNA had not been increased—or even adjusted for inflation—since Congress first authorized payment in 1972. As a result, the $25 PNA was worth less than $10 in 1972 dollars. And while the $5 monthly increase in the PNA is certainly a victory, there is no provision to provide for a cost-of-living-adjustment (COLA) in the PNA. Thus, all recipients of Social Security and SSI benefits have received COLA's to their benefits since 1974, except the frailest and most vulnerable—Medicaid nursing home residents.

For impoverished nursing home residents, the PNA respresents 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 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, preventing them from tending to personal needs.

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 and guarantee the nursing home resident a bed to come back to. While the $30 monthly PNA represents an improvement over the $25 monthly PNA, many advocates of the Nation's nursing home residents believe it still is not adequate to meet the needs of most residents.

(D) 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 imple-

mentation 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, and 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 ombudsman is to establish a regular presence in long-term care facilities, so that they can become well-acquainted with the residents, the employees, and the workings of the facility. This presence is important as it helps the ombudsman establish credibility and trust. Further, because about one-half of nursing home residents have no family, many may have only the ombudsman to speak on their behalf.

There are now more than 600 local ombudsman programs throughout the Nation. According to the Administration on Aging—the Federal agency responsible for the OAA and the ombudsman program—from fiscal year 1984 to fiscal year 1985, the number of complaints handled by programs across the country increased more than 18 percent—from approximately 71,000 to 84,000. Of these, 62 percent were either partially or fully resolved.

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) contained several provisions to strengthen and improve the long-term care ombudsman program. Among the provisions is a requirement that States provide access to facilities and to records, and immunity for good faith performance of duties. Further, they must provide adequate legal counsel and representation to ombudsmen if it is needed. Each State must also ensure that any willful interference with the official duties of ombudsmen is unlawful, and that retaliation or reprisals against facility residents and others who complain or cooperate with ombudsmen are unlawful.

The bill also requires States to provide for the training of all personnel in the ombudsman program (including volunteers) in Federal, State, and local laws with respect to long-term care facilities in the State, in investigative techniques, and any other areas the State deems appropriate. The Commissioner of the Administration on Aging is required to submit a report to Congress by December 31, 1989, on the findings and recommendations of a study on the long-term care ombudsman program, its impact on issues and problems affecting residents of long-term care facilities, and the effectiveness of recruiting, supervising, and retaining volunteers. Also,

for the first time, a separate authorization of funds for the ombudsman program is established, with an authorization of $20 million in fiscal year 1988.

(E) NURSING HOME GUIDE

In December 1988, HCFA released a 75 volume publication entitled "Medicare/Medicaid Nursing Home Information." The publication contains a profile of each of the 15,000 nursing homes that participate in the Medicare and Medicaid progams derived from on-site inspections from surveyors in 50 State agencies. According to HCFA, "it reflects conditions in the nursing home at the time of its most recent survey and includes a summary of the characteristics of the residents in each home, their functional capacities and care needs." This publication has sparked a great deal of controversy among nursing home providers and consumer groups alike. While most congratulate HCFA on their attempt to provide better information to consumers, they claim that because the data used for the report are at least 1 year old (and in many cases, nearly 2), and represent only a 1-day "snapshot" of the facility, the usefulness of this consumer guide is very limited. Consumer groups believe the guide presents nursing homes in a better light than is warranted, and provider groups claim the opposite is true. Both believe the report is inaccurate. Critics of the report believe providing reports on several inspections would give consumers a better sense of the facility's track record in complying with important quality concerns. Further, the guide only states whether or not a specific criterion was met, but does not specify the severity of the deficiency, or whether it is a one-time problem or an on-going concern. It also does not address the issue of inspector subjectivity, nor does it note that inspection and survey policies vary widely from State to State. Advocacy groups believe that consumers should be encouraged to examine the most recent inspection report at the home (homes are required by law to make these available), as well as contact the local or State ombudsman. HCFA plans to make the release of this report an annual event.

2. Home and Community-Based Care

There has been growing interest on the part of Congress to expand the Federal role in providing home and community care for chronically ill elderly. Much of the interest has centered on expanding Medicaid's 2176 Home and Community Based Waiver Program, the programs authorized by the Older Americans Act and the Medicaid Program.

The need for this type of care is enormous. More than 4 million elderly Americans have limitations in activities of daily living, and roughly one-third of the Nation's nursing home residents do not need to be institutionalized. Finding ways to meet the needs of these people in home and community settings is a growing national concern. This section outlines current Federal issues relating to the Section 2176 program and the Older Americans Act as well as various proposals now before the Congress aimed at expanding Federal support to better meet the long-term care needs of the elderly in their homes.

(A) 2176 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 "2176 waivers" for home- and community-based services for individuals who, without such services, would require the level of care provided in a skilled nursing facility or intermediate care facility. 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 services. As of 1987, 37 States had established waiver programs to serve the elderly which now are serving roughly 60,000 elderly and disabled persons.

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/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 from entering an institution is quite difficult, if not impossible.

In an effort to restrict the program, HCFA in 1984 imposed a variety of impediments on States. There was, however, an enthusiastic response from States, patients, and their families for the waiver programs, as well as a need to develop alternatives to institutionalization. Therefore, Congress, as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, enacted various legislative proposals to ensure that the 2176 waiver option would continue to be available.

The Omnibus Budget Reconciliation Act of 1987 also includes provisions aimed at expanding the program. The Act creates a new waiver authority under which the States can provide home- and community-based services. Under the waiver, the requirements for the program to be statewide, comparability, and income and resource rules applicable in the community are waived. Expenditures for skilled nursing facility services, intermediate care facility services, and home- and community-based services for individuals 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 which take into account increases in the cost of goods and services, the over-75 population, and the intensity of services. It is anticipated that several States will establish more ex-

pansive home and community care programs under this new waiver authority.

(B) HOME CARE UNDER THE OLDER AMERICANS ACT

Various social services, including in-home services, currently are provided under Title III of the Older Americans Act (OAA). But the need for in-home services is so great that last year's reauthorization of the OAA expanded in-home services authorized under Title III. The Older Americans Act Amendments of 1987 adds 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 care for families and visiting and telephone reassurance are additional examples of allowable services.

Funding for this new program is aimed at assisting persons who are ineligible for other Federal programs. Currently, many frail elderly persons who are not poor enough to qualify for Medicaid and who do not meet Medicare's medical-related criteria need in-home services to live independently. These new OAA services are targeted strictly at the elderly and may be provided without the health-related restrictions of Medicare and the income tests of Medicaid.

3. New Federal Initiatives

(A) LONG-TERM CARE FINANCING LEGISLATION IN THE 100TH CONGRESS

A number of bills were introduced in the second session of the 100th Congress to provide expanded coverage of long-term care services for the elderly. Although no action was taken on these bills (with the exception of H.R. 3436), it is anticipated that several of the bills will be reintroduced early in the 101st Congress. The key initiatives are as follows:

Medicare Long-Term Home Care Catastrophic Protection Act of 1987 (H.R. 3436, Pepper).—Establishes for the first time a long-term home care benefit under Medicare for the elderly and children. All disabled workers, children, and elderly who need assistance with at least two activities of daily living (such as eating, dressing, or using the toilet), as well as technology-dependent children, would qualify for home care benefits. Since the benefit primarily is aimed at meeting long-term care needs as opposed to post-acute care needs, patients no longer would need to be homebound and in need of intermittent care for Medicare to cover home health. The cost of this initiative—estimated to be about $7 to $8.5 billion per year—is financed by upper income workers and employers by eliminating the cap of $45,000 on income that is subject to the Medicare payroll tax. No beneficiary cost-sharing is required. The House defeated a rule to consider this bill on the floor on June 8, 1988.

Long-Term Care Assistance Act of 1988 (S. 2305, Mitchell/H.R. 4763, Obey).—Amends Medicare to provide coverage of long-term home care services, home- and community-based res-

pite care, and long-term nursing home services for qualified beneficiaries who are functionally dependent in at least two ADL's. Establishes eligibility review organizations to determine beneficiary eligibility. Beneficiaries would be eligible for coverage of nursing home care after a 2 year stay in an approved facility; there is a 30 percent cost-sharing requirement for nursing home benefits. Covered home- and community-based benefits include home health, homemaker, and chore aid services, and a separate respite benefit (which includes adult day care). There is a $500 deductible for home health care, with 20 percent coinsurance; the respite care to subject to a $2,000/year cap, with 50 percent coinsurance. The cost of this legislation, estimated to be $16 to $18 billion per year, would be financed by a combination of beneficiary premium increases, copayments, the elimination of the cap on income subject to the Medicare payroll tax, and estate and gift taxes.

Helping Expand Access to Long-Term Health Care Act of 1988 (S. 2671, Melcher/H.R. 5256, Bonker).—Amends Medicare to provide grants to States for home care, adult day care, and respite care services to beneficiaries dependent in one or more ADL's. Eligibility and management of benefits would be determined by case managers. The home care and adult day care benefits would be subject to a $5 per visit copayment. The respite care would be subject to a 25 percent copayment, and would be available for charges up to $2,000 per year ($1,500 benefit). The responsibility for administering this program would be on the States. This approach is based on the premise that States are the entity most involved in the provision of long-term care services and it would therefore utilize their expertise. As of this printing, the Congressional Budget Office has not determined the cost of this legislation. It would be financed by a combination of copayments, elimination of the Medicare payroll tax cap, and State matching funds.

Lifecare Long-Term Care Protection Act (S. 2681, Kennedy).—Amends the Public Health Service Act to provide comprehensive coverage for nursing home and home- and community-based care services for persons age 65 or older, Medicare disabled, or under age 19 who are functionally dependent in at least one or more ADL's. There are two parts to Kennedy's approach—Part A (mandatory) and Part B (optional). Part A benefits provide 6 months of nursing home care and unlimited adult day health care, homecare, and respite care; there would be modest copayments based on ability to pay. Part B would be voluntary, and would cover longer nursing home stays. Beneficiaries would have to enroll at age 45 (annual premiums of $120) or 65 (annual premiums of $300). Lifecare would cover 65 percent of the costs of nursing home care; the beneficiary (or insurance or Medicaid) would pay for the rest. It would be financed by raising the $45,000 cap on wages subject to the Medicare payroll tax to $75,000. The cost of this bill is estimated to be about $20 billion per year.

Elder Care Long-Term Assistance Act of 1988 (H.R. 5320, Waxman).—Creates a Part C of Medicare to provide coverage for long-term community care and nursing home care for those

unable to perform at least two ADL's. The Secretary of DHHS would designate for each State a community assessment, review, and evaluation (CARE) to assess eligibility for benefits. This bill would cover two-thirds of the costs of nursing home care after the first 60 days for 2 years. After that, the beneficiary would be responsible for 10 percent of the costs of care. Community services, including home health care, homemaker/health aide services, adult day health care and caregiver training, would be subject to a 20 percent copayment. This legislation is estimated to cost about $50 to $55 billion per year after full implementation, and would be financed by removing the cap on wages subject to the payroll tax, a 10 percent gift and estate tax for Medicare beneficiaries on estates and gifts that exceed $100,000, and a tax surcharge on those with a tax liability of more than $100 per year. It also amends Medicaid to require coverage of long-term care benefit cost-sharing for certain low-income persons.

Chronic-Care Medicare Long-Term Care Coverage Act of 1988 (H.R. 5393, Stark).—Amends Medicare to provide nursing home care to persons who are dependent in at least three ADL's and home and community-based care for persons dependent in at least two ADL's. Requires the Secretary of DHHS to enter into agreements with nonprofit assessment and care management agencies to assess eligibility and develop plans of care. Covers nursing home care under Part A after 3 months, with a 20 percent copayment. Under Part B, covers home health, homemaker and personal care services, and adult day care, with a 20 percent payment for home health and adult day care. It is estimated to cost $46 billion per year, and would be financed by an increase on the cap on wages subject to the Medicare payroll tax, as well as an increase in the tax, from 1.45 percent to 2.1 percent. It would also mandate the inclusion of all State and local employees in the Medicare payroll tax, increase the Medicare Part B premium, and certain estate and gift taxes. It also amends Medicaid to require coverage of long-term care benefit cost-sharing for certain low-income persons.

(B) LONG-TERM CARE AND THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

On July 1, 1988, President Reagan signed the "Medicare Catastrophic Coverage Act of 1988" into law (P.L. 100-360). Although many would argue that long-term care is the most catastrophic of all health expenses, the focus of this legislation is on acute care. For those elderly spending more than $2,000 annually on out-of-pocket medical expenses, the cost of nursing home care absorbs more than 80 cents of every dollar spent over and above $2,000. Although the new catastrophic program provides for expansion of Medicare's skilled nursing facility and home health benefit, these benefits are designed to rehabilitate beneficiaries after an acute illness—not to provide services to those needing long-term care as a result of a chronic illness. Fortunately, there were a few provisions that begin to address the issue of long-term care. (For a detailed

analysis of the catastrophic legislation, please see the Health Chapter.)

Beginning in 1990, Medicare will suport families of chronically ill beneficiaries with up to 80 hours of in-home respite care per year. Eligibility will be limited to those beneficiaries whose costs exceed either the annual Part B out-of-pocket cap ($1,370 in 1990) or the annual outpatient drug deductible ($600 in 1991). Chronically ill beneficiaries will be defined as those who need assistance with at least two ADL's, and who live with an unpaid caregiver upon whom the beneficiary is dependent. These respite services, which include homemaker/home health aide and personal care services and skilled nursing care, would be subject to a 20 percent copayment (which would be applied to the catastrophic cap). The catastrophic bill also requires the Secretary of DHHS to conduct a study on the feasibility of providing respite care services outside the home (e.g., adult day care or nursing home care).

The respite care coverage is the only provision in either version that provides for the actual delivery of services—the other long-term care-related provisions concern studies or research on long-term care services. There is a provision in the law that requires the Secretary of DHHS to evaluate and report to Congress on the various adult day care services being provided throughout the United States. The Senate provision was offered as an amendment to the original bill by Senator John Melcher.

There is also a provision authorizing up to $5 million per year to DHHS to support research on delivery and financing of comprehensive long-term care for Medicare enrollees for the next 5 years. The Secretary is required to submit interim reports by December 1990 and December 1992, with a final report due by June, 1994.

The law also establishes the Bipartisan Commission on Comprehensive Health Care 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 are: Senators 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), Pepper (D-FL), Stark (D-CA), Tauke (R-IA), and Waxman (D-CA); and John Cogan, formerly of the Office of Management and Budget, James Davis, president of the American Medical Association, and James Balog from the insurance industry. Representative Pepper is the chairman of the Commission; Senators Baucus and Durenberger are vice chairmen.

C. PROGNOSIS

Although 1988 was not a banner year for long-term health care in this country, there was some progress made. For example, several provisions of the catastrophic health care bill represent movement in the right direction, including protection against spousal impoverishment, respite care, and the Bipartisan Commission on Comprehensive Health Care. Perhaps more importantly, 1988 was a year in which several comprehensive long-term care bills were introduced. Although there was no positive action taken on these

bills in the 100th Congress, it is anticipated that some of them will be reintroduced and given serious consideration in the 101st Congress.

These bills have many common elements—their financing approach, eligibility based on ADL limitations, and cost-sharing requirements. Most incorporate a case management system, and have provisions to cover the costs of care for low-income beneficiaries. While there is limited agreement on these points, many questions remain. Should a long-term care bill cover just the elderly and disabled—or should children be included? Should there be a long exclusionary period, to encourage private sector involvement? How much cost-sharing should be required? What's the magic number of ADL limitations?

As the Senate Special Committee on Aging and Congress grapple with finding the proper Federal role in the financing and delivery of long-term care services, they will be looking for answers to these questions and more: Who is receiving long-term care services and from whom? Who needs long-term care? Where is the best place to provide it? What will the needs of future generations be and who should pay for it? How can the proper balance between public and private financing be achieved?

In the months ahead, growing importance will be placed on exploring alternatives to traditional long-term care. For example, a number of demonstration projects funded by the Office of Research and Demonstration at the Health Care Financing Administration are aimed at testing the effectiveness of community-based and in-home delivery systems for long-term care services. These projects include social health maintenance organizations, which provide for the integration of social and health care services, and respite care for impaired elderly. Similar projects are taking place at the State and local levels, as well as at colleges and universities. The Senate Aging Committee anticipates hearings and possible legislation designed to foster the development of creative alternatives to institutional care.

Faced with intense pressure to decrease the deficit and balance the Federal budget, Congress is unlikely to pass legislation that would finance the costs of long-term care in 1989. However, with a new administration in the White House, it is possible that finding solutions to the problems surrounding the financing and delivery of long-term care services in this country will come to pass despite budgetary constraints. Given its cost, however, that remains unlikely. The most progress on this issue will probably occur, as it has over the years, on the State and local levels and through creative public and private partnerships.

Chapter 19

HOUSING PROGRAMS

OVERVIEW

The housing and shelter needs of the elderly have been a concern in the area of aging social policy for a number of years, and until 1981, the Federal Government had substantially increased its involvement. Since that time, Federal activity in the area of housing has fallen off dramatically. There has been a change in Federal policy from an emphasis on long-term commitment in the form of construction of new housing and the rehabilitation and moderinization of older housing to a shorter-term commitment emphasizing the use of existing housing. As a new administration moves into the White House, housing advocates have hopes that the era of massive cutbacks is over, and that a focus of providing appropriate, affordable housing within the constraints of the Federal budget will begin.

Program activity at the Department of Housing and Urban Development (HUD) has been on a substantial downward slope since fiscal year 1981. The largest decline has been in the assisted housing category, down from $25 billion in fiscal year 1981 to $7.5 billion appropriated for fiscal year 1989—a reduction of over 80 percent when inflation is factored in. However, because approved funding of these programs is scheduled to be spent over a long period of time—20, 30, or even 40 years—cuts in budget authority are slow to result in reductions in outlays or actual spending. Thus, in spite of substantial reductions in budget authority, outlays on assisted housing program increased from $5.75 billion in fiscal year 1981 to an estimated $10.6 billion in fiscal year 1988. The number of households receiving aid increased from about 3.2 million in 1981 to 4.4 million in 1988. These increases, however, are attributable to funding made prior to the Reagan Administration as well as the shortening of contract terms. This results in the appropriation of requested budget authority being postponed to future years, therefore increasing the number of households presently assisted by a given amount of authority.

In 1987, the Congress passed its first major housing legislation since 1980. The Housing and Community Development Act of 1987 (P.L. 100-424) provides a 2-year reauthorization of most housing and community development programs at a cost of $15 billion in fiscal year 1988 and $15.3 billion in fiscal year 1989. This figure includes approximately $7.2 billion for low-income assisted housing in fiscal year 1988 and $7.3 billion in fiscal year 1989.

The need for elderly housing continues to increase, to a large extent because of a growing elderly population. Current demo-

graphic projections indicate that the number of households headed by older persons is rising steadily. More than one-fifth of all U.S. households today—approximately 17 million—are headed by persons 65 years of age or older. Seven million are headed by persons over 75. From 1980 to 1995, the percentage of households headed by persons over 65 will rise by 33 percent and those headed by persons over 75 will increase 52 percent. In 1995, 21.4 million households will be headed by Americans over 65.

In addition, there is a growing need for special living arrangements and support services for older persons. An increasing number of frail elderly—those over 75 years of age with mild to moderate impairments in their activities of daily living— are aging in place in Federal housing projects and in private residences. This stark fact raises serious questions on ways to best provide a supportive environment where social, physical, and emotional needs are met without jeopardizing the independence of older Americans.

Rapidly escalating housing costs have contributed to the need for Federal programs. This problem is expected to continue as the number of older Americans increases and the cost of housing raises 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. Elderly renters comprise about one-third of all elderly households, and two-thirds of renters are single. This problem is particularly acute for them, because they pay a far larger share of their income for housing than homeowners. A 1988 Harvard University study found that older renters pay a higher percentage of their incomes than younger renters, and older homeowners live in a higher percent of substandard housing. Recent data indicate, for example, that an elderly woman living alone spends nearly 50 percent of her income on housing. Some 2.3 million elderly households spend more than 35 percent of their incomes on housing.

The majority of the elderly have equity in their homes that could help in meeting their housing costs. Three out of every four elderly persons own their homes; 80 percent of them mortgage free. These are often elderly suburban homeowners with low incomes and for many, their home is their only asset. These factors have contributed to the growing interest in innovative housing arrangements, such as home equity conversion plans, and in strategies for allowing the "overhoused" elderly homeowner to take advantage of more appropriate, maintenance-free housing through such alternatives as life-care communities.

Although the need for affordable housing and shelter assistance argues for increased Federal efforts and resources, fiscal concerns over the growing budget deficit have made these programs targets for budget reductions.

A. FEDERAL HOUSING PROGRAMS

1. General Background

Begining 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 Amercian 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 new construction programs and rental assistance payments aimed at providing adequate and affordable housing for those who could not otherwise afford it. A second and more costly approach has been to provide tax incentives for house construction and home ownership through deduction of mortgage interest and property tax payments from individual gross income and through a variety of tax provisions favoring real estate transactions.

Heightened concern with old-age 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, only 10 percent of all the units were occupied by persons 65 years and older. 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 44 percent in 1988. In addition, 1959 saw the enactment of the Section 202 program, the first housing program specifically designed for the elderly.

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 these 65 years and older. In 1988, Section 8 provided 983,000 units of assisted housing for the elderly. Another major source, public housing, provides roughly 540,000 units for elderly families. There are now over 3,000 Section 202 projects nationwide, with over 200,000 occupied housing units. About 12,000 units are occupied by the physically or mentally handicapped.

(a) Section 202

The Section 202 program is the primary Federal financing vehicle for constructing subsidized rental housing for elderly and handicapped persons. Under the program, the Federal Government makes direct loans to private, nonprofit sponsors for use in develop-

ing Section 8 housing designed specifically to meet the needs of the low-income elderly and the handicapped.

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 loan rate was fixed at 9.25 percent in 1983, in response to rising interest rates; it will remain at 9.25 percent in fiscal year 1989.

The original Section 202 program was successful. Only one project was foreclosed during the 10-year period. The program served mostly middle-income rather than low-income elderly. Since the revised program is used in conjunction with the Section 8 program (HUD's major vehicle for the provision of housing to low-income households), it serves a wider range of elderly households.

Under the revised Section 202 program, funds are allocated on a geographic basis for metropolitan and nonmetropolitan areas among the 10 HUD regions, taking into account the number of elderly households within each region, those households lacking some or all plumbing facilities, and those with incomes below regionally adjusted poverty levels.

(B) 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 3.5 million people. In fiscal year 1988, Federal budget authority for public housing was $1.45 billion 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 541,000 units (45 percent) of the Nation's more than 1.2 million public housing units are occupied by older Americans. It is a federally financed program operated by locally established, nonprofit Public Housing Authorities (PHA's). Each agency usually owns its own projects. By law, the PHA's 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 has been in the form of annual contributions used to defray the PHA's debt. Beginning in fiscal year 1987, funding for development and modernization is 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 net income and are now 30 percent of net income. However, tenant rents 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 rather than 80 percent) have also decreased rental revenues for the public housing authorities. As a result, beginning in 1969, Congress has provided additional assistance to the projects to cover these expenses. Operating subsidies totaled $1.5 billion in fiscal year 1988.

About one-half of the units in the Nation's 10,000 housing projects are more than 20 years old, and many were built in the 1930's and 1940's. Much of it is in need of major renovation. A congressionally mandated study by Abt Associates released by HUD in April 1988 (although initially released to the Senate HUD-Independent Agencies Subcommittee in April 1987) states that about $21.5 billion would be required to restore the housing to a safe and inhabitable condition. HUD disagrees, stating that it would cost only $9.2 billion, less than one-half the amount estimated by Abt Associates. Among the funds HUD considers excessive are $5.7 billion for repairs it claims are not essential, $1.4 billion for energy conservation efforts, and moneys allocated for the 73,000 units (and possibly as much 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.

Even its staunchest supporters admit that public housing has been plagued by mismanagement in some cities and often aggravated by local political interference and patronage. It also is a system that has become home for many chronically unemployed and underemployed people who can ill-afford to pay significantly more in rents to offset the skyrocketing cost of operations and maintenance.

About half of all the units in assisted projects 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; PHA's about their rising costs and the inadequate funding levels for operation and modernization, and by the Office of Management and Budget (OMB) about ever-burgeoning outlays. Additionally, the managers of the public housing projects continue to raise their concern about the lack of congregate services for their tenants who have aged in place and need supportive services to remain independent.

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 one-quarter 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 PHA's 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 PHA's surveyed (and a total of 204,800 elderly households), about 48 percent lived in elderly developments 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 live in unmodified family units in family developments.

About 50 percent of the PHA's surveyed did not regularly collect any information about their elderly residents' functional levels, medical histories, or service use or needs. PHA's 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 PHA's 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.

(C) SECTION 8

(1) Construction/Existing

The Section 8 program was created in 1974 to provide subsidized housing to families with incomes too low to obtain decent housing in the private market. Until 1983, HUD entered into assistance contracts with owners of existing housing or developers of new or substantially rehabilitated housing for a specified number of units to be leased by households meeting Federal eligibility standards. Authority to enter into new contracts for assistance to new or substantially rehabilitated units was eliminated in 1983. Payments made to owners and developers under assistance contracts are used to make up the difference between what the rental household can afford to pay for rent and what HUD has determined to be the fair market rent for the dwelling. As of the end of fiscal year 1988, there were 2.1 million units eligible for payment. Of those units, it was estimated by HUD that approximately 48 percent were occupied by older persons.

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[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.

The concern over the Federal deficit has forced the Federal Government to re-assess the cost effectiveness of many social programs, including the new housing construction programs. Section 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 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 supplement 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, the existing housing component of the Section 8 program genenally has been alluded to as a successful form of assistance. Under Section 8 existing housing program, HUD pays the difference between 30 percent of an assisted housing tenant's income and the fair market rent standard for the jurisdiction. In fiscal year 1988, HUD paid approximately $8.7 billion in Section 8 housing assistance of all types to eligible families. This figure includes funding for the voucher program, which appears to be the Administration's answer to subsidized housing in the future.

(2) Vouchers

As an alternative to conventional public housing programs, the Reagan Administration supports a system under which low-income families receive vouchers similar to food stamps. These enable a family to rent housing in the private market, assisted by a Federal payment transmitted through a local public housing agency to a landlord. The voucher subsidizes the difference between 30 percent of the family's income and the fair market rent of a suitable sized unit, although the actual rent may be more or less than the fair market rent.

The Housing Act of 1983 continued existing Section 8 certificates, but also established a section 8(o) demonstration voucher program.

Use of the 15,000 vouchers authorized by the act was limited primarily to HUD's new 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.

Under the voucher system, also referred to originally as the modified Section 8 existing housing certificate, HUD's contribution also is based on the difference between an established rent payment standard for each market and 30 percent of a new tenant's income. Like fair market rents, the rent standard is set at the 45th percentile of the distribution of rents of standard quality in newly occupied units, and tenant eligibility is based on an income standard of 50 percent of area median income.

The tenant, however, likely will pay more or less than 30 percent of his/her income for rent. HUD's contribution still is based on a 30-percent-of-income contribution, but the rent standard is not necessarily the actual, or maximum, rent. Rather, the rent received by the landlord is based on whatever is negotiated between the tenant and landlord, as in the private market. Thus, if a tenant finds a unit that is cheaper than HUD's rent standard, that tenant would be able to keep some of the subsidy for other uses. Conversely, if a tenant rents a unit that is more costly than the rent standard HUD uses, the tenant would have to contribute more than 30 percent of income to make up the rent payment. Another difference between the two programs is the duration of the assistance contract which is limited to 5 years under the voucher program compared to the 15-year duration of the Section 8 existing housing contracts. The HUD appropriations act for 1985 provided $500,000 for HUD's research budget to evaluate vouchers versus 5- and 15-year Section 8 contracts. Abt Associates, contractors for this study, found that elderly had greater success with vouchers than with the Section 8 certificates as they use the vouchers to "age in place."

(3) Rental Rehabilitation and Development

New rental rehabilitation and production programs were enacted under Title I of the Housing and Urban-Rural Recovery Act of 1983 (P.L. 98–181). The programs authorize Federal commitments of just 5 years (much shorter than the 15- or 20-year commitments under section 8), and have greater requirements for local public and private sector investments in the projects, stricter limits on Federal per-unit costs, and greater demonstration of rental housing need by local authorities.

The Rental Rehabilitation program is designed to increase the supply of low-income rental housing in areas experiencing a shortage of suitable units. Rehabilitation subsidies are provided through a one-time front-end mechanism such as a grant, deferred payment loan, or below market interest loan. It provides the difference in what the owner of rental property can afford to borrow from a private lending institution and what it actually takes to rehabilitate the property. No distinction is made between single- and multifamily dwellings, as long as they are primarily rental and residential in nature. Rental subsidies in the form of housing certificates

or vouchers are then used to permit low-income tenants to live in the renovated housing.

According to HUD, the number of completed units has increased dramatically in the past 2 years. As of September 1988, commitments had been issued for 16,792 projects containing 85,594 units. In 10,449 projects, with 37,652 units, all the rehabilitation construction work had been completed. Elderly tenants account for approximately 11 percent of the occupied units of these buildings.

In recent years, HUD has displayed a tendency to disassociate Section 8 vouchers from the rental rehabilitation program. This would appear to go against the original design of the program. Not only was the program enacted to ensure that the housing supply in urban areas was adequate and livable, but also that those tenants displaced either physically (through the actual rehabilitation process) or economically (through higher rents) would be provided with other housing options. The Housing and Community Development Act states that those tenants physically displaced must be provided with rental assistance. Those who are economically displaced may or may not receive assistance, which will be left to the discretion of their local Public Housing Authority.

The fiscal year 1988 appropriation for the program was $200 million. The fiscal year 1989 appropriation for rental rehabilitation is $150 million; with $20 million in recaptures from fiscal year 1988, the total will be $170 million.

(D) 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 farmowners 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.

2. Issues and Legislation

(a) Limiting the Federal Role

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 find the assistance they need. Data indicate that the more than 4 million assisted units available at the end of fiscal year 1985 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. This means 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 a 1986 report of the National Low Income Housing Coalition, Federal housing efforts have fallen far short of meeting elderly housing needs. In 1984, there were 1.1 million elderly renter households with incomes below the poverty level. Only 444,000, or not quite 40 percent, of these households lived in subsidized housing. The remainder lived either in substandard housing or paid more for housing than they could afford, or both. The Coalition estimates that, at a minimum, almost 700,000 poor elderly need housing assistance. In addition, there are 1.5 million elderly homeowners with incomes below the poverty level.

A 1988 study by the National Low Income Housing Preservation Commission found that as a result of expiring Federal 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 is 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) will be lost to low-income households at the end of 15 years. Owners of 280,000 units will default on their mortgages, allowing the properties to revert to the Federal Government for disposition. Owners of another 243,000 units will likely convert

them to market-rent apartments, sell them as condominiums, or other higher paying uses. Only 122,000 would remain for use as low-income housing. According to the report, two groups—the elderly and large families—are most likely to be hurt by prepayments and defaults as they are least able to cope with displacement or find comparable replacement housing. It will also hurt those with the lowest incomes—70 percent of the tenants of the threatened housing stock have income below 50 percent of the median for their area.

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 comes 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 have made 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. The Administration's program for housing and community development has sought to limit the role of the Federal Government in housing assistance. The main trusts of the Administration's housing assistance policies have been to shrink the growth of the program and to seek less expensive solutions. Since 1981, it has attempted to contain the budgetary growth of housing programs by targeting assistance to those most in need, and relying almost exclusively on direct assistance to households in existing units.

The Administration's budget request for HUD-assisted housing for fiscal year 1989 was $6.9 billion, which included 108,000 incremental housing units, largely assisted with vouchers. There would be no new construction of assisted housing with the exception of 7,000 Section 202 units for the elderly and handicapped. The HUD Appropriations Act (P.L. 100–404) provided $7.5 billion to support assisted housing in fiscal year 1989. This funding will provide 85,000 additional units; 65,000 of these involve Section 8 vouchers or certificates.

In 1987, the first major housing bill in 7 years was sent to the President. This legislation, the Housing and Community Development Act of 1987 (HCDA), was signed into Public Law 100–242. It authorized most housing and community development programs for 2 years, at a cost of approximately $15 billion in fiscal year 1988, and $15.3 billion in fiscal year 1989. HCDA holds spending at current levels for the next 2 years for most programs. Of particular interest to the elderly are the bill's provisions relating to HUD-assisted housing, including Section 202, Section 8, and the Congregate Housing Services Program, reverse annuity mortgages, and the prepayment of mortgages.

(1) Section 202

The Section 202 program is the most visible elderly housing program, and it has had its problems and criticisms. While it generally has produced quality and financially viable housing projects for the elderly and the handicapped, it has also experienced some political controversy. These disputes stem from several problems, including the program's high costs of production, the tendency, at least of the original program, to serve primarily moderate and middle-income elderly, and the draw that the program makes annually on the Federal budget because of its use of direct loans from the Federal Government at reduced interests rates.

There are an average of six Section 202 units for every 1,000 elderly persons in the country and less than one-fifth of a project's units become vacant annually. As a result, there are lengthy waiting lists for Section 202 housing nationwide. Waiting lists represent only those who chose to apply—not those who were discouraged by the prospect of a long wait and therefore chose not to apply.

Indeed, the housing needs of several million elderly—housing that is affordable, safe, accessible, and suitable in terms of neighborhood amenities and services—have gone unaddressed. Program cuts have come not only at a time of high demand, but also at a time when demand will probably increase. The enormous projected growth of the elderly population suggests the prospect of rapidly increasing shelter and service needs that the Nation has just begun to recognize.

In 1985, $600 million was appropriated for 12,000 units of Section 202 housing. As part of the President's spending freeze to reduce the Federal deficit, his fiscal year 1986 budget proposed a 2-year moratorium of new assisted housing production. Congress, however, did not agree with this proposal and $631 million was appropriated in fiscal year 1986 for the construction of 12,000 Section 202 housing units. For fiscal year 1987, $593 million was appropriated to fund the construction of approximately 12,000 units of housing for the elderly and handicapped.

The Housing and Community Development Act of 1987 authorizes $622 million in fiscal year 1988 and $630 million in fiscal year 1989 in loans under the Section 202 program. However, the fiscal year 1988 direct loan limitation for Section 202 was $565.8 million, which was intended to provide funding for the construction of approximately 10,990 new Section 202 units. Further, the appropriations bill required that 25 percent of the loan authority under Section 202 must be used only for handicapped project loans, which represented an increase in the number of units built for the handicapped—and a decrease in the number of units built for the elderly. Ultimately, 41 percent of the funding for Section 202 in fiscal year 1988 went to handicapped housing. The fiscal year 1989 direct loan limitation for Section 202 housing is $480.1 million, with 25 percent (2,375, with 950 targeted for the deinstitutionalized mentally ill) targeted for exclusive use by the handicapped. This will fund construction of approximately 9,500 new units.

Because Section 202 is one of the only Federal housing programs where new construction is taking place, it is likely that the program will be the focus of attention of the various groups in need of

housing. While most housing advocates agree that the elderly are only one of several segments of the population in need of safe and affordable housing, many feel it is unfortunate that these various groups find themselves competing for scarce housing dollars.

Section 202 has been the target of numerous regulatory and administrative changes, however, which are aimed at making the program more cost effective and targeting assistance to the neediest of elderly and handicapped persons. These recent changes in program direction as well as those continuing policy issues mentioned earlier have been, and will continue to be, the focus of debate in years to come.

Cost containment requirements in the Section 202 program may work to change the program from providing housing with supportive services for the elderly to one of providing only minimal housing. Recent changes made to the Section 202 program to increase the cost effectiveness of the program and allow more units to be built with the same amount of money include: Requirements that Section 8 recipients in Section 202 projects pay 30 percent—instead of 25 percent—of the household's adjusted income for rent; requirements that at least 25 percent of the units in a project be efficiencies; and limits on sponsors on the size of the units, congregate space, and number of amenities. The establishment of maximum sizes for apartment units and community spaces removes much of the flexibility in design required to meet the changing needs of an aging population. To serve a more frail, elderly population, sponsors need a facility designed with smaller units and more congregate space. Policies of rigidity rather than flexibility may virtually eliminate the possibility of developing a proper facility for an increasingly frail population.

A 1986 General Accounting Office (GAO) study of cost containment in the Section 202 program revealed that although cost containment efforts had been successful in lowering costs, they were having some undesirable effects. Analysis of construction cost data revealed that cost containment projects averaged 16 percent less than the average cost of units in projects built before cost containment. GAO concluded that without cost containment, Section 202 projects for fiscal year 1985 would have cost an additional $100 million. However, there were problems related to the cost containment efforts. Units were, on average, 11 percent smaller, included more efficiencies, which are less popular than one-bedroom apartments, and fewer amenities for the residents.

One of the most significant issues raised by the study relates to the use of fair market rents (FMR) which HUD establishes for an area on the basis of rents tenants are willing to pay for housing. HUD has established 363 fair market rent areas. GAO found that FMR's for a particular area play an important role in the ability of the project sponsors to provide quality housing for the elderly. Project rents cannot exceed 120 percent of the FMR established by HUD for an area. The income from project rents is used to pay for a project's operating and maintenance expenses and to amortize project financing cost (principle and interest). Consequently, by controlling the rental income which can be collected, FMR's serve to limit the mortgage financing of loans and, in turn, the projects' construction costs. HUD's policy uses rents to determine costs,

rather than vice versa. This makes it difficult for Section 202 sponsors in areas with relatively low FMR's to provide housing consistent with higher FMR areas.

A 1987 study by Conroy & McIver supports these findings. It cites the arbitrary nature of FMR's, stating that "Fair Market Rents are neither fair nor market. How can the . . . rent be $376 in Augusta, Georgia and $502 in North Augusta, South Carolina when these two cities comprise one community . . .?" [2]

FMR's preclude the construction of some projects built in one area from being built in another because their cost would be too high. Again, these findings were corroborated by Conroy & McIver. Conroy & McIver compared the average construction costs for a typical Section 202 building in each FMR area with the construction costs "allowed" or supported by the FMR in each area (which are the costs upon which HUD bases its approval of projects). They found that in 66 of the 363 FMR areas, it would be almost impossible to build the typical project without significantly compromising underwriting criteria or without a significant contribution from the project sponsor or the locality. (Small sponsoring organizations are often unable to make contributions; if a locality is willing to make it, it often comes out of Community Development Block Grant (CDBG) funds.) Further, they found that there would be severe cost problems (shortfall between $250,000 and $499,999) in 144 other areas.

Critics of the HUD construction requirements for cutting costs say that they are so stringent that some of the new buildings are too poorly constructed to last the 40-year term of the mortgages. Therefore, amenities like meeting halls and hobby centers, which draw the elderly into a community, are being sacrificed.

There is general support for cost containment in that maximizing the number of units built enables the program to serve more people. However, because many of the cost containment policies result in either inadequate housing or discourage the development of new housing, critics believe they are misguided at best. Many housing advocacy groups support reevaluation and possible elimination of many of these policies, FMR's among them. In conclusion, the findings of GAO and Conroy & McIver strongly suggest that there are cost containment issues that must be resolved to provide the most elderly with suitable housing given the limited funds available for the Section 202 program.

(2) Limits on New Construction

The Reagan Administration's emphasis on using existing housing is based not only on cost considerations but also on its 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.

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[2] Letter from Diana L. McIver of Conroy & McIver, to Thomas Demery, Assistant Secretary for Housing, U.S. Department of Housing and Urban Development, Washington, DC, April 27, 1987.

The shift from new construction to existing Section 8 was made for a number of reasons. For the first time, substantial use could be made of the existing housing stock, with a consequent reduction in per unit subsidy costs from those incurred in new construction. It was hoped that use of the existing stock would provide recipients of aid with a greater choice of location and housing type, since they would not be restricted to specific, designated developments. A higher income subsidy provided to owners would encourage maintenance of the stock, which otherwise faced deterioration; and improvement of already deteriorated units could be fostered by the rehabilitation program. This was seen as a way not only of increasing household satisfaction but also of promoting racial and income integration. Families could move out of concentrated minority-occupied, low-income areas.

Fear was expressed by opponents of this reliance of existing housing that, in places with low vacancy rates, rents would be driven up for all renters, particularly those of lower income who did not receive a subsidy. Other concerns include fears that there might be an absolute shortage of standard-quality rental units relative to the number of subsidized households in some localities and even if there were a sufficient number of units, vacant units might not match the needs of particular types of households, such as large families. As the program has operated, further concerns has been expressed that if the acceptable rent is held at a relatively low level, it prevents the dispersion of low-income families out of inner-city areas.

The Reagan Administration has enjoyed considerable success in shifting the mix of additional units assisted by HUD from the more expensive new construction and substantial rehabilitation types to existing units leased in the open market. The primary emphasis with regard to public housing for the elderly has become preservation, maintenance, and rehabilitation of the existing housing stock.

Nonetheless, a large percentage of new construction of housing over the past 10 years has been for the elderly. The relative 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.

(3) Vouchers

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 a new construction program. In their view, it would, on the one hand, provide an incentive to families to search for lower, though standard quality, rental units. On the other hand, it would permit those who valued housing highly to rent better quality or larger units by paying more of their income for rent. Recipients of Section 8 certificates do not have this option. Moreover, since the

contract is for 5 years rather than 15, less budget authority need be appropriated in any one 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.

Shift to voucher assistance could bring some problems for the elderly in need of housing assistance. Although Abt Associates report that the elderly use vouchers more successfully than other age groups as they use them to "age in place," 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 has been met with skepticism by Congress and many housing advocates. Critics of the program point to a shortage of decent low-cost housing in the largest cities. They question whether vouchers will provide real help to those most in need or simply encourage private landlords to increase rents because they know tenants have additional funds available. Since the vouchers are only authorized for 5 years, critics also raise the point that they do not represent a commitment to providing housing for the poor. They believe the budget savings are illusory, since the need will continue and, presumably, additional funds will be appropriated to continue assistance at the end of the 5-year period.

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. According to the Senate Appropriations Committee, there is considerable evidence that in depressed housing markets such Houston, FMR's have remained artificially high, giving voucher holders an economic windfall since their housing subsidies are based on the FMR. Conversely, in New York City, voucher holders may have to pay 50 percent or more of their income for rent because the voucher payments they receive are based on an unrealistically low rent. The Committee believes 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.

In fiscal year 1987, $1.03 billion was appropriated to fund 53,500 additional housing vouchers; the fiscal year 1988 appropriation of $1.167 billion provided for 49,000 additional housing vouchers. In fiscal year 1989, $1.35 billion has been appropriated to fund 48,500 voucher units; of that amount, 47,000 are incremental units, 1,500 for Section 8 "opt-outs/prepayments."

(4) Income Eligibility Requirements

The Omnibus Budget Reconciliation Act of 1981 reduced the income eligibility limit for almost all applications for housing assistance to 50 percent of the median income in the local area. The previous limit was 80 percent. Only 10 percent of those admitted to units available before the Act and 5 percent of those who rented units becoming available after the Act could have incomes between 50 percent and 60 percent of median.

The percentage of those with incomes from 50 percent to 80 percent of median admitted to previously available units was increased from 10 to 25 in 1983, but 5 percent was kept for those becoming available after the act became law. It was assumed that this provision would better match low-income housing programs with those who are most in need of assistance. This change was to apply to new tenants only. The continued eligibility of current tenants with incomes above 50 percent of median was unchallenged. HUD regulations implementing these changes in the law were promulgated in 1984.

There have been complaints that HUD has implemented the 5-percent limitation is such a way as to prevent renting to lower income (from 50 to 80 percent of median) households in almost all projects. Efforts have been made in the last few years to liberalize enforcement of the provision. The Housing and Community Development Act of 1987 forbids HUD from establishing procedures which totally prohibit admission of lower income families, and instructs it to establish different percentage limitations in the various programs in such a way that the total when aggregated over the entire spectrum of assisted housing programs will meet the percentage limit in the Act.

As the funding for Section 202 housing becomes increasingly difficult to obtain, there may be continued efforts by some to focus the very poorest. This may be difficult to do because the program has historically served a more middle- and low-income population.

(5) Tax Reform

A large and important part of Federal housing assistance is provided through the tax system—close to $50 billion for fiscal year 1989, mostly for middle- and upper-income homeowners. The principal tax provisions encouraging home ownership are the mortgage interest and property tax deductions. The latter is probably more important to elderly owners since many have fully paid their mortgages.

While the tax deduction for property taxes remains fully deductible, there was for the first time a limit put on the amount of mortgage interest borrowed after October 13, 1987, that could be deducted. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) limits the total mortgage interest on a principal and second residence that can be deducted on debt of up to $1 million incurred after October 13, 1987. This, of course, is likely to be of little concern to most homeowners. However, since for most homeowners, the amount of deductible mortgage debt is equal to the current amount of their mortgage, and under the new law this is reduced as the mortgage is paid down, some care should be made not to prepay the mortgage with funds that they may need in the near future. This concern is considerably reduced for most owners by another OBRA 1987 provision that allows interest to be deducted on up to $100,000 of home equity loans. OBRA 1987 also allows a mortgage with a high interest rate to be refinanced up to the previously existing balance to obtain a lower rate. Of particular importance to the elderly, the one-time exclusion that allows a homeowner aged 55 and older to sell his or here home and exclude up to

$125,000 of capital gains from the Federal income tax remains in effect.

A number of important tax incentives having to do with the provisions of rental housing were reduced or eliminated under the Tax Reform Act of 1986. There is a less-generous depreciation schedule, limitation on the amount of rental loss that can be deducted by an investor, and the end of preferential capital gains taxation. Construction of new rental properties has dropped significantly in many parts of the country since 1986.

To increase the supply of rental housing units available and affordable to low-income households, including the elderly, the 1986 Tax Act created a new low-income housing tax credit. From 1987 through 1989, investors will be able to apply for 10 years of tax credits for new construction, or the substantial rehabilitation or purchase of existing buildings, where a specified percentage of units are set aside for low-income renters for at least 15 years. Some housing analysts originally estimated this new credit had the potential to add 140,000 new low-income rental units in each of the 3 program years. However, the National council of State Housing Agencies says that only about 20 percent of the 1987 tax credit authority was be used, and about 40 to 60 percent is expected to be used in 1988. Problems with the program include the failure to enact technical corrections legislation, delays in receiving Federal tax program regulations from the IRS, the complexities and restrictions of the law, and concern that the size of the credit may be inadequate.

In addition the 1986 Tax Reform Act imposed new restrictions on tax-exempt bond financing used for multi-family housing. Instead of 20 percent of a building's units having to be set aside for families earning 50 percent or less of median area income, at least 40 percent of units must be reserved for those with 60 percent or less of median income. While most housing groups applaud the deeper targeting reqirements believing this will mean more of the financing assistance will go to those who need help the most, some in Congress say that these and other changes have made it difficult to use tax-exempt bonds in areas that have particularly high housing costs, such as in New York City and parts of California. The Tax Act also lowered th amount of tax-exempt bonds that could be sold in 1987, and reduced this amount still further for 1988 and beyond.

The possibility that many federally-subsidized housing units now occupied by low-income households could soon be legally withdrawn from the market by their owners or converted to higher-priced rentals or to condominiums has housing groups very concerned. A number of legislative proposals to address this issue are likely in the near future. One bill expected to be re-introduced by Representatives Barney Frank and Charles Rangel in 1989 would offer tax incentives to current owners if they agreed to maintain the projects as subsidized housing for another 20 years or to sell them to other investors who would agree to keep them for low-income housing use.

Numerous technical amendments to the 1986 Tax Act were introduced in 1987 and 1988 that supporters to the new low-income housing tax-credit said were critically needed if this major new

housing program is to produce anywhere near the number of units expected of it.

Supporters had also hoped that the program would be extended beyond 1989. While the Technical and Miscellaneous Revenue Act passed in November 1988, did give developers 2 additional years to complete projects begun in 1988 and 1989, it did not adopt most of the needed changes not extend the program expiration date.

(6) Farmers Home Administration

Over the past several years, the Reagan Administration has tried, with little success, to dismantle most of the FmHA housing programs. It contends that FmHA plays a minor role in providing housing assistance to rural areas and that the housing needs of rural communities will continue to be served by other sources. Opponents argue that the existing FmHA programs were not created in a vacuum, but were the result of congressional response to perceived needs, and that those needs continue to be unmet for many low-income rural residents. Housing vouchers, for example, will not enable low-income rural homeowners to improve their water and sewer systems.

The Administration's budget for fiscal year 1989 would have terminated all existing FmHA rural housing programs. The programs would have been replaced with a rural housing voucher program funded at $382 million (compared to the fiscal year 1988 appropriation of $2.2 billion). Congress moved to fund FmHA programs at the fiscal year 1988 level, which provides $1.23 billion for low-income, single-family loans (Section 502), and $544 million for rural rental housing loans (Section 515). The rural housing repair loans program (Section 504) is provided with $11.3 million, and farm labor housing loans (Section 514) are provided with $11.4 million.

The Housing and Community Development Act of 1987 authorized FmHA programs for 2 years, with loan and guarantee authorizations in fiscal year 1988 at $1.775 billion and in fiscal year 1989 at $1.795 billion. It also, at the Administration's request, authorized a 2-year FmHA rural voucher demonstration program in up to five States to provide up to 7,500 vouchers in each of fiscal years 1988 and 1989. This demonstration program requires participating States to complete an inventory of the local housing supply and to certify that there is an adequate supply of decent, safe, and sanitary low-income rental housing available for voucher holders in the State. However, the program is contingent on a specific appropriation to fund the units, and there was no appropriation for fiscal year 1988, nor is one expected for fiscal year 1989.

Another provision in the legislation concerns the prepayment or refinancing of a Section 514 or 515 loan. The provision would give the right of first refusal to non-profit and public agencies, and would permit those agencies to use Section 515 loans to finance the transfer of ownership. Further, the definition of domestic farm labor (for purposes of determining eligibility for Section 514 and 516 loans) has been expanded to include retired or disabled farmworkers. Such persons are eligible to occupy assisted housing in places other than where they were employed as farmworkers if

they wish to be closer to family members or to return to their home town.

(7) Home Equity Conversion

Developers hoping to find a lucrative market among the increasing numbers of elderly in the United States are learning that their competition is not with the retirement home, but in the single-family home. Economists estimate that there is $700 billion to $1 trillion of equity tied up in the houses of people older than 65. Thus, 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 plans (HECP's) offer a choice to elderly persons facing necessity-heavy budgets that have grown proportionately faster than their incomes. HECP's also could provide funds to allow older persons to pay for needed support services, home maintenance, and other needs. Before HECP's the only source of equity borrowing available to older Americans was through the traditional financial institutions at high rates and short terms.

Homes are older Americans' 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.

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 payment of principle 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 to 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. These plans are also referred to as sale/leasebacks.

The basic theoretical forms of HECP's 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.

The Housing and Community Development Act of 1987 contains a provision—developed by Senator John Heinz—that creates a demonstration program of mortgage insurance for home equity conversion mortgages for the elderly. Under the program, a total of 2,500 mortgages may be insured by participating lenders through September 30, 1991. They are available to homeowners age 62 and older with little or no mortgage debt remaining on their homes. HUD published a proposed rule in October 1988, that proposes to offer three types of home equity conversion mortgages: (1) tenure; (2) term; and (3) line of credit.

Tenure mortgages provide for monthly payments from lenders to 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, the variable rate is capped at five points above the original rate and should only be provided on home equity conversion mortgages that provide either monthly disbursements that do not diminish for as long as the borrower owns the home as a principal residence or a line-of-credit in which interest on each disbursement accrues at a fixed rate for the life of the mortgage, but different disbursements may be subject at different rates.

Homeowners retain ownership of their property and may sell and move at any time, retaining the sale 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.

HUD and the Administration on Aging will jointly provide counseling services to assist prospective borrowers in choosing a mortgage. In an effort to encourage lenders to issue home equity conversion mortgages, Fannie Mae (Federal National Mortgage Association) and Freddie Mac (Federal Home Loan Mortgage Corporation) are participating in the demonstration program, and have agreed to purchase loans. The program is expected to begin in spring 1989, following the publication of final rules.

(8) Prepayment

Probably the most controversial issue concerning assisted housing programs is that of prepayment of Federal loans and mortgages on assisted projects. In assisted FHA-insured projects, many owners have a contractual right to prepay (without requiring permission) after 20 years.

The reasons for prepayment vary. The projects may be in a condition and/or location that permits profitable sale for condominium conversion or conversion to nonresidential use. In some instances (in Section 202 projects, for example) the borrowers argue that many projects are more than 20 years 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.

Other borrowers say that prepayment of loans should be permitted on projects no longer essential to the community. These are projects that were supplanted by newer developments. Borrowers believe that if they were permitted to repay the loans, their projects would be converted to other uses, still leaving adequate housing in the area for the elderly.

Estimates vary as to the likely number of prepayments that may occur in the assisted FHA-insured stock. A recent report (discussed earlier in the chapter) by the National Low-Income Housing Preservation Commission (NLIHPC) states that 334,000 units of the 645,000 subsidized under Section 221(d)(3) and 236 of the 1961 and 1968 Housing Acts will become eligible for prepayment over the next 15 years. The Reagan Administration estimates that about 306,000 units will reach 20 years of age between 1986 and 1996. HUD, taking market conditions into account, estimates that 154,000 of these are likely to prepay. In addition, an unknown number of the 850,000 project-based Section 8 assisted units may choose to "opt-out" of their contracts, or their contracts may expire within that same time period.

The General Accounting Office estimates that by 1995, the combination of expiring rent subsidies and potential mortgage prepayments could reduce the current inventory of privately owned low- and moderate-income rental housing by 200,000 to 900,000 units. According to the National Association of Home Builders, it would cost more than $130 billion to replace the existing stock of such housing. The NLIHPC reports that the preservation of 473,000 of the units in their study as low-income housing and assisting 50,000 displaced households would cost $17.7 billion over 15 years.

Housing activists fear that a housing crisis is truly in the making. They note that this potential reduction comes at a time when Federal subsidies for low-income housing have been reduced 70 percent over the past 8 years. Furthermore, tax reform has taken away much of the incentive to invest in low-income housing, and HUD is not committed to building any new subsidized rental housing.

The Housing and Community Development Act of 1987 (HCDA) contains several provisions that address this issue. Essentially, the provisions establish that an owner of an eligible project (Section 221(d)(3) with rent supplement or Section 8 assistance, Section 221(d)(3) below market interest rate mortgages, Section 236 mortgages, or purchase money mortgages originated by HUD in connection with the sale of HUD-owned projects) may prepay only in ac-

cordance with a plan of action approved by the Secretary of HUD. An interim rule drafted by HUD went into effect on May 20, 1988; final rules are still pending as of this writing. In October, two lawsuits were filed challenging the constitutionality of the provisions. The plaintiffs (Thetford, a limited partnership which owns and operates multi-family housing in North Carolina and Baker, a partnership that owns and operates a multi-family building in New Jersey) claim that the provisions deprive them of their property without due process, and that it destroys their contract rights. The plaintiffs are asking for $4 million (Thetford) and $8 million (Baker) in money damages. As of this writing, action on the suit was still pending. However, if the courts find the prepayment restrictions to be invalid, the HCDA puts into place a 2-year moratorium on prepayments in the area subject to the court's decision.

According to the provisions in the HCDA, an owner wishing to prepay or initiate other changes in the status or terms of the mortgage must file a notice with the Secretary and any appropriate State or local government agency. Other changes are those related to an owner's acceptance of certain incentives in exchange for an agreement to retain the housing for low- and moderate-income use for the remaining term of the mortgage. These plans of action will differ markedly from project to project. For example, an owner seeking to prepay the mortgage and terminate the affordability restrictions would be expected to provide detailed information on the impact of such actions on the current tenants and the local supply of low-income housing.

If an owner demonstrates a willingness to keep the housing affordable to low- and moderate-income households, the Secretary is authorized to offer the owner a package of incentives. These incentives include an increase in the rate of return on equity, the provision of additional Section 8 assistance, or an increase in rents under existing contracts, or the provision of a capital improvement loan.

The Secretary will take into account local market conditions and tenant populations in formulating incentives. Wherever possible, State and local agencies will be expected to take a leading role in finding appropriate solutions for projects. According to the Act, an array of Federal, State, and local incentives will be needed to solve the prepayment problem.

The Secretary must provide a written assessment of the plan within 60 days of receipt and final approval within 180 days of receipt. There will be two kinds of plans: Those that request permission to prepay a mortgage and those that request incentives to keep the housing affordable to low-income tenants. Therefore, there will also be two types of approval criteria. For the first type of plan, the Secretary must ensure that implementation of the plan will not create hardships for current tenants or materially affect the general supply of low-income housing in the area. For the second type of plan, the Secretary must ensure, among other criteria, that the housing will be maintained as low-income housing for the remaining term of the mortgage, that any rent increases for current tenants would phase in over 3 years, and that vacant units will have rents affordable to low income tenants.

Those who formulated this legislation noted that a number of private sector task forces (including those established by the National Housing Conference, the National Corporation for Housing Partnerships, and the Advisory Council of HUD Management Agents), as well as State and local organizations, have undertaken a review of the options and alternatives available to respond to the loss of low-income housing. In the interim, before the studies and recommendations of the task forces are completed, it is the intent of Congress that these provisions are to be emergency stop-gap measures to be used to avoid the the irreplaceable loss of low-income housing and the displacement of tenants. The prepayment statute is scheduled by the HCDA to expire on February 5, 1990, at which time the law would be removed and changes made to reflect the current situation.

They note that an adequate supply of low-income housing has always depended on a strong long-term partnership between the public and private sectors that accommodates a fair return on investment. Reductions in the Federal housing budget and changes in tax benefits previously associated with low-income housing have increased incentives for private industry to withdraw from the production of low-income housing. The provisions within the Housing and Community Development Act are based on the premise that efforts to preserve low-income housing must be designed with the unique financial and market conditions of individual projects in mind.

(9) Bricks and Mortar Versus Supportive Services

During a period when the Federal commitment to provide housing is in question, some concerns have been raised about the need for additional supportive programs. The primary Federal focus on the "bricks and mortar" aspect of housing fails to address the supportive service needs of those being assisted. Further, this emphasis tends to discourage the development of other shelter alternatives that incorporate such services.

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. A study on long-term care released by the Department of Health and Human Services in 1981 cited a variety of reasons for this, 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.

The philosophy of Section 202 housing is to foster independent living. 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 they originally were designed to serve healthy elderly, 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. Survey results reveal that the average age of a tenant in one of the older Section 202 projects is 78, while the average age of a tenant living in a project built under the new program is only 71. Results also indicate that, overall, 17 percent of these tenants are considered by project administrators to be frail.

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 the future, Congress will need to develop uniform guidelines to ensure that Section 202 sponsors will provide supportive service to help their aging populations to remain in their dwellings as they age, rather than be institutionalized.

In 1984, 28 million people (11.8 percent of the population) were 65 years of age or older. Of these, 1.5 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 National Gerontological Association and the American Association of Retired Persons 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. In addition, there are often reports of elderly occupants of nursing homes and other institutions who had no other choice of residence due to lack of alternatives adapted to different levels of independence, even though they did not require skilled nursing care.

Since funding for housing programs has been reduced in recent years, some States have established their own 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.

(A) CONGREGATE HOUSING SERVICES PROGRAM

The Congregate Housing Services Program (CHSP) was set up to be a demonstration program, with $20 million to be spent over a 5-year period. HUD extends multi-year 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. The program was designed to help the elderly remain in rented dwellings as they age, rather than be institutionalized. As of 1987, $30.3 million had been obligated to grantees. Sixty grantees are in operation, serving approximately 2,000 residents.

In recent years, Congress has been appropriating funds for the maintenance of congregate housing projects already in existence. Congress appropriated $3.4 million in fiscal year 1987. The Housing and Community Development Act authorizes $10 million each year in fiscal years 1988 and 1989, and deletes the reference to congregate services as a demonstration program, making it a permanent program. The Act also states that a project is not required to provide a set number of meals, as long as the nutritional needs of the frail elderly are met. The fiscal year 1988 appropriation for CHSP was $4.2 million; fiscal year 1989, the appropriation is $5.4 million. While the funds authorized and appropriated for CHSP do not represent a huge increase over previous years, they do represent a Congressional commitment to the program that has endured despite repeated attempts from HUD and the administration to eliminate it.

(B) MANDATORY MEALS

In 1987, HUD published final rules on mandatory meals programs in Section 202 units. Essentially, the rule authorizes mandatory meals programs already in existence, but will not approve any new programs in existing or future projects. In formulating these rules, HUD took into consideration a number of opposing arguments, and views it as a compromise between protecting residents' rights and independence as well as ensuring their nutrition, and protecting sponsors' housing-and-services ideal.

To put the issue in perspective, a 1985 GAO study found that only 512 of the 903 sponsors of Section 202 projects offer meals programs, and only 98 of those are mandatory. Seventy percent of residents participating in the mandatory programs report that they are satisfied with them, and 80 percent of all residents in mandatory programs would not leave the program if permitted. Only 17 percent of residents dislike the mandatory meal program. Twelve percent indicated neither like nor dislike.

Many advocates for the elderly object to this program. 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 Section 202 sponsors are dedicated. Those in support of the program cite the fact that the adequate nutrition of elderly residents is a primary concern of Section 202 sponsors. 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.

Isolation is another problem of the elderly addressed by this program. Mandatory meals encourage residents to get out of bed, get dressed and leave the isolation of their rooms for the more social atmosphere of the dining room. Daily meals also help project sponsors conduct informal "resident checks" thus aiding in awareness of which residents are ailing or missing.

It is evident that there are benefits derived from meal programs, but there is some question about whether it is necessary to main-

tain the mandatory status of existing programs, in order to offer a meal program. Ninety-two percent of mandatory meal managers believe that they could not continue to provide meals if forced to make the transition to a voluntary program. At the very least, they believe that meal prices would increase because the program receives no Federal money and runs with a very small profit margin.

Currently operating mandatory programs were established in good faith with HUD's permission, and some argue that forcing them to make what is predicted to be an unsuccessful transition to voluntary status is unfair. The General Accounting Office advised against prohibiting these programs, acknowledging the risk of eliminating meals programs entirely.

(12) Prognosis

In 1988, as in previous years, Congress opposed the Reagan Administration's housing policies. The legislators rejected White House proposals to eliminate most forms of housing assistance as well as drastic reductions in public housing operating subsidies. In this time of limited funding and intense pressure to reduce the Federal deficit, new construction is being discouraged. However, new construction continues to be funded under the Section 202 program for the elderly and handicapped. In other programs, rehabilitation and use of existing housing stock will be the norm.

Despite Congressional efforts to the contrary, Federal housing assistance meets only a small fraction of the housing needs of the low-income elderly. Yet low-income housing has taken deeper cuts than any other program providing aid to low-income people, and these cuts have come in the face of ever-increasing need.

While the role of the Federal government still remains significant because of its prior subsidy programs, it is clear that the role is diminishing and will be limited in the future. State and local commitments to public housing are becoming increasingly important. However, they vary widely, and many States do not have adequate resources to support programs. Although reductions in direct Federal spending on housing programs can be expected to result in some amount of replacement spending by the private sector, the mix and type certainly will be less oriented toward benefiting low- and moderate-income households and neighborhoods.

While the Housing and Community Development Act of 1987 did not offer many long-term solutions to the housing problems facing Americans of all ages, the legislation was nonetheless a victory for housing advocates. For example, the Home Equity Conversion demonstration program should help to stimulate interest in home equity conversion transactions. This concept has become very attractive to many of the large number of older Americans who have substantial equity in their homes, yet who are faced with meeting the high costs while living on fixed incomes. The Act also begins to address the crucial issue of prepayment of mortages for low-income housing.

In 1989, a major housing reform bill is expected to be introduced by Senator Alan Cranston, Chairman of the Subcommittee on Housing and Urban Affairs of the Senate Committee on Banking, Housing and Urban Affairs, and Senator Alfonse D'Amato, the

Subcommittee's Ranking Minority Member. Among its many provisions, this legislation would create an Office of Housing Preservation which would be responsible for retaining the current stock of affordable housing, and an Office of the Assistant Secretary for Supportive Housing. The Assistant Secretary for Supportive Housing would be responsible for the administration of housing programs that serve the elderly, handicapped, and homeless, and would also serve as HUD's liaison with the Department of Health and Human Services and other agencies on matters relating to supportive services for special tenant populations served by HUD housing programs. This bill would also substantially revamp the Section 202 housing program by restructuring the loans, changing the manner in which tenant rents are computed, etc. It will also encourage the cooperation of the Federal, State, and local governments in providing supportive services to assist the elderly to age in place.

Housing advocates look to the 101st Congress as an opportunity to develop new priorities in U.S. housing policy. There are indications that the Bush Administration will make affordable housing a major part of its domestic spending agenda, although some HUD officials say they believe there will be little change from the Reagan Administration. Passage of a comprehensive housing bill is not certain, although the housing needs of low-income Americans are becoming an increasingly important concern to politicians and the American public alike. Barring the passage of legislation, it is important that Congress not permit any further erosion of funding for housing. In the past, Congress has not acquiesced in proposals to terminate housing programs and congregate services for the elderly, and is unlikely to do so in the future.

B. INNOVATIVE HOUSING ARRANGEMENTS

The single-family house has come to represent the discrepancy between the supportive care needs of a burgeoning population of elderly homeowners and the lack of housing alternatives. Recently, 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. These include board and care homes, life-care communities, shared and ECHO, or "granny flat" arrangements.

(1) Board and Care Homes

Most of the more than 1 million residents of boarding homes and foster, adult, or domiciliary care facilities receive some form of public assistance, usually in the form of Supplemental Security Income (SSI). Managers of the 300,000 such homes often have been criticized for inadequate safety and security measures, poor care, abuse of the residents, and even financial fraud.

In 1976, after a number of fires in board and care homes, Congress added section 1616(e), known as the Keys Amendment, to the Social Security Act. This provision requires that for group living arrangements in which a significant number of SSI recipients reside, States establish and enforce standards that govern such matters as admission policies, safety, sanitation, and protection of civil rights. In making this change, Congress sought to prevent the

SSI program from becoming a source of funds for substandard institutions.

The Keys Amendment does not mandate Federal regulation or licensure of board and care homes. There is only one enforcement sanction available to punish provision violators—the power to reduce the SSI checks of residents of homes not in compliance with State regulations. This includes States with no regulations at all. 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 skilled nursing and intermediate care facilities.

(2) Life-Care Communities

Life-care communities, also called continuing care communities, typically provide housing, personal care, and 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. 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.

In 1987, there were about 680 life-care communities, each with an average of 245 residents. Life care defined in this way is viewed as a form of long-term care insurance, because communities protect residents against the future cost of specified health and nursing home care. According to the American Association of Retired Persons, the number of life-care communities doubled in the past 10 years and is expected to more than double in this decade. 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.

Some analysts view this concept as a form of long-term care insurance. 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.

Entrance fees range among life-care communities from approximately $40,000 to more than $150,000, with monthly fees ranging from $500 to $2,000. 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. Life-care communities do not cover acute health care needs such as doctor visits and hospitalization, and some may re-

quire residents to share in the cost of the health or long-term care services they receive from the community. 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. 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 profit-making 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. Although California, in 1969, was the first State to regulate life care, only 13 States today regulate the operation of life-care communities. These States are: Arizona, California, Colorado, Florida, Illinois, Indiana, Maryland, Michigan, Minnesota, Missouri, Oregon, Pennsylvania, and Virginia. New York, which bans prepaid nursing home care, effectively prohibits life-care arrangements. There is little uniformity 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 and non-arms-length transactions to enhance his personal wealth at the expense of the life-care 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 Senator Heinz which exempted the first $90,000 of an entry fee from the imputed interest rules as part of Public Law 99-121. The House version of the 1987 reconciliation bill, H.R. 3545, 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 life care 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. Others believe that while life care is an option for some elderly, it is unlikely that many with low and moderate incomes would be able to afford it. Further, many older persons are reluctant to move from their homes and into a life care community.

To address some of these concerns, researchers at Brandeis University are developing a finance and delivery model.[3] The model provides most of the same benefits to the elderly as a life-care community while enabling participants to remain in their homes. Services provided under this model would include skilled and intermediate nursing, personal care, home health and homemaker services, and respite care. The proposed costs of the model include a one-time entry fee of about $5,000 to $10,000, and monthly fees between $80 and $150, depending on local service networks and benefits offered.

(3) 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 multi-family 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 three or four residents.

The economic and social benefits of shared housing have been recognized by many housing analysts. Perhaps the most easily recognized benefit is companionship for the elderly. Also, shared housing is a means of keeping the elderly in their own homes, while helping to provide them with 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. In a recent AARP poll of a sampling of its 23 million members on the subject of shared housing, 15 percent said they would consider sharing living quarters with someone outside their family.

From an economic viewpoint, shared housing can be an important low-cost means of revitalizing neighborhoods. Abandoned large houses and buildings could be made suitable for shared housing with very little renovation. Dennis Day Lower, a director of the Shared Housing Resource Center in Philadelphia, has pointed out that shared housing is extremely cost effective when compared to new construction. He has noted that per unit capital costs could be 50 to 60 percent lower using shared housing.

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[3] Tell, E., Batten, H., Cohen, M., and Larson, M. (1986). *The Market Potential for Long-term Care Finance and Delivery Options: Results of a Telephone Survey,* unpublished manuscript, Health Policy Center, Heller Graduate School, Brandeis University.

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. They included a provision in the Housing Act of 1983 for Section 8 rental assistance to be used with shared housing. Under this provision, the existing and moderate rehabilitation programs of Section 8 can be used to aid elderly families in shared housing.

Several shared housing projects are 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.

(4) 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 neighborhood. 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, so this form of housing undergoes the same zoning restrictions and impediments already discussed in the section of this report concerning shared housing. According to one expert, about 40 percent of the single family housing stock in the country is now zoned to permit accessory apartments. According to this expert, once zoning is changed, there are a large 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. The expert suggests a basic partnership between real estate agents and remodelers to market accessory apartments.

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 grandpar-

ents 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.

Rigid zoning laws, lack of public information, and concern about adverse changes to the neighborhood, and therefore, property values, are the major barriers to the development of ECHO housing. Many civic leaders, public officials, and organizations are reporting increased interest in the possibility of ECHO units for their jurisdictions. At this time, there is no Federal legislation dealing with this concept.

(5) Prognosis

Innovative housing programs will become more and more essential in providing basic housing and support services for our Nation's elderly, handicapped, and poor. But Congress, with its full agenda of issues, is unlikely to focus much attention in 1989 on innovative housing for the elderly, with the exception of board and care homes. Hearings will be in order, but action on expanding shared housing options and further life-care facility policy is not a high priority. It is very unlikely that legislation on these issues will reach the President's desk for signature in 1989.

In addition, the life-care industry is expected to grow by leaps and bounds over the next several years, mainly appealing to the upper middle- and upper-income groups. There is consideration being given to life-care facilities for lower income Americans, primarily those that have been able to purchase a home during their lifetime. These efforts will be slow in evolving, however, and will be undertaken primarily by nonprofit life-care interests. The for-profit life-care interests will continue to expand during 1989.

Shared housing will become a more necessary option for older Americans in future years as the cost of maintaining a single residence because a larger burden than many elderly can afford. The need for quality board and care facilities, accessory apartments, and granny flats will grow with the increase in the number of older Americans, but the role of the Federal Government will not be significant in 1989.

Chapter 10

ENERGY ASSISTANCE AND WEATHERIZATION

OVERVIEW

During the 15 years since OPEC first embargoed oil sales to the United States, energy use and conservation have become major domestic policy issues, particularly for those who monitor the economic security of the elderly and poor.

Several Federal programs have been instituted to ease the energy cost burden for low-income individuals. The most significant of these are the Low-Income Home Energy Assistance Program (LIHEAP) and the Department of Energy's weatherization assistance program. They have also been severely slashed in the effort to reduce Federal budget deficits.

Although these programs have played an important role in helping millions of America's poor pay for their basic energy needs and weatherize their homes, there is a widening and dramatic gap between existing Federal resources and the needs of the population these programs were intended to serve. Fiscal year 1989 appropriations were the lowest in the program's 9 year history and preliminary estimates indicate a substantial drop in the number of households receiving heating assistance in fiscal year 1988 as compared with fiscal year 1987.

In fiscal year 1987, LIHEAP provided heating assistance to an estimated 6.8 million low-income American households, up from 6.7 million in fiscal year 1986. These households represent about 28 percent of all households with incomes under the Federal maximum standard for the program (150 percent of poverty or 60 percent of State median income) or about 38 percent of all households with incomes under the stricter income standards adopted by most States which range from 110 percent of poverty to the Federal maximum standard.

The Reagan Adminstration has attempted in recent years to substantially cut LIHEAP and to eliminate the DOE weatherization program. Since 1985, Congress has cut appropriations for LIHEAP by $716 million or 34 percent. A survey of 45 LIHEAP States program administrators indicated that, for fiscal year 1988, 22 States cut heating benefits, 13 reduced the number of households served, and 18 eliminated or reduced the use of LIHEAP funds for weatherization. Twenty-six States used oil overcharge funds to supplement LIHEAP appropriations but the majority of these still had to reduce program services.

Although Congress continued to view these programs as the Federal Government's major effort to assist low-income households with their energy costs, the perception continued to prevail that

the States had substantial oil price overcharge funds available to use for funding LIHEAP. The States also continued to transfer LIHEAP funds to other block grant programs. In addition, the programs have been reduced twice under the Gramm-Rudman-Hollings Act, in 1986 and 1987.

A. BACKGROUND

The radical changes in world oil markets following the 1973 embargo brought equally radical changes in the household budgets of Americans. The proportion of income required to purchase essential energy supplies rose dramatically and changes in the cost of this basic commodity brought changes in the cost of many other necessary items. Although these changes had different impacts depending on a household's income and fuel requirement, the pressure for change in consumption patterns and the erosion of real spending power due to energy inflation over the past 15 years has been unrelenting. The rising cost of energy has had a particular effect on the elderly and those with low incomes who consume relatively less energy than other households, but pay a larger portion of their disposable income for fuel.

According to a 1987 study by the Northeast Midwest Institute, fuel oil prices increased 428 percent from 1973 to 1985, while natural gas prices increased 371 percent and electricity 208 percent in the same period. During the same time, the Federal poverty level for a family of four increased only 142 percent.

The rise in energy costs in relation to income has been the impetus behind Congressional enactment of both the Low-Income Energy Assistance Program and the Weatherization Assistance Program. Between 1972 and 1979, electricity costs rose 84 percent, natural gas prices increased 150 percent, and fuel oil costs rose 258 percent. These figures were well above the overall increase of 74 percent in the Consumer Price Index for the same period.

According to the Department of Energy's Residential Energy Consumption Survey (RECS) for fiscal year 1986, LIHEAP households spent $992 or 15 percent of their incomes on residential energy as compared to $1,119 or 4 percent of total income for households of all income levels. All low-income households (annual incomes under the greater of 150 percent of the poverty line or 60 percent of the State's median income) spent $1,006, or 13 percent of their income, on their residential energy needs.

Analysis of the 1982–83 and 1984–85 RECS indicate that LIHEAP households consistently spent 8–10 percent more on home heating than the average of other low-income households. This may be attributed to the fact that more LIHEAP households in the survey are located in colder States and also are likely to contain more elderly members, more young children, and more households headed by females than the average low-income sample.

According to earlier RECS, beginning in 1979 and continuing for the next 2 years, the average household paid $100 more each year for household energy. In 1982, however, the increase slowed significantly. As pointed out by the Department of Energy, this slowdown in the rate of increase occurred because the increase in prices nearly was offset by the decrease in consumption. Overall, from

1981 to 1982, prices rose 14 percent while consumption dropped 10 percent.

In the early 1980's, fuel costs rose dramatically. Between December 1980 and December 1985, household fuel costs rose 32.6 percent. The trend slowed in 1985 as the average price of heating fuels increased only 0.7 percent between December 1984 and December 1985.

The U.S. Bureau of Labor Statistics reports that the consumer price index for household fuels actually declined 9.4 percent from December 1985 to December 1986. This figure reflects a 33.4 percent decrease in the cost of fuel oil, a 1.5 percent decrease in the cost of electricity, and a 5.8 percent decrease in the cost of natural gas.

However, from November 1986 to November 1987, the price index for household fuels increased again by 1.9 percent with fuel oils taking the biggest leap at 20.2 percent. Electricity prices increased 1.8 percent and the cost of natural gas declined by 2.8 percent.

By November 1988, the cost of all household fuels had increased 1.4 percent from November of 1987 although fuel oil prices dropped 9.4 percent. The price of electricity increased by 1.7 percent and natural gas went up 3.6 percent.

Using October 1988 data, the Department of Energy is projecting little change in fuel prices for 1989. The cost of fuel oil is projected to drop 1 percent, electricity to increase by 1.5 percent, and natural gas to go up 3 percent. Only about 12–15 percent of low-income households use fuel oil for heating. Most use natural gas as their primary heating source.

The Department of Energy has estimated that energy consumption is higher for households with larger incomes. There is a large difference in average energy consumption and expenditures among households with different incomes. The highest income households use about 70 percent more energy than the lowest income groups. It was noted that their living quarters are about twice the size of the lowest income group and they usually have more appliances. From 1978 to 1980, there was a trend toward parity, with high-income households lowering their energy consumption more than low-income households did. The data for 1981, however, show a slight reversal of this trend. Households earning less than $5,000 reduced their consumption by an estimated 11 million Btu's, while households with incomes over $24,000 did not show a continued drop.

Rising energy prices affect all income groups, so that energy expenditures increased across-the-board from 1978 to 1981. Average expenditures for households in the highest income group ($1,333) were almost 75 percent more than those of the lowest income group ($766). In contrast, however, expenditures increased much more for the lower income group than for the higher.

During this 4-year period, beginning in 1978, expenditures for the lowest income group increased 47 percent, in nominal dollars, while expenditures for the higher income group increased 24 percent. Additionally, expenditures as a percentage of income are much higher for lower income groups. Low-income households typically spent about 20 percent of their income on energy, while high

income households spent 3–4 percent of their income on energy. Among poor households, the burden of energy expenditures is highest in the Northeast and North-Central portions of the country. For example, in the Northeast, poor households (those below 100 percent of the poverty level) paid 29 percent of their income for household energy.

The high cost of energy is a special problem for the low-income elderly because they are particularly susceptible to hypothermia—the potentially lethal lowering of body temperature. The Center for Environmental Physiology in Washington, DC, has reported that experts estimate that hypothermia may be the cause of death for up to 25,000 elderly people each year. The center reports that most of these deaths occur after exposure to cool indoor temperatures rather than extreme cold. In addition, the situation can worsen many preexisting conditions and diseases in older adults, such as arthritis. Although another disease is ultimately listed as the cause of death, the center maintains that many deaths may be causally related to hypothermia.

1. The Low-Income Home Energy Assistance Program

The precursors of the current Low-Income Home Energy Assistance Program (LIHEAP) were a series of short-term crisis intervention programs in the 1970's that were administered by the Community Service Administration (CSA) and limited to a $200 million annual appropriation. Between the winters of 1979 and 1980, the price of home heating oil doubled and Congress expanded aid sharply by creating a three-part energy assistance progam at an appropriation level of $1.6 billion: $400 million to the CSA for continuation of its crisis intervention programs; $400 million to the Department of Health and Human Services (DHHS) for one-time payments to recipients of Supplemental Security Income (SSI); and $800 million to DHHS for distribution as grants to States to provide supplemental energy allowances.

In 1980, Congress passed the Home Energy Assistance Act as part of the crude oil windfall profit tax legislation. $1.85 billion was appropriated for the program that year. The current LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981) as amended by the Human Services Reauthorization Acts of 1984 and 1986. Appropriations for fiscal year 1988 of $1.5 billion have been cut sharply from the $2.1 billion appropriated for fiscal years 1985 and 1986 and the $1.825 billion for fiscal year 1987.

Under the LIHEAP program, block grants are made to the 50 States, the District of Columbia, approximately 122 Indian tribes and tribal organizations and 6 U.S. territories, allocated by formulas based largely on home energy expenditures by low-income households. Financial assistance is provided to eligible households, usually directly or through vendors, for home heating and cooling costs, energy-related crisis intervention aid, and low-cost weatherization. Some States also make payments in other ways such as through vouchers or direct payments to landlords.

States also are allowed some flexibility in the use of their grants—up to 10 percent may be transferred into other block grant

programs, up to 15 percent may be used for weatherization programs and up to 15 percent may be carried over to the next fiscal year. No more than 10 percent of the grant may be used for administrative costs.

States may establish their own benefit structures and eligibility rules within broad Federal guidelines. Eligibility may be granted to households receiving other forms of public assistance such as Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), food stamps, certain need-tested veterans' and survivors' payments or those households with incomes less than 150 percent of the Federal poverty income guidelines or 60 percent of the State's median income, whichever is greater. Lower income eligibility requirements may be set by States and other jurisdictions, but not below 110 percent of the Federal poverty level.

Other Federal requirements include structuring benefits so households with the lowest income and highest energy costs get higher benefits, equal treatment for renters and homeowners, outreach programs to inform those potentially eligible about the program, and equitable treatment between those who are income eligible and those who are categorically eligible.

According to DHHS, States provided heating assistance to more than 6.8 million households in fiscal year 1987. Over 1.1 million households received energy crisis assistance, almost all for winter/year-round assistance rather than only summer crisis assistance. Based on previous State estimates, DHHS calculates that about two-thirds of the households reported receiving winter crisis assistance also received regular heating assistance. This would make the unduplicated number of households receiving assistance with heating costs to be about 6.8 million. This compares to the 6.7 million households assisted in fiscal year 1986.

Preliminary estimates from a summer telephone survey of the States indicate that 5.9 million households received heating assistance in fiscal year 1988—almost a million less than in 1987. DHHS also reported that 338,000 households received assistance for cooling costs in fiscal year 1988, slightly less than the 366,721 households in fiscal year 1987 which was a 31 percent reduction from the 535,553 households receiving cooling assistance in 1986. Also in 1988 more than 979,000 households received winter/year-round crisis assistance, 81,000 less than in 1987. However, the number of households receiving low-cost weatherization or other energy related home repairs increased to 202,000, a 5-percent increase, a 10-percent reduction from the 191,300 households in 1986.

According to the DHHS report to Congress for fiscal year 1987, the average LIHEAP benefit for heating assistance was about $216. This offset about 61 percent of the average fiscal year 1987 heating costs for recipients. Average fiscal year 1987 home heating costs for all households were about $360, while average space heating costs for low-income households were about $341. Average space heating costs for LIHEAP recipient households were about $354. On average, according to DHHS, households receiving LIHEAP benefits have higher heating costs and lower income than low-income nonrecipient households.

Unfortunately, DHHS cannot estimate precisely the number of households eligible for LIHEAP. Typically, States operate LIHEAP

for only part of the year and no data source provides seasonal national information on income and participation in other programs which provide categorical eligibility for LIHEAP. Further, States' procedures for determining eligibility may annualize 1 or more month's income to test against the income standard the State has adopted. Thus, households may be eligible for LIHEAP even though their actual annual income is above the income maximum set in law.

With these qualifications, DHHS estimates that, according to the March 1987 Current Population Survey, an estimated 24.1 million households had incomes under the Federal maximum standard and an estimated 17.8 million households had incomes under the more stringent income eligibility standards of many of the States.

Poverty also has increased dramatically, from 24.5 million people living below the poverty threshold in 1978 to 32.4 million in 1986. According to a 1987 report on the energy needs of the poor by the Northeast Midwest Institute, the estimated number of households eligible for LIHEAP assistance increased from 12.6 million in 1980 to 23.4 million in 1985. Part of that increase is due to the change in Federal eligibility standards from 125 percent of Federal poverty levels to 150 percent.

2. The Department of Energy Weatherization Assistance Program

The Department of Energy's (DOE) Weatherization Assistance Program has been authorized under the Energy Conservation and Production Act of 1976, as amended. It is designed to reduce heating and cooling costs in homes of low-income households. Although it has not been reauthorized since its authority expired at the end of fiscal year 1985, Congress has continued appropriations for the program. Allocations for fiscal year 1989 are $161 million under the Department of Interior appropriation bill passed by Congress on September 8, 1988 (P.L. 100-446).

The program actually began under the Emergency Energy Services Conservation Program enacted by Congress in 1975 to provide relief to needy households by increasing the energy efficiency through insulation and repairs. By 1985, it had developed to a $191 million weatherization program. But since then, appropriations have dropped and the administration has been attempting to phase it out.

Through the program, funds are made available to States, which in turn allocate dollars to nonprofit agencies for purchasing and installing relatively low cost materials such as insulation, storm windows, and doors. Federal law allows a maximum average expenditure of $1,600 per household. To be eligible for assistance, household income must be at or below 125 percent of the Federal poverty level. States, however, may raise their income eligibility criterion to 150 percent of the poverty level to conform to the LIHEAP income ceiling. They may not, however, set it below 125 percent of the poverty level. Also eligible for assistance are households with persons receiving AFDC, SSI, or local cash assistance payments. Priority for assistance is given to households with an elderly individual (age 60 and older) or a handicapped person. The program

has served more than 1.8 million homes from the program's inception through October 1988. In 89,966 of these homes, at least one resident was 60 or older. In fiscal year 1987, 107,045 homes were weatherized and 115,120 were done in fiscal year 1988.

The goals of the program include:

—Improved energy efficiency in the homes of participants,
—Reduced fuel bills for participants,
—Reduced national energy consumption, and
—Increased employment opportunities due to installing and manufacturing low-cost weatherization materials.

A DOE-sponsored evaluation of the weatherization assistance program published in 1984 (based on 1981 data) showed that: [1]

—The program reaches elderly persons in accord with its statutory priority requirement.
—The program saves, on the average, about 13 percent of a home's heating energy. The study found that 50 percent of the weatherized homes surveyed had an energy savings of 10 percent or more; 23 percent had a savings of 20 percent or more; and 23 percent used more energy the year after weatherization.
—Energy savings relate to the type and cost of weatherization assistance materials. Homes receiving the most extensive weatherization services (insulation plus storm windows or doors) saved more than twice as much energy as weatherized homes that were not insulated. Insulation was a key measure for producing energy savings.
—Energy savings derived from a particular energy improvement, however, can be determined precisely only by measuring energy consumption under identical circumstances before and after the improvement is made. This condition is impossible to meet because conditions are always changing. For example, thermostat settings and energy use in a home changes from year to year.
—More of the homes weatherized are in colder weather zones and fewer are in temperate and warm weather zones.

As a result of these findings, DOE is examining types of occupant behavior which contribute to differences in energy savings as well as combinations of weatherization materials which optimize energy savings. A client education program relating to energy conservation behavior is also in progress.

Beginning in calendar year 1987, DOE was authorized to establish a "performance fund" from which dollars will be awarded to States meeting its criteria for the best weatherization programs. Up to 15 percent of the amount appropriated each year for the DOE program would be used for the fund. The award criteria depends on the percentage of eligible dwelling units within a State that have been weatherized, energy savings resulting from weatherization activities, and the State's actual achievement of its weatherization assistance program goals.[2] However, the program

[1] U.S. Department of Energy. Energy Information Administration. Office of Energy and End Use. Weatherization Program Evaluation. SR-EEUD-84-1. August 20, 1984. Executive Summary and pp. 1-2, 18-19.
[2] Federal Register. Part V. Department of Energy. December 5, 1985. p. 49912.

will not become operational unless $205 million or more in annual appropriations is available.

B. ISSUES

1. Evaluating Energy Assistance and Savings

Of primary concern to the Special Committee on Aging is the effectiveness of energy assistance programs in serving older persons. The elderly are particularly at risk for both hypothermia and heat stress because of physical changes associated with aging. Most elderly victims of hypothermia become ill from indoor temperatures between 50 and 60 degrees Fahrenheit. Any disease or weakness of the heart and blood vessels makes a person more vulnerable to heat stress which can cause heat exhaustion, heatstroke, heart failure, and stroke.

Both LIHEAP and the Weatherization Program give priority to the elderly and handicapped citizens in assuring that these households are aware that help is available, and to minimize the danger of unnecessary shutoff of utility services. According to DHHS, about 37 percent of households receiving assistance with heating costs had at least one elderly member age 60 or over. Thus, households containing elderly members are served roughly in proportion to their representation in the total low-income population. However, of the 12 States which operate cooling assistance programs, almost 71 percent of the households contain at least one elderly member.

Although States have come up with a variety of means for implementing the targeting requirement, several aging organizations have suggested that Older Americans Act programs, especially senior centers, be utilized as information and outreach bases for the programs. Discussions with area agencies on aging and senior center staff indicate that increased effort has been made in recent years to identify eligible elderly persons for energy assistance, and to provide the elderly population in general with information about the risks of hypothermia.

A 1986 study of 13 diverse States accounting for 46 percent of the fiscal year 1985 LIHEAP appropriation and 49 percent of the Nation's low-income households, cited that all of these States reported using local organizations and aging agencies for outreach to the elderly and eligible households.

The debate over the effectiveness of LIHEAP and the DOE weatherization program continues. Many argue that the programs have been well-directed and effective for the neediest, yet conclusive data is not available.

According to a 1986 report prepared by the Economic Opportunity Research Institute for the National Association of State Community Services Programs, frail or disabled elderly people, the very poor, and households with a history of energy shutoffs are in greater need than many households that receive energy aid. It was estimated that about 2.8 million such households, with average incomes of $2,196 are not served. Households that receive aid under LIHEAP on average have higher incomes and lower energy costs than eligible households not receiving the aid. The report stated

that meeting the needs of those not currently served under LIHEAP requires more money. Using 1984 average benefits, achieving a 55 percent participation rate would require a 23 percent increase in LIHEAP funding. A much higher increase would be necessary now because of continuing budget cuts.

According to the DHHS report for fiscal year 1987, low-income households expend a greater proportion of their income for space heating than do other households. The percentage of income for heating is greater still for LIHEAP recipient households. The average annual income of LIHEAP recipient households is more than 15 percent less than the average annual income of other low-income households. Nationally, fiscal year 1987 heating costs represented about 4.2 percent of the average income of low-income households and 5.2 percent of income for LIHEAP recipient households, compared to about 1.2 percent of income for the average U.S. household.

The National Low Income Energy Consortium (NLIEC) issued a report in October 1988, entitled "The Late Great Energy Crisis: Hidden Hardships" which analyzed data from government and private sources. It concludes that for many Americans, "who are disproportionately poor, elderly and infirm, energy remains as critical a concern today as it did to every American in the most ominous days of the oil embargo." The report estimated that, by 1984–85, almost one-fourth of poverty or near-poverty households spent more than 25 percent of their income on combined residential fuel expenditures. During the winter of 1986–87, the report stated that over 28 percent of all poor or near poor households suffered without heat for 1 or more days because their utility or fuel bill wasn't paid.

Also, according to the NLIEC report, in 42 States, 30 percent of an elderly person's maximum SSI benefits were consumed by home energy costs during the coldest months of the 1983–84 winter. In nine States, home energy costs totaled 50 or more percent of SSI benefits.

LIHEAP, however, has its critics, who generally take one of two positions. One position argues that the public welfare system, excluding LIHEAP, already is either sufficient or too generous. Another position is that assistance is needed, but not in the form provided by LIHEAP.

Those who oppose specific energy aid for low-income individuals contend that, when combined with other welfare benefits, the LIHEAP increases work disincentives, unnecessarily increases the Federal deficit, and makes the cumulative benefits under all welfare programs too generous, especially since LIHEAP benefits are not counted as income for determining eligibility and benefit levels under other means-tested assistance programs. It is also argued that LIHEAP was intended to be only a temporary emergency measure, designed to help households cope with the energy price shocks of the 1970's, and should not become part of the permanent public welfare system.

Others may favor energy-related aid for those with low incomes, but maintain that assistance would be provided more efficiently through the more established means-tested programs such as AFDC, SSI, or food stamps. However, this would exclude the cur-

rently estimated 30 percent of LIHEAP recipients who are nonwelfare poor, such as the elderly and working poor.

Others argue that LIHEAP, by increasing household income available for energy, discourages energy conservation. The twin goals of helping low-income households meet high energy costs and encouraging energy conservation would be better achieved, some assert, through home weatherization or renewable energy home improvements.

Various studies have attempted to quantify energy savings from Federal weatherization efforts. According to the GAO, it is difficult to measure such savings due to differing conditions of dwelling units and varying climatic conditions and fuel prices throughout the country. Additionally, little or no effort has been made to verify the accuracy of fuel-use records in homes that have been weatherized. Experts in this area have noted that most studies do not use control groups where fuel costs in homes weatherized are compared with fuel costs in homes not weatherized. Lacking a control group, it is difficult to accurately predict whether changes in energy consumption are due entirely to weatherization assistance or to changes in fuel prices, conservation programs, appeals from political leaders, or a combination of these. Further, it has been observed by program personnel that some households may conserve less after weatherization because they raise their thermostats to a more comfortable level.

According to GAO, the extent to which DOE's program is reducing energy costs and consumption is unknown by DOE and the States that administer the DOE program. While DOE has claimed a 20–25 percent annual energy savings in homes weatherized through its program, GAO reports that this statistic has questionable reliability because of DOE's sampling and data problems.[3]

A study conducted in the State of Minnesota of its weatherization program employed a more scientific methodology to evaluate energy savings. Based on an analysis of fuel records from both weatherized and nonweatherized homes, the study concluded that the DOE program was successful in reducing energy consumption by an average of 13 percent. The study also concluded that the cost of weatherization is likely to be repaid within 3½ years through lower fuel bills.[4]

Although this evaluation initially showed promise for a careful examination of energy savings, the GAO reported that the study was too geographically limited to reveal savings on a nationwide basis. In the final analysis, GAO has concluded that there is no nationwide study on cost savings that incorporates standardized statistical methods in a way to assure maximum reliability. However, the evaluation discussed earlier in this chapter under the DOE weatherization program description was conducted after GAO's analysis, and provides evidence that the program is working. A

[3] U.S. Government Accounting Office. Uncertain Quality, Energy, Savings and Future Production Hamper the Weatherization Program; Report to the Congress by the Comptroller General of the United States. EMB 82-2. October 26, 1982. Washington, 1982. pp. 18–20.

[4] Hirst, Eric and Raj Talwar. "Reducing Energy Consumption in Low-Income Homes." Evaluation of the Weatherization Program in Minnesota. Evaluation Review, v. 5, October 1981. pp. 671–683.

number of States have also conducted studies since that time and many show energy savings in the 14–25 percent range.

2. Block Grant Versus Categorical Funding

Another issue concerns funding Federal weatherization programs through block grants versus categorical grants. Many public officials agree that the Federal Government should support weatherization activities for low-income households. The nature of this support, however, has been somewhat controversial. While some groups favor the block grant approach to Federal assistance, others find more merit in the categorical grant approach of the DOE program. At the State and local levels, however, the two programs often have the same or similar guidelines and often are administered by the same agencies.

States have statutory authority to transfer to LIHEAP up to 10 percent of their social services block grant allotments and up to 5 percent of their community services block grant allotments, but no State has yet done so. On the other hand, the LIHEAP statute provides that a State may transfer up to 10 percent of the LIHEAP funds payable to it for a fiscal year for use in one or more of the six other block grants administered by DHHS. Thirty-three States transferred a total of approximately $92 million of LIHEAP funds to these block grants in fiscal year 1987 and an estimated $93 million in fiscal year 1986. Twenty-seven of these States transferred funds to the Social Services Block Grant. However, according to the DHHS 1988 summer survey, the number of States transferring LIHEAP funds had dropped to 28 and the amount transferred for fiscal year 1988 was $66 million, a cut of 28 percent.

C. LEGISLATION

Despite efforts by the Reagan Administration to fund LIHEAP through block grants or from petroleum overcharge funds rather than general revenues and to eliminate or phase-out the Department of Energy weatherization program, Congress steadfastly has resisted changes. For example, in the 1984 budget request, the Reagan Administration proposed replacing LIHEAP with a block grant to States and requested no funding for the Weatherization Assistance Program. Although Congress has studied numerous energy assistance proposals, it has rejected the administration's approach and continued the programs.

1. Low-Income Home Energy Assistance Program

The current LIHEAP is authorized by the Low-Income Home Energy Assistance Act (Title XXVI of the Omnibus Budget Reconciliation Act of 1981: P.L. 97-35), as amended by the Human Services Reauthorization Acts of 1984 and 1986 (P.L. 98-558 and P.L. 99-425). The 1986 amendments reauthorized appropriations through fiscal year 1990 at gradually increasing levels of $2.05 billion for fiscal year 1987 to $2.307 billion for fiscal year 1990.

(A) REAUTHORIZATION OF LIHEAP

In 1986, to extend the authorization of LIHEAP appropriations, the administration submitted draft legislation that proposed to:

(1) Extend the appropriations authorization for 3 years at $2.1 billion for fiscal year 1987 and with no specific authorization levels for later years,

(2) Remove the 15 percent limit on the proportion of a State's allotment that may be devoted to weatherization assistance,

(3) Repeal the requirement that States describe home energy usage within each State in their annual application for an allotment,

(4) Require States to take into account other assistance available to LIHEAP beneficiaries when establishing their LIHEAP benefits,

(5) Revise the method of calculating and providing special LIHEAP grants to Indian tribes, and

(6) Change certain nondiscrimination provisions of LIHEAP law.

However, Congress chose to design reauthorization legislation that, in effect, ignored many of the administration's recommendations.

In September 1986, House-Senate conferees on H.R. 3321 agreed on the 1986 reauthorization of LIHEAP (P.L. 99-425). It included the following provisions:

(1) A 4-year reauthorization of appropriations for LIHEAP with authorization levels increasing 4 percent a year:

Fiscal year:	*Billion*
1987	$2.050
1988	2.132
1989	2.218
1990	2.307

(2) Provisions stipulating time deadlines that must be met in delivering energy crisis aid and making it clear that community-based organizations such as community action agencies may be designated to administer energy crisis intervention programs.

(3) Revisions in the method of calculating and providing special LIHEAP grants to Indian tribes.

(4) Provisions emphasizing the requirement that States adjust benefits to ensure that the neediest households receive the maximum assistance.

(5) Provisions reorganizing State plan requirements and directing the development of a model State plan.

(6) A requirement for an annual report on LIHEAP.

(7) Provisions stipulating that receipt of LIHEAP benefits do not affect eligibility or benefits under the Food Stamp Program. (See Food Stamp chapter for details.)

(B) FUNDING LIHEAP

Appropriations for fiscal year 1989 of $1.38 billion have been cut sharply from the $2.1 billion for fiscal years 1985 and 1986. Congress approved this level in agreeing on the conference report of

H.R. 4783, for Labor, Health, Human Services and Education appropriations in September 1988 (P.L. 100-436). The Senate-passed appropriation level was $1.87 billion and the House of Representatives level was $1.537 billion.

For fiscal year 1988, $1.532 billion was appropriated, a cut of over $300 million from the 1987 appropriation of $1.85 billion. For the fiscal year 1987 appropriation, House-Senate conferees explicitly stated that ". . . the amount agreed to for LIHEAP should not be construed as a decline either in support for the program or in the need for such assistance. Rather, it is reflective of the unusual circumstances which exist this year: lower energy prices in general and the availability of substantial oil overcharge funds to the States."

For fiscal year 1989, the administration proposed a $1.2 billion appropriation level for LIHEAP, a $282 million or 20 percent decrease from the appropriation for fiscal year 1988. The budget resolution for fiscal years 1988 and 1989, H. Con. Res. 93, approved by the House and Senate in June 1987 assumed current funding levels for LIHEAP.

In spite of the agreed-upon budget resolution level, the Senate Appropriations Committee approved a level of $1.24 billion for fiscal year 1989, the same as the administration's request (H.R. 3058; S. Rept. 100-189). This level was approved by the full Senate in October 1987 after failure of two floor attempts to raise the level to $1.825 billion. The Chairman and members of the Senate Special Committee on Aging tried to stave off the cuts in the Appropriations Committee with letters to the Chairman and members. A majority of Senate Members also signed a letter to conferees in support of the higher appropriations level approved by the House of Representatives.

Senate proponents of the lower level argued that oil overcharge funds were available to the States to make up the difference and cited the Senate appropriations bill for the Departments of Labor, Health and Human Services, and Education requiring a significantly lower outlay amount than the same House appropriations bill. They also noted that States continued to transfer almost $100 million from LIHEAP funds to other block grants.

Those opposed to the Administration's proposed 32-percent cut and the conferees 16-percent cut noted the uncertainty of oil overcharge funds available to the States for the 1988 winter season as most State legislatures already had adjourned and allocated the money. They also cited the low percentage of eligible low-income households that actually receive LIHEAP benefits.

(1) State Allotments

Although a new formula for allocating LIHEAP appropriations among the States was enacted in the 1984 amendments to the Low-Income Energy Assistance Act, the method of allocating funds actually varies according to the appropriation level. As a result, changes in appropriations can produce what appear to be anomalous differences in State allotments. In fiscal year 1986, some States experienced a decrease in their allotments because LIHEAP was subject to a Gramm-Rudman-Hollings spending reduction of

4.3 percent. Under the LIHEAP allocation procedures, 23 States received no reduction, 7 States and the District of Columbia received the standard 4.3 percent fiscal year 1986 Gramm-Rudman-Hollings reduction, and the remaining 20 States received cuts ranging from 4.6 percent to 11.7 percent. This was criticized by many as contrary to the uniform "across-the-board" intent of Gramm-Rudman-Hollings and a bill was introduced that would have directed uniform percentage cuts in State allotments when funding reductions are caused by Gramm-Rudman-Hollings procedures. Reductions in State allocations have continued to occur every year since because of decreasing appropriations.

(2) Recouped Oil Price Overcharges

From 1973 to 1981, the United States imposed price controls on crude oil and petroleum products in response to the Arab oil embargo. Since then, a number of lawsuits have been filed against certain oil companies for alleged overcharges during that period.

Money recovered from oil companies in two recent major court decisions for oil price overcharges under the Emergency Petroleum Allocation Act of 1973 (P.L. 93-159) has been made available to the States as possible additional funding for LIHEAP and other energy-related programs. The courts stipulated a restitutionary principle originally adopted by Congress which requires that these funds be used to "supplement, not supplant" existing Federal and State resources. Each State decides how it will allocate the funds.

The first national distribution of oil overcharge funds was a $200 million settlement referred to as Warner Amendment funds, named after the Senate sponsor of the legislation (section 155 of P.L. 97-377). Held in escrow by the Energy Department, the funds were allocated to the States in early 1983 according to each State's share of the national usage of petroleum products during the period of the oil price overcharges involved in the court settlement.

Under the 1985 $2.1 billion EXXON decision, the Department of Energy also allocated the award to the States according to their use of petroleum products. States were to use the funds for LIHEAP and four other programs which include the Low-Income Weatherization Program, the schools and hospitals weatherization program, the State Energy Conservation Program, and the Energy Extension Service. All of these programs, except LIHEAP, are administered by the U.S. Department of Energy (DOE). States may use their allocations over a period of years. DOE, through its Office of Hearings and Appeals, also is requiring the States to spend their overcharge funds in a "balanced" manner.

The other case, the Stripper Well decision, is projected to yield a total of $4 to $5 billion of which $2 to $2½ billion goes to the States. Almost $1 billion has been allocated to the States through fiscal year 1988 and the rest will be distributed over the next 5 to 10 years. These funds may be used for LIHEAP and the other four energy conservation programs as well as a broader range of energy programs. In addition, States are required to spend "an equitable share" on low-income programs.

Since 1981, more than $3.5 billion has been provided to the States in all recouped funds, nearly all of it distributed in 1986. Ac-

cording to a November 1988, report by the National Consumer Law Center, the States have allocated 93.3 percent of $2.83 billion of the total $3.04 billion of Exxon and Stripper Well funds which they have received from 1986 through August 1988. Of the combined funds, 44 percent was allocated for low-income uses. Twenty percent has been designated for LIHEAP, including weatherization, and 20 percent for the Department of Energy weatherization program. Another 3.4 percent has been allocated to other low-income programs such as weatherizing public housing and homeless shelters and transportation for the poor and elderly. Most States have decided to allocate the actual spending of the overcharge funds over a number of years.

Data from the Department of Health and Human Services indicate that appropriation cuts were clearly not supplanted by oil overcharge funds. From fiscal year 1986 through fiscal year 1987, the States used a total of $353.65 million of oil overcharge funds for LIHEAP while the Federal funding for LIHEAP was cut by $475.52 million.

Preliminary telephone survey estimates by DHHS indicate the States used about $160 million of oil overcharge money for LIHEAP in fiscal year 1988. For fiscal year 1987, DHHS estimated the States used $187 million of the available overcharge funds for LIHEAP—$116 million on energy assistance and $71 million on the weatherization program. According to DHHS, the States used $27 million of the funds for LIHEAP in fiscal year 1986.

More recently, a 1986 Federal district court ruling approved a settlement in the so-called "Stripper Well" case. The first and largest distribution was $753 million. Another $49 million in Diamond Shamrock overcharge funds were disbursed by DOE in 1986 and a disbursement of about $90 million of Stripper Well funds went to the States in 1987.

Although the settlement potentially involved a total of $2 to $2½ billion, $500 million was designated to be paid to major fuel users (airlines, railroads, etc.) and the balance of the settlement will be split evenly between the States and the Federal Government.

One of the larger cases, with the Texaco Corp., was settled in August 1988. Under the agreement, Texaco is to pay a total of $1.25 billion over 5½ years. The first payment of about $348 million may be made during the winter of 1989 with at least $90 million going to the States. The next payment, of $190 million plus interest, will occur 18 months later followed by four annual payments of $165 million plus interest.

The availability of money from recouped oil overcharges has become an issue with regard to LIHEAP. To the extent that States have access to this money and use it to fund LIHEAP efforts, it is argued that Federal appropriations can be frozen or reduced. Indeed, the Senate reduced appropriations for both fiscal years 1987 and 1988 in recognition of overcharges. Rather than reduce Federal appropriations, some argue that any Federal share of the recouped overcharges should be earmarked to fund LIHEAP.

Those who disagree with these positions argue that the availability of oil overcharge funds should not affect appropriations for LIHEAP or the low-income weatherization program. They state that oil overcharge funds are neither Federal nor State funds, but

represent lost resources by purchasers across the country as a result of illegal action. Since they are intended to remedy past injuries, they should be applied in a way that addresses those past injuries and should not be used to replace current funds in on-going Federal programs. They also argue that through the Warner amendment, congressional intent, reinforced by the courts, made the oil overcharge money available to the States to be used in addition to (not instead of) existing Federal and State money for five designated Federal programs.

In addition, many States have spent a larger amount of their overcharge funds on weatherization programs, arguing that these are long-term investments that reduce the need for energy assistance. Many State legislatures also have allocated the overcharge funding and could not reconvene in time to appropriate for the 1988 winter after Congress made the final decision for significant cuts in the LIHEAP appropriations in 1987.

According to an April 1988 GAO report, 7 of the 13 States reviewed had little or no oil overcharge funds remaining. The average cuts in LIHEAP allotments was 41 percent for fiscal years 1986 through 1989 for all 13 States. The average oil funds available were 13 percent less than the Federal funding reduction.

As more oil price overcharge funds become available to the States, it is uncertain what effect the availability of this recouped money will continue to have on Federal appropriations over the long term and on State support for LIHEAP beyond Federal allotments of LIHEAP funds.

(B) WEATHERIZATION

In his fiscal year 1986 budget request to Congress, the President recommended a $152.9 million funding level for the DOE weatherization program with a plan to phase out the program over a 5-year period. The President also recommended helping States develop strategies for conducting weatherization activities without Federal assistance during the phase-out period. In response to this recommendation, DOE began to help States with techniques for carrying out weatherization activities without Federal funds and awarded 38 "opportunity grants" ranging from $40,000 to $60,000 each to State and local agencies for demonstrating strategies to weatherize homes without Federal funds.

Congress, however, has not acted on the President's request to phase out the program. The program operated at a level of $161 million in fiscal year 1987 and will have the same allocation for fiscal years 1988 and 1989. In fiscal year 1986, revenues dropped to $178 million from the $182 million appropriation, reflecting reductions under Gramm-Rudman-Hollings.

For fiscal years 1987, 1988, and 1989, the President proposed phasing out Federal assistance for the Department of Energy Weatherization Assistance Program in future years and funding was proposed to come from settlement of petroleum pricing violation cases.

D. PROGNOSIS

There is clear evidence that Federal energy assistance programs have been successful in providing emergency relief and basic energy needs to millions of elderly and poor Americans. These programs have also reduced the energy expenditures for many of the poor through weatherization assistance. The level of the programs' success and their philosophical appropriateness, however, continue to be debated.

Nonetheless, the energy expenses of the elderly and poor will continue to grow during the next decade, creating a wider gap between their needs and the Federal Government's response. According to the Community Action Foundation (CAF), 4 million households had utility service terminated for nonpayment in 1982. To prevent service termination from increasing and to keep the percentage of real income devoted to energy by the poor at a manageable level, billions of dollars in assistance will be needed. CAF estimates that if energy costs grow 2 percent per year, the eligible population would need $7.3 billion in 1989, just to maintain its purchasing power.

The Alliance to Save Energy has demonstrated that cost-effective low-income conservation programs are possible through installation of new heating system technologies. The development and field testing of much of the new heating system technologies was supported through Federal research and development efforts. Funding for these research activities has been decreasing in recent years, even though these investments in research could result in saving elderly households millions of dollars in energy costs. The availability of research funds will play an important role in determining future conservation successes.

In the past few years, many gas and electric utilities have been required by State public utility commissions to undertake low-income and elderly conservation programs. These programs could have a positive effect on the energy needs of the elderly. This approach encourages greater State and local control and funding of such conservation activities.

It is obvious to those who know the Administration's philosophy regarding domestic spending and the current mood in Congress, that appropriations at levels to meet eligibility and research needs will not be forthcoming. In fact, it is probable that both LIHEAP and the DOE Weatherization Assistance Program will be targeted again in fiscal year 1990 by the Administration and/or Congress for cuts or elimination. Continued congressional support and expanded private efforts will be needed to prevent the continuation of further appropriation cuts.

It is unclear what the impact of changing oil prices will have on consumers of home heating fuels, but overall home fuel costs are continuing to rise. Congressional perceptions that oil overcharge funds will continue to be available to the States for use in LIHEAP and weatherization programs undoubtedly will remain the largest deterrent to more fully funding the program. The amount that States will receive from future oil overcharge cases is uncertain. But it is apparent that they will not receive another large distribution like the Exxon and Stripper Well disbursements in 1986 and

future, smaller distributions will be made in a series over a number of years. Another variable in addition to the Congress, home heating costs and oil overcharge allocations, is the weather. These questions aside, what is clear is that millions of eligible families will continue to be underserved.

Chapter 11

OLDER AMERICANS ACT

OVERVIEW

For the past 24 years, the Older Americans Act (OAA) (the Act) has served as the cornerstone of Federal involvement in a wide array of community services to older persons. Created during a time of rising societal concern for the needs of the poor, the Act marked the beginning of a categorical approach to programs specifically designed to meet the social and human needs of the elderly. The Act itself was one of 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 health and income-transfer programs. Although older persons could receive services under a number of other Federal programs, the Act became the first major vehicle for the organization and delivery of community-based social services to older persons.

The Older Americans Act followed on the heels of a similar but somewhat more expansive grouping of social service programs initiated under the Economic Opportunity Act of 1964. With a concept framework similar to that embodied in the Economic Opportunity Act, the Older Americans Act was established on the premise that decentralization of decisions would create a responsive service system at the community level.

When enacted in 1965, the Act established a series of broad policy objectives designed to meet the needs of older persons. These objectives, lacked both legislative authority and adequate funding. However, the 1965 Act established a structure through which the Congress would later expand aging services.

Over the years, the essential mission of the Older Americans Act has remained very much the same: To provide a wide array of social and community services to those older persons in the greatest economic and social need in order to foster maximum independence. 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. Some of the services supported under the Act include congregate and home-delivered meals, senior centers, and nursing home ombudsman activities, and community service employment programs.

Funding for the OAA grew slowly during the 1960's but during the 1970's Congress followed up on improvements in income-transfer programs with significant modifications to the Act by broadening the scope of operations and establishing the basis for a "net-

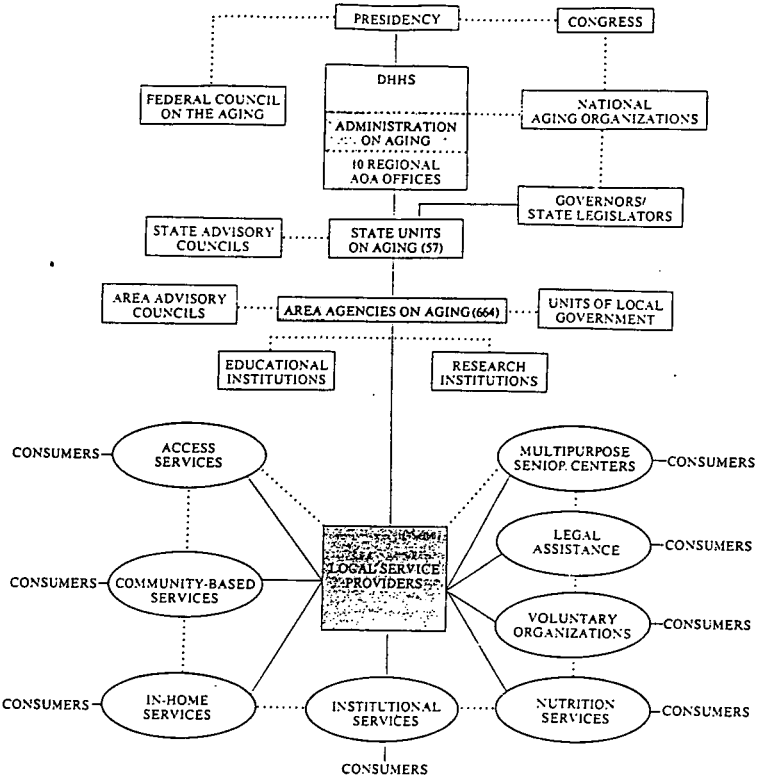
work" on aging under the Title III program umbrella. In 1972, a national nutrition program for older Americans was created. Area agencies on aging (AAA's), authorized by legislation enacted in 1973 along with the State units on aging, constitute the administrative structure for programs under the Act. In addition to funding specific services, they have broad responsibilities to act as advocates on behalf of older persons and to plan for the effective development of a service system that will best meet these needs. As originally conceived by the Congress, this system was meant to encompass both services funded under the Act, and services supported by other Federal, State, and local programs. The purpose of the community service employment program is to subsidize part-time community service jobs for unemployed persons aged 55 and over who have low incomes. The program, administered by the Department of Labor, awards funds to national organizations and to State agencies to operate the program.

Fiscal years 1978 and 1981 saw further improvements in the level of financial support directed toward Older Americans Act programs, continuing development of the structures for providing community-based services (AAA's) and the added emphasis on the provisions of certain priority services, such as access (transportation, outreach, and information and referral), in-home and legal services.

This expansion trend 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 were cut by approximately 50 percent. However, widespread congressional support for other OAA programs, especially nutrition and senior employment, served to protect them. This broad congressional support for OAA programs continued during the 1987 reauthorization of the Act and can be expected to continue in the future.

Chart 1

OLDER AMERICANS ACT NETWORK



SOURCE: National Association of State Units on Aging

A. THE OLDER AMERICANS ACT AMENDMENTS OF 1987 [1]

The following is a brief description of each title of Older Americans Act of 1965 and the key provisions added by the Older Americans Act Amendments of 1987:

1. TITLE I—DECLARATION OF OBJECTIVES

Title I outlines broad social policy objectives aimed at improving the lives of all older Americans in a variety of areas such as income, health, housing, and long-term care. The amendments added an additional objective, the protection of the elderly from abuse, neglect, and exploitation.

2. TITLE II—ADMINISTRATION ON AGING

Title II establishes the Administration on Aging (AoA) to administer most Older Americans Act programs and to act as the chief Federal agency advocate for older persons. It also establishes the Federal Council on Aging to advise the President and Congress regarding the needs of older persons.

The issue of the organizational status of the AoA has been a recurring one during previous OAA reauthorizations due to concern that AoA, because it is located within the Office of Human Development Services, does not have the visibility to effectively advocate on behalf of the elderly on a broad range of issues. The 1987 amendments addressed this concern by elevating the status of the Commissioner within the Department of Health and Human Services. The Commissioner now will report directly to the Secretary, as compared to the prior law provision which required the Commissioner to report to the "Office of the Secretary."

The Commissioner also is to establish within AoA a new Office for American Indian, Alaskan Native, and Native Hawaiian Programs to be headed by an Associate Commissioner. In addition, the amendments added a number a new provisions requiring increased data collection by AoA.

With respect to the Federal Council on Aging, the law now requires that 9 of the 15 members be older persons as compared to prior law which required that 6 of 15 members be older. The Council also is to have representation from Indian tribes.

3. TITLE III—GRANTS FOR STATE AND COMMUNITY PROGRAMS ON AGING

Title III establishes authority for the network of State and area agencies on aging and requires the development of a comprehensive and coordinated services system for older persons.

Under prior law, Title III contained three parts authorizing funds to State agencies on aging for supportive services (part B), congregate nutrition services (part C-1), and home-delivered nutrition services (part C-2). Although the 1987 OAA amendments made certain changes relating to the administration of these services by

[1] For a more detailed description of the 1987 Older Americans Act Amendments, see U.S. Senate Special Committee on Aging Committee Print 100-C and U.S. House Select Committee on Aging Committee Print 100-683.

State and area agencies on aging, the major amendments included a number of new authorizations of funds for a number of programs. These programs areas are:

Nonmedical in-home Services for the frail elderly under a new part D,

Services to meet the special needs of the elderly under a new part E,

Health education and promotion activities under a new Part F,

Elder abuse prevention activities under a new part G,

Long-term care ombudsman services, and

Outreach services to older persons potentially eligible for Supplemental Security Income, Medicaid, and Food Stamp Programs.

While State and area agencies have had responsibilities in these areas under prior law, separate authorizations of Title III funds were not specified. Except for in-home services for the frail elderly, the amendments include a funding trigger that prohibits appropriations of funds for the new authorizations unless total appropriations for programs in effect in fiscal year 1987 increase by at least 5 percent. These funding restrictions are in effect through fiscal year 1990.

Under prior law, each area agency on aging was to provide assurances that it would spend an "adequate proportion" of its allotted funds for supportive services on 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. The 1987 amendments changed this requirement to stipulate that each State agency is to set a minimum percentage of funds to be used for these three service categories by each area agency.

Several amendments 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 new Title III provisions require State and area agencies on aging to focus on the needs of older Indian, including requirements that the distribution of this group be considered when planning services with the State and the planning and service area. The law also added a new provision requiring area agencies to conduct outreach activities to identify older Indians and inform them of services under the Act if their population is significant within the planning and service area. Finally, other provisions were added to clarify the eligibility of Indians to receive services under both Title III and the Title IV grant programs.

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.

The 1987 amendments added several new demonstration authorities, including areas related to health education and promotion, volunteerism, coordination of the long-term care ombudsman program with protection and advocacy systems for the disabled, and consumer protection activities in long-term care. For the latter two, the amendments authorized separate funding amounts distinct from the overall Title IV funding. The funding of long-term care gerontology centers was made mandatory. These centers previously were supported at the discretion of the Commissioner.

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 eight national organizations and to State agencies. Enrollees are paid at the Federal or State minimum wage or the local prevailing rate of pay for similar employment.

The 1987 amendments set the allowable administrative cap for the program at 13.5 percent, but retained a prior provision allowing the Secretary of Labor to raise the cap to 15 percent. Also, a new provision was added to exclude Title V wages received by enrollees from consideration when determining eligibility for Federal housing and Food Stamp Programs. In addition, a provision authored by Senator Melcher, Chairman of the Senate Special Committee on Aging, requires the Secretary of Labor and Title V grantees to distribute to program participants information to help them identify age discrimination and to understand their rights under the Age Discrimination in Employment Act. Finally, some Title V funds are to be reserved for national Indian aging organizations and national Pacific Island and Asian American aging organizations in the first fiscal year in which Title V appropriations exceed the fiscal year 1987 level. Appropriations for fiscal year 1989 exceeded the 1987 level. The Department of Labor will make funds available to the additional national organizations on July 1, 1989.

6. Title VI—Grants for Native Americans

Prior to the enactment of the Older Americans Act Amendments of 1987, Title VI of the Act authorized funds for grants to Indian tribes for supportive and nutrition services that are comparable to those provided under Title III. The amendments expanded the title to include a new part B authorizing funds for Native Hawaiians.

The 1987 amendments included two changes to prior law provisions on eligibility of Indians for Title VI services. The first provision amended the law to make a tribal organization eligible for Title VI funds if it has at least 50 older Indians, as compared with the prior provision which specified that tribal organizations must

have at least 60 older Indians to receive funds. Second, the amendments eliminated prior law provisions prohibiting individuals or tribal organizations receiving services or funds under Title VI from also benefiting from the Title III program. As amended, the law now allows older Indians to receive assistance under both the Title VI and Title III programs.

The amendments added a new part B, the Native Hawaiian Program, and specified separate authorizations of appropriations for it within the overall authorization amount for Title VI.

7. Other Provisions

(A) REPEAL OF TITLE VII

Title VII, Older Americans Personal Health Education and Training Program, added to the Act in 1984, has never received an appropriation and was repealed by the 1987 amendments. However, an amendment was added to Title IV to preserve its intent. That provision authorizes the Commissioner to commit funds to institutions of higher education to develop prototype health education and promotion programs to be used by the network on aging.

(B) 1991 WHITE HOUSE CONFERENCE ON AGING

The 1987 amendments authorize the President to call a White House Conference on Aging in 1991 to increase public awareness of the contributions of older individuals to society, to identify problems as well as the well-being of older individuals, to develop recommendations for the coordination of Federal policy with State and local needs, to develop specific and comprehensive recommendations for both executive and legislative action to maintain and improve the well-being of older individuals and to review the status of recommendations adopted at previous White House Conferences on Aging.

The conference will bring together representatives of Federal, State, and local governments, persons working in the field of aging, and the general public, particularly older persons. The new provisions also set forth requirements regarding delegate selection, committee composition, conference agenda, and reporting requirements.

(C) CONSUMER PRICE INDEX FOR OLDER AMERICANS

Another provision, authored by Senator Melcher, requires the Secretary of Labor to develop an index of consumer prices to reflect the consumption expenditures for persons 62 years of age or older. This index and a report on the research necessary to develop and accurately measure the rate of inflation for older persons was provided to Congress in June 1988.

(D) AMENDMENT TO THE NATIONAL SCHOOL LUNCH ACT

Another provision introduced by Senator Melcher amends the National School Lunch Act to permit adult day care centers to receive reimbursement under the Child Care Food Program for meals or meal supplements (snacks) to persons 60 years or older or to chronically impaired disabled persons.

B. ISSUES

1. Cost-Sharing

During reauthorization hearings, the administration's proposal included a provision which would authorize States, at their option, to permit area agencies on aging to charge fees, based on ability to pay, for supportive services under part B of Title III. It was to be left to the State's discretion to determine which supportive services would be subject to charges.

Organizations representing States and area agencies on aging submitted their own proposal for amendments to allow State agencies on aging to establish procedures for either voluntary or mandatory cost-sharing for selected services under Title III and allow area agencies on aging to solicit voluntary contributions. The State and local levels of the aging network are increasingly pressed to find alternative sources of funding to supplement the limited availability of Federal funding and continue to provide needed services. In addition, the State and area agencies in advocating the cost-sharing proposal, believed that a sliding fee scale would allow coordination of OAA program services with other services that are means-tested in some way. It was argued that cost-sharing would permit an increased level of services without increasing Federal funding, and could be structured to increase services to those most in need, thus increasing low-income and minority participation in Title III programs. Some services, such as referral, outreach, advocacy, and ombudsman services, were to be exempt as well as those persons who had incomes of less than 125 percent of the poverty level.

This latter proposal, which drew sharp opposition, later was amended to request that a limited number of States be given authority to conduct studies on cost-sharing in the programs under the Older Americans Act. Cost-sharing or fee-for-service, however, is viewed by many in Congress as either a preliminary step to or a pseudonym for means-testing. There was concern that cost-sharing would produce an unintended opposite effect causing participation of the neediest individuals to decline due to either a misunderstanding of the cost-sharing requirements or an unwillingness to disclose financial information.

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 and did so again during the 1987 reauthorization. However, the Senate Committee on Labor and Human Resources requested the General Accounting Office to study current State cost-sharing systems and report its findings to the committee by September 30, 1990. The study should identify the similarities and differences between Older Americans Act programs and State-funded programs with regard to the scope of services covered, funding levels, and the social and economic charcteristics of the participants. The study is also to examine the effects of cost-sharing systems on: access to services by older individuals; increases or decreases in the number of older individuals served, particularly low-income and minority

individuals; the nature of the fee scales used and the differential effects of such arrangements; and the characteristics of participants who pay fees and those who do not.

2. Targeting

Another major issue during the 1987 reauthorization process was how to improve targeting and outreach to certain subgroups of older persons, particularly low-income minority persons. Although the Act has required that State and area agencies on aging are to give preference to the elderly with the greatest economic or social need, with particular attention to low-income minority individuals, many advocates stressed it should be specified in all relevant sections of the law to ensure that the preference actually was achieved.

The reauthorization hearings documented that participation by minorities in Title III programs has declined by a disturbing 27 percent since 1981. 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 the minorities were absent or excluded from the service delivery planning process on local advisory councils.

In response to these concerns, the 1987 Older Americans Act reauthorization incorporated a number of provisions designed to strengthen prior law requirements with respect to planning and service delivery for elderly minority persons. These provisions include requirements that State and area plans on aging identify the number of low-income and minority older persons in the State or planning and service area, and describe methods used to meet their needs in the previous year. Another new provision to address this issue requires service providers to specify how they will meet the needs of low-income minority older persons and to attempt to provide services to such individuals in at least the same proportion as they represent the total older population in the area.

President Reagan, in signing the 1987 amendments into law, expressed his opposition to these changes by questioning the constitutionality of the targeting provisions.

As a result of the 1987 amendments, the question of how to target services to those in greatest economic and social need, with particular attention to low-income minority individuals, without use of a means-test to determine eligibility was a frequent topic of discussion within the aging network during 1988. The Federal Council on Aging devoted one of its quarterly meetings to the issue.

3. Organizational Status of the Administration on Aging

One of the perennial issues under the Older Americans Act has been the organizational status of the Administration on Aging (AoA). Even before the creation of AoA as part of the Older Americans Act in 1965, the appropriate placement of an agency to oversee aging issues within the Federal framework was debated. The

original sponsors of the legislation conceived of placing such an agency at the White House level so it would not be subordinate to any one agency or department; rather, it would be an independent agency able to carry out broad interdepartmental functions. This placement, however, was strongly opposed by officials of the executive branch. Therefore, the sponsors turned to a compromise position to expedite passage of the Act. Under the 1965 legislation, AoA was placed within the then Department of Health, Education, and Welfare (DHEW) and did not have independent status. However, over the years, many policymakers have questioned whether AoA could carry out its interdepartmental functions and serve as a Federal coordinator and advocate for the elderly as well as influence Federal programs and policies from its positions within a Federal department.

The 1973 amendments placed AoA within the Office of the Secretary of DHEW, made the Commissioner of AoA directly responsible to that Office and prohibited any delegation of the Commissioner's functions to any other officer not directly responsible to the Commissioner. When the Office of Human Development Services (OHDS) was subsequently created as part of the Office of the Secretary, AoA was placed as a separate unit within that office as part of an executive branch reorganization. During consideration of the 1978 amendments, discussing concerning the appropriate placement of AoA ranged from making it an independent office at the White House level to retaining the agency in the current position. The amendments, however, did not change prior law, thereby retaining the agency within OHDS.

Discussion about the proper placement of AoA and the Commissioner on Aging again occurred during the 1981 reauthorization process. However, despite airing of the issue, Congress did not change AoA's status. Again in 1984, discussion developed around AoA's organizational placement. Although the House-passed reauthorization bill provided for an Office on Aging to be headed by a Commissioner on Aging reporting directly to the Secretary of Health and Human Services, the Conference agreement retained the pre-existing placement of AoA, but amended the law to emphasize a direct reporting relationship between the Commissioner and the Office of the Secretary of DHHS.

In 1987, Congress further clarified the issue of AoA's organizational status and reporting relationship with the Secretary by elevating the AoA to the same level of authority as assistant secretaries and other commissioners within the Department. Congress amended the law to require that the Commissioner report directly to the Secretary rather than to the Office of the Secretary.

However, as there were various interpretations within DHHS of the extent of Congressional intent in regard to the status of AoA, the Secretary directed the Assistant Secretary for Management and Budget "to examine and make recommendations on organizational and support matters concerning the Administration on Aging raised by the amendments . . . including use of AoA funds in consolidated research and evaluation activities." Until the study was completed, AoA was to continue to receive logistic and other support through existing arrangements. The study ordered by the

Secretary was delayed throughout 1988 and AoA remained organizationally within OHDS.

C. FEDERAL RESPONSE

1. Older Americans Act Authorization and Appropriations

The 1987 amendments to the Older Americans Act (P.L. 100–175) provided for the following authorization levels from fiscal year 1988 through fiscal year 1991:

TABLE 1.—OLDER AMERICANS ACT AUTHORIZATION LEVELS, FISCAL YEARS 1988–91

[In thousands of dollars]

Act title	(As contained in Public Law 100–175)			
	1988	1989	1990	1991
TITLE II				
Federal Council on the Aging	$210	$221	$232	$243
TITLE III				
Grants for State and community programs on aging:				
Supportive services and centers	379,575	398,554	418,481	439,406
Nutrition services	645,130	684,837	727,778	773,017
Congregate	(414,750)	(435,488)	(457,262)	(480,125)
Home delivered	(79,380)	(83,349)	(87,516)	(91,892)
USDA commodities	[1] (151,000)	[1] (166,000)	[1] (183,000)	[1] (201,000)
In-home services for frail elderly	25,000	26,250	27,563	28,941
Assistance for special needs	[3] 25,000	[3] 25,000	([3] [4])	([3] [4])
Health education and promotion	[3] 5,000	([3] [4])	([3] [4])	([3] [4])
Elder abuse prevention	[3] 5,000	([3] [4])	([3] [4])	([3] [4])
Long-term care ombudsman	[3] 20,000	([3] [4])	([3] [4])	([3] [4])
Outreach for SSI, Medicaid, and food stamps	([2])	[3] 10,000	[3] 10,000	([4])
TITLE IV				
Training, research, and discretionary projects and programs	32,970	34,619	36,349	38,167
Home care demonstration projects	([2])	[3] 2,000	[3] 2,000	([2])
Ombudsman and advocacy demonstration projects	([2])	[3] 1,000	.....	([2])
TITLE V				
Community service employment for older Americans	386,715	406,051	426,353	447,671
TITLE VI				
Grants for Native Americans	[5] 13,400	[5] 16,265	[5] 19,133	[5] 22,105
Part A—Indian program	(12,100)	(14,900)	(17,700)	(20,600)
Part B—Native Hawaiian program	(1,300)	(1,365)	(1,433)	(1,505)
TITLE VII				
Older Americans personal health education and training program	([6])	([6])	([6])	([6])
Total	[7] 1,538,000	[7] 1,604,797	[7] 1,667,889	[7] 1,749,550

[1] Public Law 100–175 requires the Secretary of Agriculture to maintain a reimbursement level of 56.76 cents per meal for fiscal year 1986–91.
[2] Not authorized.
[3] The law requires that total appropriations for programs funded in fiscal year 1987 increase by at least 5 percent over the previous year before appropriations for these new authorizations are made.
[4] Such sums as may be necessary.
[5] The law creates a separate Part B for funds for a Native Hawaiian program. As shown in the table, the law authorizes specific amounts for Part A, the Indian Program, and for Part B. The law further specifies that Part B receive funding only if the total appropriations for title VI exceed the fiscal year 1987 funding level ($7.5 million). Part B will receive the first $250,000 of any appropriations exceeding the fiscal year 1987 level, and half of any increase above the first $250,000 up to the authorized amount.
[6] This title is repealed.
[7] Plus such sums as may be necessary for certain programs.

Source: Congressional Research Service.

Although the President's budget request for fiscal year 1989 represented a slight increase over the total fiscal year 1988 appropria-

tions level, it did not fully reflect the impact of the projected rate of inflation on providing services and, for most individual programs, did not reflect any inflation adjustment. For most of the Older Americans Act programs the administration requested the same amount in fiscal year 1989 as appropriated in fiscal year 1988. An increase of $4.7 million was requested for Title V, the Community Service Employment Program. Congress, in the fiscal year 1989 appropriations measure (P.L. 100-436), funded the Older Americans Act programs at a level of $1.2 billion for fiscal year 1989, an increase of $36.6 million over fiscal year 1988 funding. The following table provides a specific breakout by major title areas:

TABLE 2.—*Older Americans Act Appropriations, Fiscal Year 1989*

[In thousands of dollars]

Title II: Federal Council on Aging	$188
Title III:	
Supportive services and senior centers	275,652
Ombudsman activities	[1] 988
Nutrition services:	
Congregate	356,668
Home-delivered	78,546
USDA commodities	141,293
In-home services for frail elderly	4,834
Subtotal, Title III	857,981
Title IV: Training, research, and discretionary projects and programs	24,173
Title V: Community Service Employment	343,824
Title VI: Grants for Native Americans	7,410
Total	1,233,576

[1] Congress appropriated this amount for the ombudsman program despite authorizing legislation requiring an appropriations trigger.

In the fiscal year 1989 appropriations bills, Congress gave the Administration on Aging further direction on Congressional intent particularly in regard to research, training, and special projects. The Senate Appropriations Committee directed the Commissioner to increase funding for career preparation training in the field of aging, particularly for minorities. AoA is also to fund at least five university-based, long-term care gerontology centers to conduct research, training, and demonstrations on long-term care services and to provide technical assistance to State and area agencies on aging.

The House Appropriations Committee expressed concern with the participation rates of minority persons, and the poor elderly in Title III supportive service and nutrition programs and requested AoA to provide a report prior to the fiscal year 1990 budget hearings on the actions being taken to ensure that special populations are being adequately served by OAA programs. The Committee also restated statutory intent permitting the continued inclusion of area agencies on aging within an umbrella agency such as a regional development commission.

Congress held three hearings on the Older Americans Act in 1988. Shortly after the Administration on Aging published proposed regulations in March, the Subcommittee on Human Services of the House Select Committee on Aging held a hearing on the subject. Other hearings looked at improving minority participation in

OAA programs and the future of the Title V, Community Service Employment Program for Older Americans.

2. Regulations

The Administration of Aging published proposed rules for Titles III and VI on March 29, 1988. Several of the proposed rules generated reactions from aging organizations, including those representing State and area agencies on aging. Some concerns raised included language describing area agencies on aging as "agents" of the State units on aging; deletion of a provision allowing States to approve the use of Title III B service funds by area agencies for program development and coordination; and mission statements for State and area agencies. The final regulations, published on August 31, addressed the major concerns raised during the comment and review period.

AoA published notice of discretionary funds availability under Title IV on December 13, 1988. Regulations for Title V, the Senior Community Service Employment Program, were last issued in final form by the Department of Labor (DOL) in 1976. Proposed revised rules were published in 1985. Although changes to SCSEP rules were required by the 1984 and 1987 OAA amendments, DOL has not issued final revised regulations due to the refusal of the Department of Justice (DOJ) to approve the "proportionality" requirement. Under the provisions of the OAA, SCSEP sponsors must assume that their projects serve minorities in proportion to their numbers in the State. As a result of DOJ's inaction, SCSEP sponsors have operated under the 1985 proposed rules only.

D. PROGNOSIS

Fiscal year 1989 will mark the 24th anniversary 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, commuity services, and gerontological research and education. Since its inception, the gradual evolution of the programs and services authorized by the Act has been remarkable. Although progress has been realized, it has not been without some growing pains.

As originally conceived, the Congressional intention underlying the Older Americans Act 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 assist 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 concurrently. 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 Act has been the vehicle for the education and training of thousands in the field of aging.

Despite the increase in authorizations for existing programs and adequate authorizations for new programs with the 1987 reauthorization, the programs operated under the Older Americans Act will 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 the available resources to specific categories of older persons, those most in need, is a natural consequence of limited funding. It is also inevitable the 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 was implemented, it is unlikely to generate sufficient funds to finance services necessary to successfully address the many unmet needs of numerous older Americans.

Although the Act prohibits the direct provision 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 assuming increasing responsibilities for case management and preadmission assessment have propelled State and area agencies into new functional areas and it is likely that this trend will continue in the future.

Without question, future demographic pressures will place increasing burdens on the delivery systems under the Older Americans Act. The challenge for State and area agencies on aging will be not only to maintain necessary services, but also to assume the quality and accessibility to these services. As has been the case in the past, with continued broad support from the Congress, the OAA can be expected to adapt to and be strengthened from these challenges in the years to come.

Chapter 12

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.

During the Reagan Administration, two basic themes have emerged with respect to the delivery of social services for the elderly. First, the Administration has sought to give States greater discretion in the administration of social services as part of its "New Federalism" initiatives. Second, the shift toward block grant funding has been accompanied by a general trend toward fiscal restraint and retrenchment. As a result, the competition for scarce resources has been accelerated between the elderly and other needy groups. In addition to cuts accompanying the block grants, the Administration proposed to reduce spending for education, transportation, and legal services. Fiscal restraint in these programs has affected service delivery in varying degrees, with the most significant cuts coming in legal services, which the Administration has sought to eliminate entirely. Older American Volunteer Programs, by contrast, have enjoyed strong support from the Administration.

For the most part, Congress has resisted the Administration's efforts to reduce funding for social, community, and legal services. Following the cuts sustained in the fiscal year 1981 budget, Congress increased spending for the Social Services Block Grant, Community Services Block Grant, and legal services. In fiscal year 1985, Congress significantly increased authorized spending levels for adult education and other education programs benefiting the elderly. The focus on Federal spending, however, is now clearly framed by the widespread concern over budget deficits. Advocates of human service programs are hopeful that the Democratic majority in the Senate will be able to direct more resources toward social services programs. The likelihood of this is unclear considering the limitations created by the Gramm-Rudman-Hollings legislation and an apparently strong desire to avoid initiating tax increases. The resolution of this debate may very well determine the Federal role in providing social services to the elderly in the years ahead.

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. The law required that at least half of each State's Federal allotment be used for services to recipients of Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or Medicaid. The remaining funds could be used to provide services to anyone whose income did not exceed 115 percent of the State's median income. Fees were mandatory for individuals with incomes between 80 percent and 115 percent of the State median income. All services provided by a State had to be tied to at least one of five legislative goals that related to self-sufficiency and self-support. At least one service for each of the five goals had to be provided. Further, Title XX required States to offer at least three services for aged, blind, or disabled people receiving SSI payments.

In 1981, Congress created the Social Services Block Grant (SSBG) as part of the Omnibus Budget Reconciliation Act. By eliminating most of the restrictions in Title XX, Congress granted the Reagan Administration added flexibility to transfer maximum decision-making authority to the States and reduce domestic Federal spending. 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. Although the agency's budget peaked in fiscal years 1969 and 1970 with an annual funding of $1.9 billion, the funding then steadily declined until fiscal year 1981, when appropriations were $526.4 million.

Under a mandate to assure greater self-sufficiency for the elderly poor, the CSA was instrumental in developing programs that assured access for older persons to existing health, welfare, employment, housing, legal, consumer, education, and other services. Programs designed to meet the needs of the elderly poor in local communities were carried out through a well-defined advocacy strategy which attempted to better integrate services at both the State level and the point of delivery.

In 1981, the Reagan Administration proposed elimination of the CSA and the consolidation of its activities with 11 other social services programs into a social services block grant as part of an overall effort to eliminate categorical programs and reduce Federal overhead. The Administration proposed to fund this new block grant in fiscal year 1982 at about 75 percent of the 12 programs' combined spending levels in fiscal year 1981. Although the General Accounting Office and a Congressional oversight committee had criticized the agency as being inefficient and poorly administered, many in Congress opposed the complete dismantling of this antipoverty program. Consequently, the Congress in the Omnibus 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 en-

courage 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.

Funding for the new block grant in fiscal year 1982 amounted to a 30 percent reduction from the CSA's fiscal year 1981 appropriation. The CSBG received $348 million in fiscal year 1982, plus an additional $18 million for activities related to the phaseout of the CSA.

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 block 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 passthrough 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.

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 General Accounting Office (GAO) report refutes this claim.

In May 1986, GAO issued a report on the operation of Community Action Agencies (CAA's) funded by the CSBG. Specifically, the GAO addressed the Reagan 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, CAA's 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 CAA's in 32 States. The remaining 11 percent of the 1984 budgets of reporting CAA's 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.

The administration continued to attempt termination of the CSBG in fiscal years 1985–87, requesting funding only to cover administrative expenses of closing down the program. For fiscal years 1988 and 1989, the Administration requested $310 million and $282 million respectively for a 4-year phase-out of the CSBG program. Congress, however, has resisted the Administration's proposals and has continued to support funding for the operation of the CSBG program.

(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 board 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 un-

certainty 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 difficult 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 standard format and are of limited value in determining the impact of program and funding changes on specific populations.

The American Association of Retired Persons conducted a telephone survey in 1987 to determine the amount of SSBG funds being used for services to the elderly. The survey showed that 47 States use some portion of their SSBG funds to provide services to older persons. Forty-four of the States submitted estimates on the amount provided, running from less than 1 percent up to 50 percent, with an average of 18 percent. 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, adult day care, transportation, and nutrition services. At the same time the areas of unmet need were home-based, adult protective, transportation, and respite services. The majority of States characterized their services as preventive, that is, attempts to maintain the independence of older people in the community. The survey also found that while the level of SSBG funding of services to older persons appears to have held steady or declined only slightly, there nevertheless has been a large decline in the numbers of older persons assisted. This is partially due to focusing on very-low-income persons. This finding is supported by a 1986 Urban Institute report that found that the lowering of income eligibility levels may have reduced the availability of in-home services to older persons.

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 flexi-

bility in deciding the type of information they would collect under the grant. As a result of the minimal reporting requirements under the CSGB, there is very little information available at the Federal level regarding State use of CSBG funds.

A 1987 study by the Center for Community Futures, in conjunction with the National Association for State Community Services Program (NASCSP), on State use of fiscal year 1986 CSBG funds provides some intersting clues. Although the survey was voluntary, all but six jurisdictions eligible for CSBG allotments answered all or part of the survey. Thus, NASCSP recieved 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 38 States show expenditures for employment services, which includes job training and referral services for the elderly, accounted for 11 percent of total CSSB expenditures in those States and served over one-half million persons. Housing programs, in fiscal year 1986, including home ownership counseling, shelters for the homeless, and construction of low-cost housing, 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, although 18 States reported they collect such statistics. 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 1981 Budget Reconciliation Act fixed authorization levels 20 percent below those in fiscal year 1981, with slight increases for inflation. Authorization levels were set at $2.4 billion in fiscal year 1982, $2.45 billion in fiscal year 1983, $2.5 billion in fiscal year 1984, $2.6 billion in fiscal year 1985, and $2.7 billion in fiscal year 1986 and beyond. The program is permanently authorized. States are entitled to receive a share of the total according to their population size.

For fiscal year 1986, President Reagan requested that the full entitlement level of $2.7 billion be appropriated for the SSBG, and Congress appropriated that amount. However, under the Gramm-Rudman-Hollings deficit-reduction procedures, $116 million was lost through automatic sequestration. Although the Supreme Court invalidated the process, Congress upheld the budget cuts in March 1986 with Public Law 99-366.

The President again requested $2.7 billion for the SSBG for fiscal years 1987-89, the full amount authorized by law. Congress incorporated the $2.7 billion into a governmentwide continuing appropriations resolution for fiscal year 1987 and authorized a one-time

$50 million increase for fiscal year 1988 for a total of $2.75 billion (P.L. 100–202). Congress appropriated the full authorized amount of $2.7 billion again for fiscal year 1989 (P.L. 100–436).

(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) has since extended the CSBG Act through fiscal year 1990 at the following levels: $390 million for fiscal year 1987, $409.5 million for fiscal year 1988, $430 million for fiscal year 1989, and $451.5 million for 1990. 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 $3 million annually through fiscal year 1990 for the Community Food and Nutrition Program, and authorizes an additional $5 million annually, through fiscal year 1989, for a demonstration program of innovative antipoverty approaches. The Stewart B. McKinney Homeless Assistance Act authorized appropriations for grants to States for services to the homeless.

The administration has submitted similar budget requests for the CSBG for several years. It hoped to close down the CSBG during each of the fiscal years 1984 through 1987. Only $3.6 million was requested for fiscal year 1987 to cover Federal administrative expenses related to the phasing out of the program. However, Congress rejected the Administration's proposal and appropriated $405.1 million for the CSBG in fiscal year 1987 including $2.5 million for the Community Food and Nutrition Program.

One of the Administration's primary contentions was that the CSBG program duplicates other Federal activities and is nonessential. This, however, runs contrary to the 1986 GAO report mentioned earlier. CSBG funds often are used to fill specific unmet needs or to pay for services not eligible for funding under the SSBG.

In an apparent change of strategy, the Administration requested $310 million for the CSBG program for fiscal year 1988 and $282 million for fiscal year 1989 to begin a 4-year phase-out of the CSBG program. No appropriations were requested by the Administration for the Community Food and Nutrition Program for fiscal year 1989. The Administration made no request for extension of the authorization of homeless services.

Congress appropriated $382.2 million in fiscal year 1988 for the CSBG program including $2.4 million for the Community Food and Nutrition Program and $19.1 for homeless services. The appropriations for fiscal year 1989 are $377.6 million for CSBG including $2.4 million for Community Food and Nutrition and $18.9 million for homeless services (P.L. 100–436). The homeless services were reauthorized in the McKinney Act Amendments of 1988 (P.L. 100–628).

B. HOMELESS SERVICES

1. Background

Over the past few years, the plight of the Nation's homeless and hungry has attracted a great deal of concern and publicity. Although reliable statistics are hard to find, it is clear that a large number of Americans are homeless. The Department of Housing and Urban Development (HUD) unleashed a storm of controversy with a 1984 report that concluded that there were only 250,000 to 350,000 homeless persons nationwide. Other groups that work with the homeless insist that the total is about 10 times that amount. In a report which examined estimates of the numbers of homeless persons published between 1975 and 1987, the General Accounting Office concluded that because of flawed data gathering methods, none of the estimates are sound. A more recent calculation was issued by the Urban Institute in 1988. Using a sample which represented only those homeless persons who used meal and shelter services in 20 cities with populations over 100,000, the Urban Institute estimated the number of homeless to total between 567,000 and 600,000.

The National Alliance to End Homelessness calculates that on any given night, there are 735,000 homeless people in the United States, and that 1.3 million to 2.0 million people will be homeless for 1 night or more during 1988.

While no one knows precisely how many Americans are going hungry or are malnourished, institutions involved in providing emergency food assistance have seen dramatic increases in the numbers of people seeking assistance during the past few years. According to a report released in 1988 by the U.S. Conference of Mayors of a survey of city officials in 27 major cities, requests for emergency shelter in 1988 rose by an average of 13 percent from 1987. Requests for food rose by an average of 19 percent.

Homelessness stems from a variety of factors, including unemployment, social service and disability cutbacks, lack of aftercare services for the deinstitutionalized mentally ill, personal crises, substance abuse, and housing shortfalls in urban areas. The chronically mentally ill comprise one of the largest portions of the homeless, between one-fourth and one-third of the total. According to the Administration's Interagency Task Force on Food and Shelter for the Homeless, the number of patients in mental hospitals dropped from 560,000 in the mid-1950's to 100,000–150,000 in the early 1980's. In some cities, veterans of Vietnam or earlier conflicts are thought to make up one-third to one-half of the homeless. The fastest growing segment among the homeless, however, is unemployed individuals and their families.

The 1988 U.S. Conference of Mayors report states that families demanding shelter increased by 18 percent in the past year and represented one-third of the homeless in the cities surveyed. Recent studies also have documented a new dimension—the suburban homeless. In some relatively affluent suburban communities with rising housing costs, families who earn the minimum wage, or barely above it, cannot afford apartments or houses, and instead,

are living on the streets, in publicly funded shelters, or in their automobiles.

The Aging Health Policy Center at the University of California, San Francisco, using data gathered from shelters in eight cities, estimated in 1985 that between 14.5 percent and 28 percent of the homeless are 50 and older and that as many as 27 percent are 60 and older. A 1987 report by the National Coalition for the Homeless estimates that 15–20 percent of the homeless are over age 60. For those elderly who are homeless, a great deal of the problem results from the lack of health care and affordable housing due to skyrocketing rents, elimination of single-room-occupancy hotels, and a shrinking supply of low-income housing. The Reagan Administration has, for example, stopped new construction of low-income housing while cutting annual Federal subsidies. In the meantime, the number of people on waiting lists for low-income public housing has grown.

For the mentally disabled, the policy of deinstitutionalization has led to the emptying of State hospitals. The Community Mental Health Centers, which provide intermediate community services, are often underfunded, uncoordinated, and do not adequately address the shelter needs of the chronically mentally ill. Unfortunately, the homeless who are suffering from significant physical and mental health problems must negotiate their way through a fragmented, complicated, and often hostile system of income, housing, health, and social service agencies and programs.

In the past, Congress responded to the problem of homelessness with legislation that was essentially of an emergency nature, primarily because homelessness was perceived as a temporary crisis. The major programs authorized in the 98th Congress were the Emergency Food and Shelter Program (P.L. 98–8) funded through the Federal Emergency Management Agency (FEMA) and the Temporary Emergency Food Assistance Program (TEFAP) administered by the Department of Agriculture (P.L. 98–92). In the 99th Congress, statutes governing various welfare programs were amended to provide for the needs of the homeless through provisions included in the Homeless Eligibility Clarification Act (Title XI of the Anti-Drug Abuse Act of 1986, P.L. 99–570). Among the new provisions were removal of restrictions limiting food stamp eligibility of homeless persons living in shelters, Supplemental Security Income payments to eligible homeless persons, and establishment of methods of delivering veterans' benefits to persons lacking a mailing address.

Legislative efforts to expand assistance to the homeless were among the first items on the agenda of the 100th Congress. Most Members of Congress believe that solutions to the problem of homelessness should be developed at the local level. Unlike the Administration, however, Congress felt that the Federal Government had an important role to play in the solution to the homeless problem. In January 1987, Congress passed a measure reallocating $5 million in disaster relief funds to programs aiding the homeless (P.L. 100–6).

Congress followed up with the Stewart B. McKinney Homeless Assistance Act which was signed into law on July 22, 1987 (P.L. 100–77). In parallel action, Congressional conferees for the fiscal

year 1987 supplemental appropriations bill, H.R. 1827, agreed to appropriate most of the funds for the programs included in the McKinney bill, and that measure also was signed into law in July 1987 (P.L. 100-71).

Following is a summary of the newly authorized provisions under various programs contained in the Stewart B. McKinney Homeless Assistance Act of 1987:

Federal Emergency Management Agency:

Authorizes an additional $15 million for fiscal year 1987 ($10 million of which was appropriated) for a total of $125 million for the emergency food and shelter program. The fiscal year 1988 authorization was $124 million.

Department of Housing and Urban Development:

(1) Emergency Shelter Grants Program (Title IV-B) authorizes grants to States, local governments, and private nonprofit organizations providing assistance to homeless individuals according to the community development block grant program formula. Eligible activities include renovating or converting buildings for use as emergency shelters, providing essential services concerned with employment, health, drug abuse, or education (if not provided by local government and not to exceed 15 percent of assistance), and covering the cost of maintenance, insurance, utilities and furnishings. Each grantee is required to match the grant with funds from other sources.

(2) Supportive Housing Demonstration Program (Title IV-C) authorizes financial and technical assistance to States, local governments, and private nonprofit organizations for the provision of transitional housing and supportive services for the homeless, including permanent housing for homeless handicapped persons who are capable of moving into independent living.

(3) Supplemental Assistance for Facilities to Assist the Homeless (Title IV-D) authorizes awards to States, cities, urban counties, tribes, or private nonprofit organizations to cover costs in excess of assistance provided under the emergency shelter grant or the supportive housing demonstration programs or provide comprehensive assistance for particularly innovative programs or alternative methods of meeting needs. To the extent practical, at least 50 percent of the funds are to support projects which primarily benefit homeless elderly individuals and homeless families with children.

(4) Assistance for Single Room Occupancy Dwellings (Title IV-E) authorizes competitive awards for the rehabilitation of single-room occupancy units to be used solely to house the homeless.

(5) Identification and Use of Surplus Federal Property (Title V) authorizes HUD to locate underutilized Federal property that might be converted into housing for homeless individuals and authorizes the General Services Administration and Department of Health and Human Services to make the buildings available to States, local governments, and nonprofit agencies.

Department of Health and Human Services:

(1) Health Services for the Homeless (Title VI-A) authorizes grants through the Health Resources and Services Administration to public and nonprofit private entities for delivery of outpatient primary health services and substance abuse services to homeless individuals.

(2) Community Mental Health Services for the Homeless (Title VI-B) authorizes a block grant to the States to provide outpatient mental health services to homeless people who are chronically mentally ill.

(3) Community Mental Health Demonstration Projects for Homeless Individuals who are Chronically Mentally Ill (Title VI-B) authorizes demonstration grants to State, local governments, and private nonprofit organizations to provide community-based mental health services to homeless individuals who are chronically mentally ill.

(4) Community Demonstration Projects for Alcohol and Drug abuse Treatment of Homeless Individuals (Title VI-B) authorizes grants, contracts, and cooperative agreements to develop and expand alcohol and drug abuse treatment services for homeless individuals. At least 1.5 percent of the appropriated amount is to be allocated to Indian tribes.

(5) Emergency Community Services Homeless Grant Program (Title VII-D) authorizes additional Community Service Block Grant funds to be allocated to States according to the same formula set forth in the Community Services Block Grant Act.

(6) Study of Youth Homelessness (Title VII-E) is authorized to be awarded by the Secretary for a recipient to research the underlying causes of youth homelessness.

Department of Education:

(1) Adult Education for the Homeless (Title VII-A) authorizes a program of "Statewide Literacy Initiatives" for grants to the States to develop a plan and implement a program of literacy training and basic skills remediation.

(2) Education for Homeless Children and Youth (Title VII-B) authorizes States grants to establish an Office of Coordinator of Education on Homeless Children and Youth in each State to assure that homeless children have access to public education.

Department of Labor:

(1) Job Training for the Homeless (Title VII-C) authorizes job training demonstration grants for the homeless.

(2) Homeless Veterans Reintegration Projects (Title VII-C) authorizes grants to expedite the reintegration of homeless veterans into the labor force.

Department of Agriculture:

(1) The Food Stamp Program is an ongoing program. Changes in the program would allow individuals to use their food stamps to purchase meals served by public or private nonprofit establishments that feed homeless persons, authorizes

State outreach programs to inform the homeless about food stamps, requires "expedited service" for the homeless, and allows related families with children who live together to be treated as separate households for the purpose of obtaining food stamps.

(2) The Temporary Emergency Food Assistance Program was extended through fiscal year 1988. The program allocates federally donated foods and some administrative funding to the States.

In addition, the new law authorized $200,000 for fiscal year 1987 and $2.5 million for fiscal year 1988 to establish a 3-year Interagency Council on the Homeless, composed of most Cabinet Secretaries and the heads of several independent agencies.

2. Issues

(A) PRIVATE AND PUBLIC SECTOR ROLES

Most would agree that homelessness is a problem deserving the attention of policymakers. However, the Administration has contended that homelessness is a local problem and maintains that the Federal role should be limited to making available, surplus resources, such as food and buildings to the homeless. Consistent with that philosophy, the Administration has consistently opposed the existence of Federal agencies which provide additional forms of assistance. In fact, the Administration has attempted to eliminate the Federal Emergency Management Agency, an agency which provides emergency funding for food and shelter, since 1983. The President also called for cutting block grants for community services and development that have been used by some States and localities to provide food and shelter to homeless individuals. In addition, the Administration wanted to eliminate the Temporary Emergency Food Assistance Program within the Department of Agriculture.

Those who support the Administration's position question whether the Federal Government should take on new functions that traditionally have been under the purview of voluntary organizations and local governments. While recognizing a need for more Federal resources to aid the homeless, there is concern that Federal legislative initiatives will elevate discretionary choices traditionally made at the State and community levels to the Federal level. They maintain that State and local governments are better suited to gauge their communities' needs and believe that Federal intervention will become institutional. Unfortunately, a recent poll shows that about half of all adult Americans think local governments are not demonstrating enough concern for the homeless.

Others argue that the problem is so acute that major Federal intervention is needed. However, even with substantial Federal emergency funding, supporters of more Federal involvement contend that primary decisionmaking still will reside at the community level.

Yet another facet of the problem is how much relief can result from Government efforts and how far governments should go. Even with an abundant availability of services, an unknown portion of the population may be reluctant to accept them, raising basic ques-

tions about what can be done to impose services on them. A subtle indication of this has emerged in a few major cities which have or are considering new ordinances to temporarily detain mentally ill homeless or others refusing to accept shelter from the elements. And since so much of the problem is thought 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.

Something of a new frontier in the law recently has begun to develop in the realm of 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 on State constitutions and statutes and on provisions in the Federal laws. It can be expected that advocates for the politically powerless homeless will continue to use the courts to obtain and to enforce the basic rights and benefits of the homeless.

One experimental project initiated in 1987 to reach the homeless elderly is being conducted by the Indiana Department of Aging with Older Americans Act funds. Three area agencies on aging are working with older persons who are homeless or marginally housed in an attempt to find long-term solutions to the housing problems of those persons through employment. An enrolled person receives assessment of employment needs and skills, individual counseling, job-readiness training, peer group support through job clubs, wages for work experience, and skills training through existing programs such as the Job Training Partnership Act and Community Services Block Grant programs.

In Boston, a group of concerned citizens have formed the Elderly Homeless Coalition, and developed a plan to provide rooms and meals, health, mental health, and case management services for the city's homeless elderly.

The Emergency Food and Shelter program, currently administered by the Federal Emergency Management Agency [FEMA], has provided more than $400 million for food, shelter, and other forms of assistance to the homeless. The program was initiated in the Emergency Jobs Appropriations Act approved in 1983 (P.L. 98-8), and has continued through appropriations, supplemental appropriations, and a continuing resolution in subsequent years. Originally, funds for the program were disbursed through two channels. One was through a national board composed of representatives from six charitable organizations and from FEMA itself. The other was through the States to whom FEMA was authorized to distribute $50 million for distribution to local distributors and service agencies. The State channel subsequently was eliminated.

Delays in the State channel were likely the cause of its elimination. In an evaluation of the shelter program in 1985, the Urban Institute noted that delays in the State channel resulted from a lack of State authorizing legislation, State requirements for written regulations, State requirements for proposal and assessment processes, obligations without distribution, and time lags because of State coordination requirements. The study also mentioned the speed and flexibility with which the National Board and the nonprofit sector were able to get money for emergency food and shelter to the local communities.

By most accounts, the FEMA program, which has utilized local programs rather than duplicating their efforts, has worked well. In 1988, the FEMA program funded about 121 million meals at a cost of $55 million. "Meals" includes meals provided on site, vouchers for meals, and meal counts from food banks. A meal provided from these funds is estimated to cost approximately 75 cents. The estimated cost of a night in a shelter is $2.25. "Shelter" includes motels/hotels and one month's rental assistance as well as actual shelters. The total cost in 1988 for shelters was $24 million.

Hundreds of citizens also have voluntarily donated time and money to help feed the hungry and house the homeless. But even with these efforts, optimistic statistics show that only one in three homeless individuals had a bed and a bowl of soup in a public or private shelter in the winter of 1988. Other figures suggest that only 1 of 20 were so fortunate. Both figures illustrate how much has yet to be done. The HUD report, for example, states that in 1984 there were about 111,000 shelter spaces available nationwide for as many as 350,000 homeless, indicating a serious shortage. Moreover, these shelters are at risk in many communities because of neighborhood opposition, inner-city redevelopment, and other factors. More recently, the U.S. Conference of Mayors reported that in the 27 cities they surveyed, 19 percent of the requests by homeless people for emergency shelter went unmet and the demand for emergency food frequently goes unmet.

(B) 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 has decreased considerably during the Reagan Administration while the number of people needing such housing has increased. 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 and 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 a remedy to the shortage of low- and moderate-income housing is the only systemic solution to homelessness.

Critics of an expansion of Federal 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 pro-

grams did not cause homelessness, rather that the local government policies, particularly rent control, reduced the number of low and moderate housing units.

(C) EMERGENCY SHELTERS AND WELFARE HOTELS

When homelessness orginally 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 that the costs of housing families in hotels far exceed the normal housing allowance for welfare recipients and the media exposure of the plight of the people fuel the debate.

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.

In December 1987, the Department of Health and Human Services proposed new regulations restricting the use of EA and AFDC funds for the purpose of housing in hotels. Congress, however, prohibited DHHS from implementing these regulations during fiscal year 1988.

(D) INSTITUTIONALIZATION

Some communities are enacting laws that allow local authorities to institutionalize the chronically mentally ill homeless without their permission. The debate extends beyond the mentally ill homeless to include ordinances that detain any homeless person who refused to accept shelter from the elements. Questions of civil liberties and rights of the homeless will increasingly become an issue the resolution of which will be sought in the courts.

(E) HEALTH, SOCIAL, AND WELFARE SERVICES

The delivery of health, social, and welfare services to the homeless has also become an issue. Some maintain that many of the McKinney programs are not actually 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, aiding them with existing programs.

Others express the view that the homeless have special needs that are best handled by targeted services. While few assert that the Federal Government should establish a separate system of services for the homeless, many state that special programs geared for the acute needs of the homeless should be operated within the public welfare system. Advocates assert that if money is not earmarked at the Federal level for these specific programs, the homeless will lose to other competing demands for limited resources.

(F) IMPLEMENTATION OF THE 1987 MC KINNEY ACT PROGRAMS

In oversight and reauthorization hearings in 1988, Congress expressed concern with the slowness with which the Department of Housing and Urban Development was moving in approving the suitability of surplus Federal structures that could be made available to the homeless. In late 1988, only 12 of approximately 335 excess and unused Federal properties had been reviewed and found suitable for use by the homeless and only 3 had been made available. Advocates for the homeless filed a lawsuit against HUD, the Government Services Administration, and three other government agencies in an attempt to accelerate Federal action. A Federal court subsequently ordered HUD to review the surplus Federal properties for possible use by the homeless within 1 month.

There was also Congressional concern whether the Inter-Agency Council on the Homeless was fulfilling it's duties. The Council was created by the McKinney Act to review and evaluate Federal agencies, work with States and local governments to coordinate programs and to develop new programs for the homeless, and report to Congress. Due to the Council's unresponsiveness to Congressional inquiries, the Government Accounting Office was asked to undertake an investigation of the Council's activities.

3. Federal Response

The primary response of the Federal Government to the plight of the homeless has been through the McKinney Homeless Assistance Act of 1987. However, that act 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 passage of H.R. 4352 was the result of several committees working simultaneously. The House Education and Labor Committee gave their authority over sections of H.R. 4352 to the Banking Committee which, along with the Energy and Commerce and Ways and Means Committees, reported the sections of the omnibus McKinney bill that fell within their purview. Specific bills covering housing (H.R. 4351 and H.R. 4024) and health care for the homeless (H.R. 4003) were introduced in the House. The problem of "welfare hotels" was considered in H.R. 4237 which offered demonstration programs de-

signed to phase out the practice. Provisions of these bills were incorporated into H.R. 4352. The Agriculture Committee folded the TEFAP provisions of the McKinney Act into H.R. 4060, The Emergency Hunger Relief Act.

In contrast to the House which began with omnibus homeless legislation, the Senate started with each committee handling the homeless programs under their authority. The Senate Banking Committee favorably reported S. 2554, legislation to extend the authorizations of the HUD programs of the McKinney Act through fiscal year 1990. The Senate Governmental Affairs Committee favorably reported S. 2607 which reauthorized the FEMA Emergency Food and Shelter Program and the Interagency Council on the Homeless. the Senate Committee on Labor and Human Resources included the reauthorization of the mental health block grant for the homeless and the demonstration grants for chronically mentally ill homeless and for substance abusing homeless as part of S. 1943, which reauthorized many of the alcohol and drug abuse and mental health programs under the Public Health Service Act. The Committee also passed the reauthorization of the community health services for the homeless program as part S. 2385, the Family Health Services Amendments Act of 1988; and the Labor and Human Resources Committee merged the job training, education, and community services provisions for the homeless with the health and mental health provisions previously reported into S. 2742, the "Social Services for the Homeless Reauthorization Act of 1988". This bill also contained an amendment to include the "Jobs for Employable Dependent Individuals Act" (JEDI) to amend the Job Training Partnership Act to improve job training and placement for long-term welfare recipients and individuals with disabilities.

On September 28, 1988, the Senate passed Amendment No. 3297 which Majority Leader Robert Byrd offered as an amendment to H.R. 4352. This amendment incorporated much of the language recommended by the various Senate authorizing committees, including the JEDI provision. The programs for homeless veterans also were part of the reauthorizing package. It did not include the House-passed provisions concerning emergency assistance, AFDC, and "welfare hotels."

The conference report on H.R. 4352 was passed in the House on October 19, 1988, and in the Senate 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 JEDI program. The act also prohibits DHHS from promulgating proposed regulations to limit use of Emergency Assistance and AFDC funds for homeless families, and requires DHHS to recommend demonstration projects designed to reduce the number of AFDC families in "welfare hotels." Other provisions encourage Federal agencies to identify unutilized as well as underutilized Federal facilities that can be used to shelter the homeless on a temporary basis, and encourage States to establish State Interagency Councils on the Homeless.

TABLE 1.—APPROPRIATIONS FOR PROGRAMS PRIMARILY BENEFITING THE HOMELESS

[In millions of dollars]

Type of services	Fiscal year—		
	1987 [1]	1988 [2]	1989
Emergency services:			
Emergency food and shelter	$125.0	$114.0	[3] $114.0
Emergency shelter grants	[4] 60.0	8.0	[3] 46.5
Runaway and homeless youth	23.3	26.1	[5] 26.9
Housing (nonshelters):			
Supportive (Transitional)	85.0	65.0	[3] 80.0
Supplemental Assistance	15.0	0	[3] 0
Section 8 (SRO)	35.0	0	[3] 45.0
Mental Health Services:			
Mentally Ill Veterans	[6] 10.0	0	[3] 13.3
Community Mental Health	32.2	11.5	[5] 14.1
Mental Health Demonstrations	9.3	0	[5] 4.6
Alcohol/Drug Demonstrations	9.2	0	[5] 4.5
Community Support Program [7]	1.1	6.6	[5] 12.3
Health Services:			
Health Services for Homeless	46.0	14.4	[5] 14.8
Veterans' Domiciliary Care	15.0	0	[8] 10.4
Education:			
Adult Literacy	6.9	[9] 7.2	[5] 7.1
Youth and Children	4.6	4.8	[5] 4.8
Job Training:			
Job Training	0	7.7	[10] 9.4
Veterans' Reintegration	0	1.9	([10])
Social Services:			
Community Services for Homeless	36.8	19.1	[5] 18.9
Total	514.4	286.3	426.6

[1] Unless otherwise noted, Public Law 100–71, the Supplemental Appropriations Act for fiscal year 1987, is the appropriations law for fiscal year 1987. Public Law 100–71 stated that for Urgent Relief for the Homeless, unexpended fiscal year 1987 dollars could be carried over into fiscal year 1988.

[2] Public Law 100–202, the Continuing Resolution for fiscal year 1988, is the appropriations law for fiscal year 1988.

[3] Public Law 100–404 appropriated these funds.

[4] Public Law 99–591, a fiscal year 1987 continuing resolution, appropriated $10 million of this total.

[5] Public Law 100–436 appropriated these funds.

[6] This total includes $5 million authorized as a transfer from FEMA disaster relief funds by Public Law 100–6, and an additional $5 million authorized and appropriated by Public Law 100–71.

[7] Congress has not specified how much of CSP's total appropriations should be earmarked for projects serving the homeless; however, Conference Report 100–256, to accompany H.R. 3058, the Departments of Labor, Health and Human Services, Education and Related agencies Appropriations Act, 1988, stated that at least $5 million of the total CSP appropriations were to be used for demonstration projects serving the homeless. Richard Pine of the National Institute on Mental Health Budget Office indicated that the figures reported here are the portions of the CSP appropriations spent on projects for the homeless in fiscal year 1987, fiscal year 1988, and fiscal year 1989.

[8] Public Law 100–404 appropriated a total of $10.5 billion for the VA medical care programs in fiscal year 1989, and the VA plans to continue the specific domiciliary care program for homeless veterans of $10.4 million in fiscal year 1989, according to Arthur Klien, VA Department of Medicine and Surgery Budget Formulation Office.

[9] The conference report on House Joint Resolution 395 indicated that $124.5 million was appropriated for adult education which included funds for the state literacy initiatives. According to Tom Johns and Marilyn Hall of the Department of Education, the House and Senate Appropriations Committees agreed that $7.2 million was to be spent on adult education for the homeless.

[10] Public Law 100–628 states that $2.2 million of the $13 million authorized for Job Training for the Homeless shall be made available for the Veterans' Reintegration Job Training program administered by DOL. Public Law 100–628 also provides that if the total appropriation for Job Training for the Homeless falls below $13 million, the funding for the Veterans' Reintegration should be ratably reduced.

Source: Congressional Research Service.

C. 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 educational

opportunity, to enhance the quality of education, 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 older people. The 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 education 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 youth, including those of the traditional college ages. This is due largely to the perception of education as 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 a need exists for learning beyond the informal environment for the elderly. This need for structured learning may appeal to "returning students" who have not completed their formal education, older workers who require retraining in skills adaptable to rapid technological change, or retirees who desire to expand their knowledge and personal development. A growing awareness of the importance of education to the elderly has resulted in some reordering of priorities and resource allocation away from the basic education/literacy and training programs established for older adults in the early 1960's. While Federal programs generally have lagged, private and public-based education programs have emerged that are designed to better meet the growing educational needs of older persons.

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 established number at over 1 million. However, literacy means more than just 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 thought necessary for the comprehension of a literate person. As various experts defined clusters of needed skills, definitions proliferated. These definitions became more complex as

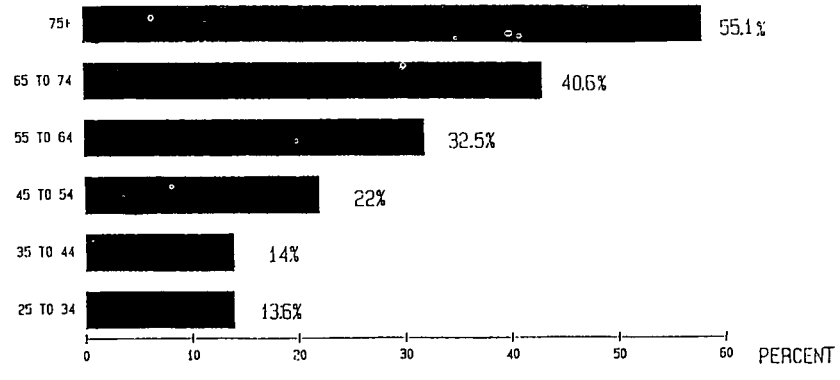
the technological and information needs of the society increased. Thus, despite apparent consensus that some measure of functional illiteracy must replace the conventional definition, no agreement has been reached on a definition. Without a standard definition and widely accepted measure of illiteracy, it is difficult to determine the extent of illiteracy in the country and whether it is increasing or decreasing.

However, the results of some studies have revealed cause for concern. In a 1986 study of illiteracy by the National Advisory Council on Adult Education, an estimated 40 percent of armed services enlistees were found to read below the 9th grade level. 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 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 groups of adults 16 years and over with less than a high school education.

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

Data from the Office of Vocational and Adult Education within the Department of Education (ED), shows that of the total eligible adult population receiving Adult Basic Education services (ABE)—basic literacy and English as a second language instruction—in 1986, 7.4 percent or 217,488 were in the 60 plus age group as compared to 185,000 the previous year—a 11.8 percent increase. On the State levels, 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 to read to their grandchildren, to read the Bible, to read medicine levels, to accomplish a life time goal of earning a General Education Development (GED) certificate, to learn more about money and banking, and to learn more about available community resources.

(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 establish adult education programs to help adults 16 years and older to acquire basic literacy skills necessary to function in society, enable adults to complete a secondary school education, and 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 serves almost 3.2 million participants annually.

In 1977, a major change began in adult education enrollment. The enrollment of those age 16 to 44 decreased while the enrollment of those 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 people 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 older persons 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 for the skills needed for volunteer or paid work later in life. As the median years of schooling for older adults increases, the 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 include 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 and low population density. Lack of public transportation in rural areas hinders program participation by the elderly, and programs may be offered at locations that are hard to reach.

3. Federal and Private Response

(A) PROGRAMS

(1) Literacy

(a) Public Efforts

The first significant Federal adult literacy programs began in the military services. Programs for civilians started with the Manpower Development and Training Act of 1964, providing job training for the unemployed. Many participants were found to be functionally illiterate and the program was amended to provide basic educational skills. The Economic Opportunity Act of 1964 provided the first State grants for persons needing basic literacy skills. 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 then.

During its first term, the Reagan Administration requested a one-third reduction of Federal funds for the Adult Education Act, with the ultimate intent of turning over such programs to the States under the "Federalism Initiative." In response to the President's Commission on Excellence in Education report, the Reagan Administration made the elimination of illiteracy a major focus. The Adult Literacy Initiative was launched in the Department of Education on September 7, 1983. It is not a legislatively mandated program, but is based on various discretionary authorities available to the Secretary of Education. The thrust of the initiative is to increase public awareness of the problem, recruit volunteer tutors, and encourage private sector involvement.

The program's current operations include:

(1) Cooperating with the Coalition for Literacy and the Advertising Council in sponsoring a National Awareness Campaign on Adult Literacy, including a toll-free "Literacy Hotline",

(2) Redirecting part of the College Work-Study Program to employ students in literacy programs,

(3) Encouraging student and adult volunteers as literacy tutors,

(4) Working with the Federal Employee Literacy Training program, whereby all Federal agencies are encouraging employees to volunteer as literacy tutors,

(5) Sponsoring national meetings and conferences, and

(6) Developing private/public sector partnerships, including support for the Business Council for Effective Literacy.

The Department of Education's Office of Educational Research and Improvement sponsored the National Adult Literacy Project, which issued research reports in 1985 on a number of topics, including history and description of adult basic education programs, literacy and employment, an agenda for literacy research and development, support systems for adult education, literacy and television, alternative strategies for adult education participation, and a guidebook on effective literacy projects.

Much of the public effort by States and localities to address literacy problems is organized under the AEA program which is federally funded and State administered. Section 353 of the Adult Education Act requires States to set aside 10 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, 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 (30,000 tutors) and Literacy Volunteers of America (15,000 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 Coalition and the Advertising Council began a 3-year advertising project in December 1984, the National Literacy Awareness Campaign, to increase public awareness and recruit literacy volunteers.

The Business Council for Effective Literacy is a foundation 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.

(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. A recent study found that younger students studying together with persons their parents' and grandparents' age broadened their attitude toward older persons beyond rigid stereotypes and were able to identify them as 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. Approximately 93 colleges and universities participate in the College Centers for Older Learners (CCOL) program. 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, DC, 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 moving to reduce the cost of higher education for adults age 60 and over. Although policies differ from State to State, most offer 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) include a new 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. It is anticipated that access to such information will increase the enrollment of older persons in higher education programs.

(3) Elderhostel

Elderhostel was inspired by the youth hostels and folk schools of Europe, and is based on the belief that retirement and later life represents an opportunity to enjoy new experiences. Elderhostels are short-term residential, campus-based educational programs provided to older persons at modest cost. Courses offered are in the liberal arts and sciences and presuppose no particular level of formal education on the part of the student. Most Elderhostel programs deliberately avoid age-specific focus on the problems of aging.

Since the inception of Elderhostel in New Hampshire in 1975, older adults in dramatically increasing numbers have enrolled in the programs. In 1988, more than 900 private and public colleges

and educational institutions in 50 States and Canada served 163,000 summer and academic year hostelers. In addition, hostelers participated in programs in 40 other countries including Scandinavia, France, Germany, the Netherlands, Italy, Great Britain, Israel, and Australia. Even with the burgeoning number of participants, however, Elderhostel remains essentially an educational opportunity reserved for mobile older adults with a relatively high education attainment level.

(4) Intergenerational Programs

Intergenerational programs in schools were introduced in the early 1970's in an effort to counter the trend toward an increasing 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 providing the support, teaching, and caring that would enhance the learning and development of schoolchildren. 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 programs spanning several school districts. One example of a successful intergenerational program is the Teaching Learning Community, begun by an elementary art teacher in 1971 in Ann Arbor, MI. Teaching Learning Community links older persons with a small group of student-apprentices. They work together on a joint activity on a regular, weekly basis with the focus on teaching the students a new skill and creating a product while communicating with and developing respect and regard 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 schoolchildren to develop a more positive view of older persons 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 of 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 include a provision that allows the Commissioner on Aging to award demonstration grants, providing expanded, innovative volunteer opportunities to older persons which are designed 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.

(B) LEGISLATION

In 1988, the 100th Congress acted on several measures related to the Adult Education Act and other literacy/education programs.

The Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988 became Public Law 100-297 on April 28, 1988. This legislation amends and extends the AEA through fiscal year 1993 and strengthens AEA provisions of programs serving educationally disadvantaged adults. Two new AEA programs are authorized: workplace literacy partnership grants and English literacy grants. Demonstration grants for literacy partnerships provide adult literacy and training skills to improve the productivity of the workforce. Partnerships consist of (a) business, industry, labor organizations, or private industry councils, and (b) State or local educational agencies, institutions of higher education, or schools. Demonstration grants for English literacy assist programs for adults with limited-English proficiency. The amendments also authorize an "even start" program for adult literacy for parents and their children.

Further, the amendments provide for the establishment of a information clearinghouse on literacy curricula and, the Secretary of Education is required within 2 years to define the basic skills needed for literacy and to estimate the number of illiterate adults in the country. In addition, the Secretaries of the Departments of Education, Labor, and Health and Human Services are required to conduct a joint study of Federal funding sources and services currently available for adult education programs and are to jointly facilitate interagency coordination. The findings of the study are to be submitted to Congress within 2 years.

The Hawkins-Stafford Amendments also extend the Ellender Fellowship program. Under this program, grants are made to the Closeup Foundation which provides educational programs on Federal Government activities and public affairs, usually bringing participants to Washington, DC, for this purpose. A new provision authorizes fellowships for older Americans and recent immigrants.

The Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77) authorized an Adult Education for the Homeless program of statewide literacy initiatives for grants to States to develop and implement a program of literacy training and basic skills remedi-

ation. The States, in turn, coodinate these programs with community-based organizations, VISTA recipients, adult basic education program recipients, and nonprofit literacy-action groups. Funds are allocated according to each State's homeless population, with each State receiving at least $75,000.

Section 701 of the McKinney Act also amends the Adult Education Act to include homeless individuals as a category in the Research and Demonstration program. The Stewart B. McKinney Homeless Assistance Amendments Act of 1988 (P.L. 100-628) reauthorized the two programs for 2 years, through fiscal year 1990.

In other legislative action during 1988, H.R. 4848, the Omnibus Trade and Competitiveness Act of 1988 was signed into law on August 23, as Public Law 100-418. An earlier version of the legislation, H.R. 3, was vetoed by the President on May 24, 1988, due to a notification of plant closing provision. H.R. 3 was reintroduced as H.R. 4848 on June 16, 1988, without the plant closing provision and passed both Houses unamended. The Trade Act contains several identical or similar provisions, such as the partnership and English literacy grants, as the within the Hawkins-Stafford Amendments. Among the vocational, postsecondary, and adult education provisions, the Act creates a Federal Literacy Coordination Office, directs the National Diffusion Network to disseminate literacy skills information, establishes a technological literacy demonstration program, and amends the Job Training Partnership Act (JTPA) to provide employment and training assistance for dislocated workers, including basic and remedial education and literacy and English training for non-English speaking persons.

The fiscal year 1989 appropriations bill for the Departments of Labor, Health and Human Services, and Education, and related agencies was signed into law on September 20, 1988 (P.L. 100-436). The Adult Education programs received a combined appropriation of $162.2 million for fiscal year 1989, including $7.1 million for homeless literacy, $11.9 million for literacy partnerships, and $4.9 million for English literacy. The AEA grants to States total $136.3 million for fiscal year 1989, an increase of nearly 20 percent over the fiscal year 1988 level.

D. 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 including Volunteers in Service to America (VISTA) and the National Student Volunteer Program, both previously administered by the Office of Economic Opportunity, and the Foster Grandparent Program (FGP) and Retired Senior Volunteer Program (RSVP), which had been administered by the Administration on Aging.

ACTION was given statutory authority under the Domestic Volunteer Service Act of 1973. This act also repealed prior legislative authority for ACTION's domestic programs, which had been authorized under several different acts, and reauthorized them under

a single authority. The act was last reauthorized through fiscal year 1989 during the 99th Congress. The 101st Congress will re-examine the programs under the act during reauthorization proceedings in 1989.

Today, programs administered by ACTION include the Title I-A VISTA program, the Title I-B service learning programs, the Title I-C special volunteer programs, and the Title II Older American Volunteer Programs (FGP, RSVP, and the Senior Companion Program). Generally, 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 Senior Companion Program (SCP), is the largest of the ACTION program components. For fiscal year 1988, OAVP funding constituted 68 percent of total ACTION funding, and continues to support the majority of ACTION's volunteer strength. The various programs provide opportunities for persons 60 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 resources. According to ACTION estimates, State funding to support ACTION-funded volunteer projects is estimated at more than $24 million annually—$13.7 million for the FGP, $6.1 million for the SCP, and $5 million for the RSVP. In the past few years, State funds to support each of the programs have exceeded the Federal requirements for matching funds. In addition, OAVP has benefited from $12.5 million provided annually by city and county governments and $19.2 million from private sector sources. To a great extent, the fact that these projects continue to generate additional funding at the State and local level and are a cost-effective means of providing community services have made them enormously popular with both Congress and the Administration.

(1) Retired Senior Volunteer Program

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. The program is designed to provide a variety of volunteer opportunities for persons 60 and older. In fiscal year 1988 there were 750 projects and 400,000 RSVP volunteers who are estimated to have generated approximately 72.3 million volunteer hours. This includes volunteers supported by non-Federal funds as well as federally funded volunteers. In fiscal year 1989, it

is estimated that 425,000 older persons will participate in this program.

Volunteers serve in such areas as youth counseling, literacy enhancement, in-home care, consumer education, crime prevention, and housing rehabilitation. 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 the volunteer activities.

(2) Foster Grandparent Program

The 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, 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 three or four children. A foster grandparent may continue to provide services to a mentally retarded person over 21 years of age as long as that person was receiving services under the program prior to becoming 21.

Volunteers receive an hourly stipend, transportation assistance, an annual physical examination, insurance benefits, and meals when serving as volunteers. 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 1988, this annual income level was $7,215 for an individual in most States and $9,665 for a two-person family. For fiscal year 1988, ACTION estimates that about 26,000 federally and non-federally funded foster grandparents assisted approximately 68,500 children in 264 projects.

(3) Senior Companion Program

The Senior Companion Program (SCP) was authorized in 1973 by Public Law 93–113 and incorporated under Title II, section 221(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 and older to assist

them in providing supportive services to vulnerable, frail older persons. The volunteers assist homebound, chronically disabled older persons to maintain independent living arrangements in their own residences. Volunteers also provide services to institutionalized older persons and persons 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, volunteers must meet the same income test as for the Foster Grandparent Program.

In fiscal year 1988, about 9,000 SCP volunteers served in 169 projects, including volunteers in non-federally funded projects. ACTION estimates that these volunteers served about 27,500 persons.

(B) VOLUNTEERS IN SERVICE TO AMERICA

Volunteers in Service to America (VISTA) was 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 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 small stipend for food, lodging and incidental expenses. They also are provided health insurance and receive a monthly stipend not to exceed $75 that is paid in a lump sum at the end of their service. At least 20 percent of the volunteers must be age 55 and older. In fiscal year 1988, 698 volunteers over the age of 55 served in VISTA and represented 28 percent of the VISTA corps.

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 continues for volunteer efforts to address the problems of poverty and to utilize the skills and experiences of volunteers, notably the elderly. Despite the interest among volunteer programs to utilize elderly volunteers, there has been relatively little structured evaluation of this mechanism for providing care and services.

In the Domestic Volunteer Service Act Amendments of 1984 (P.L. 98-288), Congress authorized senior companion demonstration projects to explore ways that 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 (SCVL's) to assist other senior companions. 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 relevant public policy to meet the long-term care needs of the rapidly increasing older population, Congress mandated an evaluation of the demonstration projects specifying 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 displacing them. Nevertheless, the projects proved to be a relatively low-cost means of providing needed services to frail older persons who could generally not afford to purchase them. In an economic cost-effective analysis, the programs were cost-effective compared to the private market only if the private market administrative costs are less than the SCP administrative costs. 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 stability of the senior companions' high degree of social integration and well-being. There was limited indication of improvement in health. The training by volunteer trainers was generally found to be helpful to the senior companions. However, pre-service 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. This reflects the concern expressed by project staffs that the role of SCVL's established a hierarchy among the volunteers, thereby jeopardizing senior companion relationships. Senior companions were found generally to provide informal support services for each other regardless of the presence of SCVL's. Finally, the evaluation 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.

Associations representing local project directors experienced with administering the Older Americans Volunteer Programs have identified for Congress a major concern for successful continuation of the programs: The need for increased funding support for administration of the projects. Due to administrative restrictions, cost-of-living increases for the Older Americans Volunteer Programs approved by Congress in the past 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

Authorizations of appropriations for the Domestic Volunteer Service Act were to expire at the end of fiscal year 1986. The Act was reviewed during the 99th Congress and on October 27, 1986, Public Law 99-551 (H.R. 4116) was signed into law, extending the volunteer programs through fiscal year 1989. (See Table 2 for authorization and appropriation levels for the programs.)

TABLE 2.—ACTION PROGRAMS AUTHORIZATIONS AND APPROPRIATIONS

[In millions of dollars]

	1988authorizations	1988 appropriations	1989 authorizations	1989 appropriations
VISTA	26.0	19.8	27.0	21.6
RSVP	33.3	30.6	34.6	30.8
FGP	62.4	57.4	64.9	58.9
SCP	30.9	23.1	32.2	25.1

This legislation also amended the FGP and SCP programs to permit enrollment of non-low-income persons to serve as foster grandparents and senior companions as long as they are willing to serve without a stipend or reimbursement for expenses other than for transportation, meals, and out-of-pocket expenses, and agree to work 20 hours a week as well as comply with other program requirements. Prior law allowed only enrollment of older persons who met specific income eligibility requirements. Non-low-income, unpaid individuals may participate in the program only in communities where there are no RSVP volunteers (such volunteers do not receive stipends). The 1986 law specifies that volunteers not receiving stipends cannot replace low-income persons who serve as volun-

teers with stipend. The cost of administering programs for non-stipend volunteers may be supported by funds received by the Director of ACTION as gifts, funds contributed by volunteers, or locally generated contributions in excess of the required matching share for the volunteer programs.

For fiscal year 1989, Congress appropriated $1.9 million above the Administration's request for the Older American Volunteer Programs. Congressional intent is that the increase for the Foster Grandparents Program shall be used to enhance volunteer services within current projects. In addition, Congress intends that increased funds appropriated for the SCP be used to fully fund the new senior companion projects begun in fiscal year 1988. Any funds in excess of this level are to be used to enhance volunteer services in current SCP projects.

The ACTION programs are scheduled for review by Congress in 1989 when the 101st Congress considers reauthorization of the programs.

E. TRANSPORTATION

1. Background

Transportation is the 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) Director 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 major federally sponsored transportation programs that provide assistance to the elderly and handicapped are administered by the Department of Health and Human Services (DHHS) and the Department of Transportation (DOT). Under DHHS, a number of programs provide specialized transportation services for the elderly, incluing Title III of the Older Americans Act (OAA), the Social Services Block Grant Program (SSBG), the Community Services Block Grant Program (CSBG) and, to a limited extent Medicaid,

which will reimburse elderly poor for transportation costs to medical facilities. Under CSBG, more dollars (approximately 32 percent) are spent on so-called linkages with other programs—including transportation for the elderly and handicapped which links clients to senior centers, 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. In fiscal year 1989, nearly 7 million 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 of 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 for improved access by the elderly and handicapped. Section 16 of UMTA declares it to be 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 so that the availability to the elderly and handicapped persons of mass transportation is assured, and that all Federal programs offering assistance in the field of mass transportation should contain provisions implementing this policy. Essentially, 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 mass transit funding for urban and nonurban areas nationwide through block grants. 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. Also, passage of the Surface Transportation Assistance Act (STAA) of 1978 provided funding at the Federal level, known as the Section 18 program, to support public transportation program costs, both operating and capital for nonurbanized areas. Elderly and handicapped people in nonurban and rural areas benefit significantly from Section 18 projects because they generally are less mobile than other people and might be more isolated and in need of transportation assistance.

The STAA of 1982 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 for recipients of Federal mass transit assistance to offer half-fares to the elderly and handicapped people during non-peak hours.

The programs administered by the Department of Health and Human Services have proved highly successful in providing limited supportive transportation services necessary for linking 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 sources for primary transportation services for older Americans. Recognizing, nevertheless, the overlapping of funding and services, and the need for increased coordination, DHHS and DOT established an interdepartmental Coordinating Council on Human Services Transportation in 1986 the Council is to coordinate relate programs at the Federal level and promote 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 program initiatives, however, Federal strategy in transportation remains essentially one of providing seed money for local communities to design, implement, and administer transportation systems to meet their individual needs and resources. In the future, the Federal response to the increasing need for specialized services for the elderly and handicapped will dictate the range of services available and, to a large extent, the fiscal responsibility of State and local communities to finance both large-scale mass transit systems and smaller neighborhood shuttle services.

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 followup 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), finding a statewide need for additional transportation services, particularly nonemergency services, characterizes transportation as its top priority. This same State conducted a survey and 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 reasons.

This barrier results in less socialization and less satisfaction with life in general. In addition, it is anticipated that the demand for transportation services will increase.

TABLE 3.—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
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	
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 not taken because of lack of transportation			24,908,652,616

Note: Table is based on high population projections for 2000.

Source: Calculated from the driving-loss model and derived from cohort-specific activity limitation rates and non-age-specific HIS data (49, 50), and mid-series population estimates (51). Also based on unpublished 1983 Nationwide Personal Transportation Study data.

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 status across the country 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. In an effort to draw attention to these critical transportation issues, 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, with implementation for such a system initiated at the local level in order to ensure appropriate design for the unique needs of the individual community. 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 to 9 million rural elderly lack adequate transportation, and as a result, are severely 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 transportation, 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.

(C) SUBURBAN TRANSPORTATION NEEDS

The graying of the suburbs is a phenomenon which has ony 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 elapsed since have changed entirely the profile of the average American suburb. The suburbs have aged with profound implications for social service design and delivery. In 1980, for the first time a greater number of persons over 65 lived in the suburbs (10.1 million) than in central cities (8.1 million). This phenomenon which is continuing is due 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, there is the desire of many older persons to remain in the homes and neighborhoods in which they have grown old, i.e., "aging in place." The growth of the suburban elderly 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 generally. Consequently, Federal support for primary transit systems de-

signed especially for the elderly suburban dweller is almost nonexistent, and consists mostly as a supportive service. State and local governments have been unable to harness sufficient resources to fund costly transportation systems independent of Federal support. Often, alternative revenue sources are not politically expedient. For example, user fees alone are insufficient to support suburbanwide services and are generally viewed as penalizing those most in need of transportation services in the community—the elderly poor.

The fact that the suburbs have aged 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 particularly critical need. Institutions that serve the needs of elderly persons, such as hospitals, senior centers, and convenience stores, necessarily 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 degree 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 meeting the mobility needs of 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 ones. However, although they are involved in a small number of crashes, after age 75, other 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 65 and older are more than three times more likely to die than a 20-year-old occupant from serious injuries of equal severity. The study emphasizes that as age 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.

Walking is second in importance to driving as a mode of transportation for older persons. For those older persons without driver's licenses, between 20 and 40 percent of all their trips are made by walking. Yet the suburban environment, in particular, does not provide for safe walking—pedestrian crossings are frequently not available and signals are set to maintain a high volume of through auto traffic. In addition, signal timing assumes a walking speed faster than that of many older pedestrians.

3. Federal and State Responses

(A) FEDERAL

Funding for the most crucial transportation programs serving older Americans was put on hold during the closing days of the 99th Congress when the Surface Transportation and Uniform Relocation Assistance Act of 1986 died in conference committee after lawmakers were unable to come to agreement on several unrelated issues. States subsequently were left with limited funding.

Congress appeared intent on an early reauthorization in the 100th Congress. The House passed H.R. 2 on January 21, 1987, and the Senate passed its substitute bill, S. 387, on February 4, 1987. Both houses passed the omnibus highway conference bill, known as the Surface Transportation and Uniform Relocation Assistance Act of 1987, in mid-March. President Reagan, however, vetoed the legislation on March 27, objecting to provisions for 120 demonstration projects for particular States and Congressional districts. Congress overrode the veto and the 5-year reauthorization act became law on April 2, 1987 (P.L. 100-17). Of the authorizations from the mass transit account of the trust fund for discretionary programs, $35 million was authorized for each year for the elderly and handicapped and innovative research programs. This section of the legislation which is cited as the Federal Mass Transportation Act of 1987 also provides for a 95 percent Federal share of the cost of all projects specifically targeted at improving elderly and handicapped access to public transit systems. Previously, the Federal share was 80 percent for all formula grant programs and 75 percent for discretionary grants.

The Older Americans Act was also reauthorized in 1987 (P.L. 100-175). The amendments provide for a 5-percent increase for support services, including transportation, each year through fiscal year 1991.

The appropriations bill for fiscal year 1989 (P.L. 100-457) appropriated the full authorized amount of $35 million for elderly and handicapped, and innovative research programs under the discretionary grants of the Urban Mass Transportation Administration.

(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.

Montana, for example, has developed an interagency coordination 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 applications for 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 policy on issues that affect 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.

F. LEGAL SERVICES

1. BACKGROUND

(A) THE LEGAL SERVICES CORPORATION

Legislation creating 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. President Nixon, however, recognized that because some of the litigation initiated by legal services brought it in direct conflict with local and State governments and because the program is concerned with social issues, it is subject to unusually strong political pressures. In 1971, in an effort to insulate the program from those political pressures, he requested legislation creating a separate, independently housed corporation. The Legal Services Program then was established as a private, nonprofit corporation headed by an 11 member board of directors, nominated by the President and confirmed by the Senate.

The Corporation does not provide legal services directly; rather, it funds local legal aid projects. Each local legal service project is headed by a board of directors, of which 60 percent are lawyers who have been 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 guidelines. The Corporation places primary emphasis on the provision of routine legal services and the majority of LSC-funded activities involve routine legal problems of low-income people. According to the most recent report of the Corporation in 1985, almost one-third of legal services cases are family related,

such as divorce and separation, child custody and support, and adoption. Another 19 percent of legal services cases deal with housing problems, primarily landlord-tenant disputes in non-Government subsidized housing. Problems with welfare or other income maintenance programs, and consumer and finance problems, form the next two largest categories of legal services cases. Individual rights, employment, health, juvenile, and education cases make up the remaining caseload. 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 develop and provide specialized expertise in various aspects of poverty law to legal services attorneys in the field. Three of these centers are involved specifically in issues that confront older people: the National Senior Citizens Law Centers, in Los Angeles and Washington, DC; and Legal Counsel for the Elderly, in Washington, DC. In addition, LSC currently is funding 27 law school clinical programs to assist eligible clients during the academic year 1988-89.

Several restrictions on the types of cases legal services attorneys may handle were included in the original law and several others have been added since then. Most of the restrictions were made in response to critics of the program who charge that legal services funds have been used to promote the social and political goals of activist attorneys under the guise of providing legal assistance to the poor. Opponents believe that although legal services attorneys theoretically are prohibited from pursuing their own political and social interests by a requirement that they represent a particular client before getting involved in an issue, this requirement easily is circumvented without specific restrictions. The current restrictions include a prohibition on cases dealing with school desegregation, nontherapeutic abortions, certain violations of the Selective Service Act, and Armed Forces desertion. The fiscal year 1987 appropriations measure (P.L. 99-500) contained additional prohibitions against lobbying with Corporation funds, representing aliens who do not meet specified conditions, and class action suits against Federal, State, or local governments except under certain circumstances.

Other restrictions were promoted by supporters of legal services who were concerned that the broad scope of the Corporation's work would be curtailed sharply by its detractors. For example, the 1987 appropriations measure also require prior notification of Congress when regulations are to be promulgated. This restriction was added in response to concerns that proposed regulations issued by the LSC, such as those curtailing legislative and administrative advocacy by LSC attorneys on behalf of poor clients, would change drastically existing Corporation policy.

In the fiscal year 1988 appropriations measure (P.L. 100-202), Congress retained all prior restrictions and prohibited the LSC from imposing its own additional requirements on government boards of recipients of LSC grants.

(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 among those made at the 1971 White House Conference on Aging. Regulations promulgated by the AoA in 1973 identified for the first time, legal services as 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. Amendments to the OAA, in 1978, established a funding mechanism and a programmatic structure for legal services. The 1981 amendments required area agencies on aging to 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 as well 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 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 which 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 have fulfilled the adequate proportion requirement. Congress intended the minimum percentage to be a floor, not a ceiling, and encouraged area agencies to devote additional funds to each of these service areas to meet local needs.

In addition, the Act also requires that area agencies contract with legal assistance providers who can demonstrate the experience or capacity to deliver legal assistance and to involve the private bar in legal assistance activities. If the legal assistance grant recipient is not also a Legal Service Corporation 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, among other things, 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 ombudsman 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 mutual 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 designated 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 in 1987 indicate that, through both formal and informal agreements, legal services attorneys and paralegals help ombudsmen secure access to facilities, residents, and residents' records; provide consultation to ombudsman on law and regulations affecting institutionalized persons; represent clients referred by ombudsman programs, and work with ombudsmen and others to bring about changes in policies, laws, and regulations which 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 officers, bar associations, private attorneys, paralegals, elderly organizations, law firms, attorney generals, and law schools. The 1984 amendments to the Older Americans Act required States to fund this position.

In addition, the 1984 amendments also mandated that the AoA fund national legal support centers. Through grants and contracts, AoA currently supports 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, all in Washington, DC; and the Center for Social Gerontology in Michigan.

Today, OAA moneys support over 600 legal programs for the elderly in the greatest social and economic need. Unfortunately, the amount of Title III funds expended on legal services for recent fiscal years is not available. As part of its past efforts to reduce State reporting burdens, AoA discontinued the requirement that States report expenditure data on types of services. According to the AoA fiscal year 1987 Program Performance Report, about 458,000 older persons received legal services. The 1987 amendments to OAA, however, requires that beginning in fiscal year 1989, the Commissioner collect data on funds expended on each type of service, as well as the number of persons who are recipients of such services and the number of units of services provided. These data are to be collected annually thereafter.

(C) SOCIAL SERVICES BLOCK GRANT

Under the block grant program, Federal funds are allocated to States which, in turn, provide services directly or contract with public and nonprofit social service agencies for providing social services to persons and families. For the most part, States determine which 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,

there is no information available on the number of persons or the age breakdown of those persons who are being served.

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 are dependent 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 relate to consumer fraud, property tax exemptions, special property tax assessments, guardianships, involuntary commitment to an institution, nursing home, and probate matters. Legal services and professional legal representation are of vital importance to the elderly because they help them obtain basic necessities and assure that they receive benefits and services to which they are entitled.

Legal Services Corporation programs do not necessarily specialize in serving older clients but do attempt to meet the legal needs of the poor of which the elderly are a significant proportion. Legal services provided by LSC attorneys are given to people based on financial needs. 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 since eligibility is based on both economic and social need, and means testing for eligibility is prohibited. Nevertheless, a White Paper developed by several legal support centers in 1987 demonstrated that, in spite of advances in the previous 10 years, the need for legal assistance by 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 back the flow of Federal dollars to local programs for the delivery of elderly legal services and 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 2 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, however, the LSC is not funded to provide even minimum access to legal assistance for poor persons.

In most States, there is only 1 attorney for every 10,000 poor persons. In contrast, there are approximately 28 lawyers for every 10,000 persons above the Federal poverty line.

The Private Attorney Involvement (PAI) project under LSC requires each LSC grantee to spend at least 12.5 percent of its basic field grant on 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. LSC states that data indicates that the PAI requirement is an effective means of leveraging funds, closing a higher percentage of cases per $10,000 of funding with PAI dollars than with dollars 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 divert cases from LSC field offices.

In fiscal year 1982, Congress reduced funding to the LSC by 25 percent (from $321 million to $241 million), resulting in the immediate loss of 1,793 attorneys and the closing of more than 108 local offices, making it more difficult for older persons with legal needs to gain access to legal representation. In fiscal year 1988, there were 324 legal services programs in the 50 States, the District of Columbia, the Virgin Islands, Puerto Rico, Micronesia, and Guam. The number of field program offices in 1988 was approximately 1,150, down from 1,475 in 1981. At the end of 1987, the LSC employed 4,767 attorneys, as compared to 6,559 in 1980.

LSC programs handled and closed 1,421,805 cases in fiscal year 1988. About 13 percent of the cases handled in 1988 involved a client age 60 or older.

Cuts in funding has also meant a decrease in the LSC's ability to meet clients' legal needs. Legal services field offices report having 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 which poor person will be denied service and which will receive legal attention.

An essential component of legal services delivery systems for the elderly is the private bar. 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 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, with little chance of generating a fee for services rendered. 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 to serve the elderly in need of legal assistance has not yet been fully realized.

(B) LEGAL SERVICES CORPORATION

(1) Board Appointments

Since President Reagan took office in 1981, there has been continuing conflict between the White House and the Congress over appointees to the LSC's board of directors. During the summer of 1981, the appointments of all 11 LSC board members appointed by former President Carter expired. President Reagan, however, did not appoint new members of the board until December 1981, after it became apparent that his proposal to terminate the Corporation would not be accepted. Between 1981 and 1984, he appointed a succession of people to the board on an interim basis. Because these appointments were made while Congress was in recess, they could serve without any Senate confirmation. During the same period, President Reagan announced a number of prospective nominees, but none was confirmed by the Senate. Some of them were opposed by liberals and moderates who questioned their qualifications and their commitment to legal services to the poor. Reports in 1982 that LSC board members were receiving extraordinarily large consulting fees for their services and that the LSC president was given unusually generous fringe benefits further affected the nomination process. In 1984, President Reagan granted recess appointments to 11 individuals he had unsuccessfully nominated earlier in the year. These people served without Senate confirmation until the end of 1985. The names of these individuals, however, also were re-submitted formally to the Senate on January 3, 1985, when the Congress convened. Although a couple of the nominees were controversial and faced stiff opposition, all were approved by the Senate Labor and Human Resources Committee and subsequently by the full Senate on June 12, 1985. The Board members appointed in 1984 have continued to serve even when their terms have expired as new board members have not been confirmed by Congress.

(2) Elimination of Legal Services Corporation

Few people disagree that provision of legal services to the elderly is important and necessary. Yet there has been continuing controversy as to how best to provide these services. This dispute was touched off again when President Reagan proposed in 1981 to terminate the federally funded Legal Services Corporation and to include legal services activities in a social services block grant. Funds then going to the Corporation, however, were not proposed for inclusion in the block grant. The block grant approach is consistent with the 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 that allowing States to make funding decisions regarding legal services would make the program accountable to elected officials.

At the time of this proposal, the Administration 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 re-

sparked 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 against the use of group orientation methods on the basis that the poor can be protected only by allocation and litigation procedures which treat each poor person equally as a unique individual and not by procedures which weigh group impact. As a result of these changes, the ability of legal services attorneys to bring class action suits has been severely restricted.

President Reagan also justified his proposal to terminate the Legal Services Corporation by stating his belief that added pro bono efforts by private attorneys could substantially augment legal services funding provided by the block grant. The administration noted that elimination of restrictions on advertising by attorneys would increase the availability of low-cost legal services. They pointed to a Congressionally mandated study which found legal services provided by private attorneys to be as effective as those provided by staff attorneys hired directly by local legal services programs. Their 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. Finally, the administration argued that regardless of the continued existence of LSC, some funding is available at the State and local level for civil legal assistance to truly needy individuals.

The Chairman of the Board of Directors of LSC, in a speech before the ABA's Board of Governors in 1987, also called for the elimination of the LSC. In its place he suggests a system of lay advocates to deliver services to the poor. He maintains that bar associations, motivated by self-interest, prevent more widespread use of paraprofessionals and lay advocates. Opponents of this proposition, including Members of Congress, point out that the founding principle of the LSC was that the poor should have access to professional legal services provided by attorneys.

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 created by 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 move forward to 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 not as likely to have this experience nor are they as likely to have the

interest in dealing with the systematic abuses that poor people encounter.

Defenders of LSC say 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. One author has concluded that only about 15 percent of the legal problems of the poorest segment of the population receive any kind of legal attention. 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 to the whole system of justice. They counted that it is also inconsistent to assure low-income people representation in criminal matters, but not provide them with legal assistance in civil cases.

(3) Elimination of Support Centers

In lieu of the abolition of the LSC entirely, the Administration and the majority of the Board of Directors of the Corporation have also attempted to cut off funds to the national and State support centers, as well as for computer assisted legal research, the clearinghouse, and the network of programs designed to aid migrant workers.

At a meeting in October 1987, the LSC Board approved 6–5 a motion for the cutoff. In the Senate an effort was made to implement LSC's intent in the form of an amendment to the appropriations continuing resolution. However, the Senate viewed the LSC proposal as an attempt to change the structure of the Corporation, instituting in its place a voucher system, and soundly defeated the proposed amendment by a 70–28 vote. It was pointed out during Senate debate that the 17 national support center staffs provide the only in-depth coverage of issues of special importance to poor people—affordable health care and housing, Social Security, consumer problems, welfare, and employment—and, are expert in the interpretations of regulations, statutes, administrative and legislative procedures in these areas.

In 1988, President Reagan, in an appendix to his State of the Union message to Congress, stated his support of actions ensuring that grantees are involved in individual cases and not broader "law reform" activities. The Administration did not request any funding for support centers although for the first time, it did request some funding for LSC. The Corporation, in a revised budget request to match that of the Administration's, justified eliminating the support centers in order to guarantee local control of limited LSC funds.

In a survey of legal services program directors conducted by the LSC itself, 90 percent urged the continuation of national support centers rather than a proportional increase in their own program funding. The $7.2 million that goes to national support centers would provide less than a 3-percent increase for each field program, an increase so small that it would not fill the gap that would be created by the loss of specialized assistance.

(4) Lobbying

The President, for the first time since taking office, requested funding for the Legal Services Corporation for fiscal year 1989. Although the Corporation had initially requested the same funding as fiscal year 1988, the Board of Directors, in a 6–5 vote, decreased its budget request to match that of the Administration.

The Corporation then briefly engaged the services of three Washington law firms to lobby Congress for the decrease. An immediate outcry from Congress led the Corporation to rescind its agreements with the law firms, although the Chairman of the Board of Directors of LSC maintained that the prohibition on lobbying Congress by LSC did not apply to law firms retained by the LSC. An opinion by the Comptroller General on the issue, however, held that the retention of law firms to influence Congress to reduce LSC's appropriations is contrary to the law. A resolution was introduced in the Senate calling for the Corporation Chairman's resignation.

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. At that time, much of the controversy surrounding the program, which grew from a perception that the program was one of social activism and reform rather than routine legal assistance, had abated. Since the early 1980's, however, the controversy as to whether Federal legal aid money is being misused to promote liberal political causes has re-emerged. This is due, in part, to the fact that for fiscal years 1981–88, the Reagan Administration has announced plans not to seek reauthorization of the program and has requested no funding for it. Congress, however, has rejected these proposals and has responded with bipartisan support to restore funding.

Funding for the LSC in its first year was $92.3 million. It rose to its highest level of $321.3 million in fiscal year 1981. In fiscal year 1982, funding for the Corporation was cut by 25 percent to $241 million. Since then, funding for LSC has been at a reduced level.

Although President Reagan 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 directing that provisions regarding legislative and administrative advocacy 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 pub-

lished proposed regulations which 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 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 includes the procedures of appointment, including the political affiliation and length of terms of office of members, and the size, quorum requirements, and committee operations of the governing bodies.

Although the President requested a reduction of $55.5 million for the fiscal year 1988 funding level for LSC for fiscal year 1989, this marked the first time since taking office that the President requested any Federal funds for LSC activities. The Administration did continue, however, to recommend elimination of the national and State support centers, as well as all other programs except for "direct delivery" of services, some support and training, and administrative costs. The LSC Board initially requested $305.5 million, the same funding level as fiscal year 1988. After the Administration submitted its budget, however, the LSC Board voted 6-5 to change its request to match that of the Administration. Congress rejected the Administration's and LSC Board's revised budget and funded LSC at $308.6 million for fiscal year 1989 (P.L. 100-459). The increase of $3.1 million is designated to go to field programs.

Provisions effective in fiscal year 1989 that are continued from past years' appropriations include restructions on lobbying, class action suits, representation of aliens, and 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 the President after January 20, 1989. The new LSC Board of Directors is to develop and implement a system, to take effect after September 30, 1989, for the competitive award of all grants and contracts, including support centers. Congressional intent is to give future confirmed Boards of Directors the opportunity to implement or revise such regulations as they may deem appropriate.

(2) Older Americans Act

In response to prior conflict between legal assistance providers and area agency staff on confidentiality and reporting, the 1987 amendments to the Older Americans Act (OAA) (P.L. 100-175) spe-

cifically provides 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 require the State agency to establish a minimum percentage of Title III B funds which each area agency must spend on legal services and requires the area agencies to spend an adequate proportion of the funds on legal services, defined as the minimum percentage established by the State agency. 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 offer the opportunity for a hearing to any individual or provider who makes such a request. The conference 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.

Four national organizations have continued to receive funding from the Administration on Aging in 1988 to support legal services activities: Legal Counsel for the Elderly (sponsored by the American Association of Retired Persons); the American Bar Association's Commission on Legal Problems of the Elderly; the Center for Social Gerontology; and the National Senior Citizens Law Center. In addition, in 1988, the Administration on Aging awarded grants to three additional national legal service organizations to work with States and area agencies on aging to help vulnerable older individuals with legal problems.

(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 have begun to devote more of their time to the poor on a pro bono basis. These programs are in conformity with the lawyer's code of professional responsibility which requires every lawyer to support the provision of legal services to the disadvantaged. While such 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 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 into federally funded, bar affiliated, and private and nonprofit providers of legal services. 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. The Legal Services Corporation reported receiving $29 million through IOLTA in 1988. An Ameri-

can 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 for those programs serving the elderly. Although many of the IOLTA programs are voluntary, the ABA, passed a resolution at the February 1988 meeting suggesting that IOLTA programs be mandatory in order 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. To this argument, 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, it appears to have potential value as a needed 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. Since 1976, the ABA Young Lawyers Division has had a Committee on the Delivery of Legal Services to the Elderly.

The Commission 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 the 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. Currently, there are 35 State and 12 local bar association committees on the elderly. 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. Nearly 50 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 which 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 released time to provide legal help for eligible older persons. In 1987, 20 Aetna attorneys participated in the program, handling over 140 cases. The Ford Motor Company Office of the General Counsel 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 needs of older Americans for legal help. 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 sevices programs for the elderly exists.

G. PROGNOSIS

Despite Federal funding cutbacks, States will continue to spend as much of their block grant funds on social services for older persons as is 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 call for reinstituting a reporting system.

The Stewart B. McKinney Homeless Assistance Act of 1987 marks the first major piece of legislation that has addressed the homeless 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 they 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 with attention toward 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 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 terms of 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 stringency in 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 laws 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, the continued funding of legal services by the Federal Government and the strengthened efforts of the private bar will be necessary.

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Chapter 13

FEDERAL BUDGET

OVERVIEW

Both President Reagan and Members of Congress expressed concern over increasing reliance on omnibus budget legislation, as epitomized by the December 1987 passage of the over 1,000-page $605 billion appropriations measure for fiscal year 1988, and the even longer reconciliation law. In his final State-of-the-Union Address in January 1988, President Reagan chastised Congress for the omnibus packages and vowed that if still another omnibus appropriations measure followed this year, he would not sign it.[1]

Soon after the President's address, 49 Members of the House of Representatives sent a letter to Speaker Jim Wright, pledging in advance their opposition to future omnibus measures. By the end of February, 34 Senators (an adequate number to sustain a Presidential veto) and 76 Members of the House had forwarded similar letters to President Reagan.

Provisions contained in the 2-year agreement between the President and Congress, resulting from the "Budget Summit" in the fall of 1987 and incorporated in the reconciliation law, limited the scope of action for both the President and the Congress in fiscal 1989 budget considerations. The possibility of an automatically triggered sequestration, as stipulated in the Gramm-Rudman-Hollings deficit reduction law, and its great potential to seriously threaten important defense and domestic programs served to impose constraints and discipline on Congress in its budgetary deliberations. (Sequestration permanently cancels previously allocated budgetary resources to achieve a required amount of outlay savings.)

Developments relating to the Federal budget process in 1988 proved particularly noteworthy largely because of the "return to normalcy" regarding appropriation actions. Following 2 years of omnibus continuing resolutions, in the fall of 1988 Congress completed action on all 13 regular appropriation bills before the start of the new fiscal year on October 1. This was the first time since 1976 (fiscal year 1977) that Congress had avoided the need for even a short-term continuing resolution to tide over funding of the Federal Government at the start of a new fiscal year.

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[1] This chapter was prepared with the assistance of Virginia A. McMurtry, specialist in American National Government, Federal Budget Process Section, Government Division, Congressional Research Service, the Library of Congress.

A. BACKGROUND

1. The Budget Process

The Federal budget process is a prime example of the American Government's concept of shared powers. The provisions of Article 1 of the Constitution relating to the "power of the purse" gives Congress primary control over financial affairs. However, while the budget is not explicitly mentioned in Article II detailing executive powers, the President's general prerogative to see that the laws are faithfully executed makes the President a major partner in the budget process. From the outset, Congress has had to rely on the discretion of executive branch officials to implement the legislative provisions regarding public expenditures.

The Constitution does not contain specific provisions regarding a budget process. Informal procedures were developed and sufficed for many years until the Budget and Accounting Act of 1921 provided the framework for executive budgeting. This law requires the President to submit a consolidated budget proposal to the Congress each year. The President's budget, which has the status of recommendations, provides the starting point for Congressional consideration of upcoming budgetary decisions.

In recent years, Congress has sometimes used the vehicle of a single omnibus continuing resolution to fund the entire Federal Government; this was the case in both fiscal years 1987 and 1988. However, in 1988 there was a return to more traditional budget procedures in the action on measures for fiscal year 1989 with appropriations enacted in 13 separate bills, each of which is in the purview of a subcommittee of the House and Senate Appropriations Committees. Also, according to long-standing Congressional procedures, the Appropriations Committees are supposed to conform to provisions in the "authorizing" legislation, emerging from the various Congressional authorizing committees.

In practice, particularly in recent Congresses, this procedure has not been closely followed. After the enactment of the regular appropriations for a given fiscal year, it is sometimes necessary to provide additional funding in a supplemental appropriations measure. Further, when appropriations laws are not enacted before the start of the fiscal year on October 1, short-term continuing resolutions often are used to provide temporary funding and allow Government operations to continue uninterrupted.

2. Congressional Budget Resolution and Reconciliation Legislation

The budget process underwent substantial change as a result of the Congressional Budget and Impoundment Control Act of 1974. This law sought to restore to Congress some of the fiscal powers had been surrendered over the years to the President by providing for a more coordinated and systematic Congressional decisionmaking approach to the budget. The intent was to improve Congress' ability to view the budget as a whole and also to promote discipline among the authorizing committees.

The 1974 Budget Act established a Congressional budget process centered around a concurrent resolution on the budget, scheduled for adoption prior to legislative consideration of revenue, spending, or debt-limit measures. (The law originally provided for adoption of two budget resolutions each year, but was amended in 1985 to provide for a single resolution to be adopted by April 15.) The budget resolution then sets the parameters for subsequent spending and revenue decisions that are made in separate tax bills, appropriations bills, and other measures.

Another component of the Congressional budget process provided for in the 1974 law and in use since 1980 is the reconciliation process. This is a procedure to change existing laws to conform spending and revenues with the decisions in the budget resolution. The submissions from the committees are assembled by the House and Senate Budget Committees into a single reconciliation measure. According to the timetable, the deadline for action by Congress on reconciliation is supposed to be June 15.

3. Recent Developments

One recent development affecting the Federal budget process was the "Budget Summit" held in the aftermath of the stock market plunge in October 1987. After declining previous requests to meet with Congressional leaders, President Reagan apparently recognized the necessity of bipartisan action to calm the financial markets. A series of meetings, referred to as the Budget Summit between the White House and Congressional leaders ensued. In these negotiations, all elements of the budget, with the exception of Social Security, were on the table.

A compromise Summit Agreement on deficit reduction measures was reached on November 20, 1987. The summit deal proposed a package consisting of new revenues, user fees, spending cuts, and asset sales, projected to net a total savings of $30.2 billion for fiscal year 1988 and $45.9 billion for fiscal year 1989. The agreement stipulated limits on new budget authority and outlays for defense, international affairs, and domestic discretionary spending. In December, Congress enacted two laws to implement the agreement—a full-year omnibus continuing resolution in lieu of separate appropriations bills for fiscal year 1988 (P.L. 100-202), and an omnibus reconciliation measure (P.L. 100-203), to bring entitlement programs and revenues into line with the requirements of the agreement.

The Omnibus Budget Reconciliation Act of 1987 also created the National Economic Commission (NEC), consisting of 14 members to be appointed by Congressional leaders (both majority and minority) and the White House (both President Reagan and the President-elect). The NEC has the mandate of studying the deficit problem and then recommending actions to reduce it, while concurrently promoting economic growth and providing for equitable distribution of any sacrifices entailed by deficit reduction initiatives. Co-chaired by Drew Lewis and Robert Strauss, the NEC suggested that a preliminary report might be available before the end of 1988. However, this did not occur and it appears that the report to the Congress and the President will not be available until at least its

due date of March 1, 1989. Moreover, the final submission might be delayed further as the new President has the authority to extend the deadline to September 1, 1989.

B. THE GRAMM-RUDMAN-HOLLINGS ACT

In recent years, Congress has become increasingly frustrated with its budget process. Efforts to control the deficit in the context of appropriations bills have caused numerous delays and additional differences complicated the ability to produce conference reports. Congress has resorted to a series of continuing resolutions to permit agencies and departments to continue to pay salaries and operate programs until their regular appropriations become law. Reconciliation bills have been delayed further and further each year, to where the reconciliation bill for fiscal year 1986 was not passed until April 6, 1986—more than 6 months after the fiscal year started on October 1, 1985.

The Federal deficit has increased at what most consider to be an alarming rate. The total national debt surpassed the $2 trillion mark in 1985. Concerned about the potentially harmful economic effects of spiraling debt and spurred by constituent pressure to control the deficit, Congress searched for measures to enforce discipline in the budget process and limit Congressional discretion. Measures proposed have included a constitutional amendment to require Congress to report a balanced budget each year and legislation to provide the President with authority to veto individual line items in appropriations bills.

1. History of the Act

The need to raise the debt ceiling above $2 trillion in the fall of 1985 triggered a response in the Senate. In September, Senators Phil Gramm, Warren Rudman, and Earnest Hollings offered an amendment to the debt ceiling bill to reform the budget process by forcing the Congress to achieve specific deficit reduction targets each year to eliminate the deficit by 1991. Early versions of the bill received considerable bipartisan interest from both Houses as well as from the White House. Many Members feared the political and economic consequences of increasing deficit spending, yet were unwilling to set automatic reductions in motion. However, pressures to reduce the deficit were overwhelming and the Balanced Budget Act was signed into Public Law 99-177 in December 1985.

2. Deficit Reduction Targets and Sequestration

Gramm-Rudman-Hollings provides for annual reductions in the budget deficit. To reach the original goal of a balanced budget by fiscal year 1991 (stretched out to fiscal year 1993 by the 1987 amendments), it specifies deficit targets for intervening years. In any year in which deficit targets are exceeded, the excess amount is to be automatically cut from the budget under a process known as sequestration. The act allows for a $10 billion margin-of-error over the deficit target for each year except the last, before sequestration occurs. The 1987 revisions also set maximum sequestrable

amounts for fiscal years 1988 and 1989 at $23 billion and $36 billion respectively.

The Gramm-Rudman sequestration process does not list specific cuts for particular programs, but calls for arbitrary, across-the-board reductions in all programs not specially protected. Only when Congress and the President do not pass a budget within the target limit will automatic spending cuts be set in motion. When this occurs, the excess deficit is to be divided in half, one-half of the cuts are taken from the defense budget and the other half from domestic programs. The act sets up a procedure for calculating the resulting cuts in each program. Cuts in each program must come from unobligated funds. Obligated funds cannot be cut because this would put the Government in a position of breaching numerous contracts and commitments.

Gramm-Rudman-Hollings originally provided that a Presidential sequestration order be triggered automatically upon the issuance of a sequestration report (prepared by the Comptroller General of the General Accounting Office) that projected a deficit for a fiscal year in excess of the amount allowed under the act. This procedure was invalidated in 1986 by the Supreme Court, which, in *Bowsher* v. *Synar*, found the procedure to be unconstitutional because it violated the separation-of-powers principle by vesting executive power in a legislative branch officer. However, in anticipation of the possible invalidation of the automatic triggering procedure, Congress included fallback procedures in the act. These provided for the triggering of sequestration dependent upon the enactment into law of a joint resolution setting forth the contents of the joint Office of Management and Budget/Congressional Budget Office sequestration report. The 1987 revision further modified the process by restoring an automatic mechanism for sequestration, triggered by an OMB report.

3. Reductions in Programs Affecting the Elderly

Gramm-Rudman-Hollings controls the funding for Federal programs in two ways. First, the deficit targets encourage Congress to reduce spending by cutting or even restructuring programs. Second, if targets are not met and sequestration is called for, programs affecting senior citizens would be affected, at least partially, by the automatic cuts. Benefits paid under Social Security, Railroad Retirement Tier I, Medicaid, Food Stamps, SSI, and veterans pensions are fully protected from sequestration. However, no such protection is given to the administrative costs of these programs, and there is a danger that the quality of service might deteriorate.

The Federal civil service and military retirement programs, Railroad Retirement Tier II, and Black Lung disability, originally were subject to reductions up to the full amount of the annual cost-of-living adjustments (COLA's). In fact, as directed by Gramm-Rudman-Hollings, the 3.1 percent COLA's scheduled to go into effect January 1, 1986, were canceled under a Presidential sequestration order and reaffirmed by Congress after the Supreme Court decision. Subsequent legislation, however, has exempted these programs from further sequestrations.

If deficit targets are not met, most health care programs including Medicare, veterans' health care, and community health centers are subject to cuts in excess of inflation, but not more than 2 percent. When a sequester occurred in fiscal year 1986, these programs were reduced by 1 percent. Although benefits were not directly reduced, payments to health care providers were cut, straining hospital resources. Further abrupt reductions in payment levels could result in reduced quality of care for Medicare and Medicaid beneficiaries.

Other domestic programs on which the elderly depend are vulnerable to unlimited across-the-board reductions based on a uniform percentage of current spending. When exempted and specially treated programs are removed from nondefense spending, approximately one-sixth of total outlays remain and these programs are particularly vulnerable to severe reductions. In fiscal year 1986, for example, programs that provide important services such as housing, low-income energy assistance, older Americans programs, social services, transportation, health research into Alzheimer's and other diseases, block grants, and home weatherization projects were cut by 4.3 percent.

4. Legislation Affecting Gramm-Rudman-Hollings in 1987

At the conclusion of the second session of the 99th Congress in 1986, it was evident that Congressional budget reform would be an important issue before the 100th Congress. Despite some notable legislative accomplishments, such as the Tax Reform Act of 1986, Members expressed continued dissatisfaction with the outcome of Federal budget policies and the operation of legislative budgeting procedures.

Much of the criticism focused on the level of the deficit. Although sequestration had been avoided for fiscal year 1987 by the enactment of several deficit reduction measures, some Members predicted that the actual deficit would exceed the target by a wide margin, like in fiscal year 1986, because of unduly optimistic economic assumptions and other factors. Additionally, some Members complained that the two principal deficit reduction measures for fiscal year 1987, the Tax Reform Act and the Omnibus Budget Reconciliation Act of 1986, would make deficit reduction even harder in future years. Reconciliation, they maintained, relied on the use of gimmicks such as postponing payments so that they fall into the next fiscal year, and one-shot savings like selling Federal loan assets next fiscal year, and one-shot savings like selling Federal loan assets. The tax reform law was expected to reduce the fiscal year 1987 deficit by about $11 billion, but add $15 billion or so to the deficits for fiscal years 1988 and 1989.

In August 1987, the Senate passed a measure raising the debt limit with an amendment restoring an automatic sequestration trigger. (This was in response to the 1986 Supreme Court ruling which invalidated the automatic trigger for sequestration.) The House and Senate did not go to conference on the sequestration proposal, however, and Congress extended the debt limit until May 15, 1987. Proponents of the automatic sequestration trigger vowed to renew their efforts at that time.

The initial OMB/CBO joint sequestration report for fiscal year 1988, issued in August 1987, projected a fiscal year 1988 deficit of $153 billion—$45 billion above the statutory target. Sequestration implemented according to the terms of this report (without any modification of the deficit target) would have required that outlays be reduced by 12.9 percent for defense programs and 19 percent for nondefense programs. There was widespread agreement that cuts of this magnitude not only would be overly severe, but also could actually harm the economy.

After months of debate about how to fix the Gramm-Rudman-Hollings sequestration process and modify the deficit targets, Congress in September 1987 enacted changes in the 1985 Balanced Budget Act as part of H.J. Res. 324 extending the permanent statutory limit on the public debt. The two major purposes of these changes were to restore the automatic trigger for sequestration that had been invalidated by the Supreme Court and modify the timetable for achieving a balanced budget in light of persistently high deficits. (See table 1.)

TABLE 1.—ORIGINAL AND REVISED DEFICIT TARGETS IN THE 1985 BALANCED BUDGET ACT AS AMENDED

[Amounts in billions]

	Original target	Revised target
Fiscal year:		
1986	171.9	.....
1987	144	.....
1988	108	144
1989	72	136
1990	36	100
1991	0	64
1992	.....	28
1993	.....	0

C. BUDGET LEGISLATION

1. Administration's Proposals for Fiscal Year 1989

President Reagan submitted his budget proposal for fiscal year 1989 to Congress on February 18, 1988 (although due in early January, the President's Budget was delayed because of the late action on appropriations for fiscal year 1988. On the basis of the economic assumptions put forth by the Office of Management and Budget, the President's Budget adhered to the 1987 Summit Agreement and projected a deficit of $129.5 billion, somewhat under the revised Gramm-Rudman-Hollings target for fiscal year 1989 of $136 billion.

In domestic programs, the President proposed the largest reductions in outlays for energy programs, commerce and housing credit, and community and regional development. The President proposed smaller reductions in some human-resources programs, including Medicare. The President requested increases in three major functional areas—general science, space and technology, and the administration of justice.

2. Congressional Budget Resolution

With the constraints of the Summit Agreement and the Gramm-Rudman-Hollings deficit likewise limiting its scope of action for budgetary decisions in 1988, Congress turned quickly to the fiscal year 1989 budget process, with the House approving the budget resolution (H. Con. Res. 268) on March 23, by a vote of 319–102. The Senate approved the measure, as amended, on April 14, by a vote of 69–26. Despite this early start, final adoption of the budget resolution did not occur until well past the April 15 deadline, due to extended deliberations in conference. As approved by the House on May 26, by a vote of 201–181 and by the Senate on June 6, by a vote of 58–29, the fiscal year budget resolution provided for $1.1 trillion in spending, $964 billion in revenues, and a deficit of $135 billion.

During consideration of the budget resolution Congress addressed some budget reform issues, a practice seen in previous years as well. For example, the fiscal year 1989 resolution contained "sense of the Congress" language regarding the budgetary treatment of trust funds, asset sales and loan prepayments. It also stipulated that certain legislative initiatives for fiscal year 1989, such as catastrophic health insurance, drug control, and welfare reform must be deficit-neutral.

3. Appropriation Measures

The 1987 Budget Summit Agreement stipulated that supplemental funding for fiscal year 1988 was to be considered only in cases of "dire emergencies," but the precise import of this phrase became subject to debate. In April 1988, a supplemental bill, providing $709 million in emergency funding for certain veterans programs, was enacted as Public Law 100–304. President Reagan had requested this funding in order to keep the veterans housing programs afloat, along with moneys for mandated spending for veterans education, training assistance, and rehabilitation programs.

A second supplemental appropriations bill, providing $672 million in funding for "dire emergencies" in various Government agencies, was enacted in August (P.L. 100–393). Over $500 million in this second supplemental went to the Veterans Administration as well, with the remainder destined for several programs that were quickly running out of funds, including assistance for State employment offices, emergency assistance to Soviet and other political refugees, Trade Adjustment Assistance, black-lung disability, and small business disaster relief.

Congress completed action on all 13 of the regular appropriation bills for fiscal year 1989 by September 30, 1988. However, final action on some of the bills occurred close to midnight, and so five measures were not signed by the President until October 1, 1988. Congress did not quite meet the "deadline," last achieved in 1948, of having all the appropriation bills signed by the President before the end of the fiscal year. But the 1988 achievement was significant in that Congress avoided the need for a continuing resolution to tide funding for the Federal Government over even temporarily at the start of a new fiscal year, a feat last achieved in 1976.

The revised Gramm-Rudman-Hollings deficit target for fiscal year 1989 was $136 billion. On October 15, 1988, the President issued a final sequestration order for fiscal year 1989, indicating that no spending cuts were required. While the deficit was projected at $145.5 billion, the amount remained within the $10 billion margin over the target that must be exceeded before sequestration is triggered.

D. PROGNOSIS

The 1987 budget summit marked an important watershed for significant Federal actions to reduce the deficit. It arguably was the first year during the 2-term reign of the Reagan Administration that both the Congress and the executive branch actively and successfully worked together toward achieving notable deficit reduction. As a result, budget deliberations during 1988 were significant because of the generally more cooperative manner that marked the development of the fiscal year 1989 budget. However, without the benefit of another budget summit agreement, there is concern that deliberations on the fiscal year 1990 budget will be much more difficult.

Recognizing the potential for partisan conflict, President Bush has attempted to bolster and extend his "honeymoon" with the Congress by promising to work with the Congress in a nonconfrontational, bipartisan manner. Cooperation between the Congress and the President, however, historically has never been a given and, particularly in light of the fact that the Gramm-Rudman-Hollings deficit reduction target for fiscal year 1990 drops to a very difficult to reach $100 billion, there is little doubt that there will be disputes about budget priorities and the budget process.

Disputes on the budget started early in 1989, when President Reagan submitted his last budget for fiscal year 1990. Beyond the Social Security program and the National Institutes of Health, programs serving the elderly did not fare well. For example, Medicare, Medicaid, Federal housing programs for the elderly, and civil service, military and railroad retirement programs were targeted for significant cuts. Advocates for older Americans became concerned because they feared President Bush's upcoming budget proposal would largely mirror President Reagan's proposal.

These fears were found to have been largely justified as President Bush's February 9, 1989, budget proposal, while not being as severe and specific, was very similar to the January budget submission. Among a number of proposals of concern was his $5 billion-plus proposed reduction in the Medicare Program ($2 billion of which would come from unspecified cuts) and savings of $1.4 billion from his proposal to freeze civilian, military and railroad (Tier II) retirees cost-of-living adjustment raised particular concerns.

Adding insult to injury, President Bush and his Administration was criticized for using what were viewed as overly optimistic economic assumptions. As a result, the Senate Budget Committee scored his proposals as falling $15 billion short of the required $100 billion deficit target required by the Gramm-Rudman-Hollings law. If the Budget Committee's estimate is correct, there will be even greater pressures to cut programs serving older Americans, par-

ticularly if the Congress and the Administration refuse to look at revenue raising options.

At the time of this writing, most prognosticators had concluded that the Bush honeymoon could not last too much longer. They based this conclusion on the belief that the Congress would be unwilling to take the political heat for the painful budget proposals necessary to reduce the Federal deficit. Some believe, however, that a bipartisan compromise on the budget can be achieved if the new President continues his positive gestures to the Congress and if all parties are willing to get together to craft a budget agreement similar to the 1987 2-year budget summit agreement.

Absent some kind of bipartisan agreement, it may be difficult to avoid the pressures and delays conducive to the inevitability of an omnibus continuing resolution and an omnibus reconciliation measure. At minimum, completing action on all the regular appropriation bills before the start of the fiscal year, as occurred in 1988, will be a most difficult achievement.

If an agreement on reducing the deficit cannot be reached, the Gramm-Rudman-Hollings budget-cutting measure looms in the background ready to make its across-the-board cuts. With these unknown variables in mind, aging advocates will continue to closely monitor congressional budget activity on programs affecting the elderly during 1989.

SUPPLEMENTAL MATERIAL

Supplement 1

1988 HEARINGS HELD BEFORE THE SENATE SPECIAL COMMITTEE ON AGING

Long-Term Care: From Housing and Health to Human Services, Minneapolis, MN, January 5, 1988, Hon. Dave Durenberger, Presiding

Witnesses

Steve Keefe, chairman, Metropolitan Council
Sandra Gardebring, commissioner, Minnesota Department of Human Services
Jim Solem, executive director, Minnesota State Housing Finance Agency.
Dr. Robert Kane, dean, University of Minnesota School of Public Health
Cynthia Polich, president, Interstudy
Etta Furlow, citizen, long-term care consumer
Gladys Murray, citizen, long-term care consumer
Iris Freeman, Minnesota Alliance for Health Care Consumers
Harold Berntsen, chairman, Long-Term Care Committee, Metropolitan Senior Federation
Dale Thompson, CEO, Cambridge Nursing Home
Gayle Kenvold, executive vice president, Minnesota Association of Homes for the Aging
Pat Adams, director, Dakota County Public Nursing Service
Adele Mehta, case manager, Senior Community Services
Sally Knutson, medical personnel pool
Peter Falkman, director, LifeScope, Northwestern National Life Insurance
Lloyd Pearson, human services, Honeywell Corporation
John Drozdal, product administration, Blue Cross/Blue Shield
Charlaine Tolkien, H.R. Generalist Services, IDS Financial Services Corporation
Ron Johnson, president, Senior Care Services

Issues Raised and Testimony Summary

This was the first of 12 hearings and forums which were held around the State of Minnesota. The hearings were convened to hear some of the state's most experienced and knowledgeable people speak on health care issues, including long-term care, and to help define the State and community long-term care problems.

Results of a recent study by AARP shows that 81 percent of Americans have had, or expect to have, direct experience with long-term care, which is uniquely intergenerational in nature. Senator Durenberger's Long-Term Care Initiative was discussed. It includes:

* Tax incentives for long-term care insurance;
* Tax-deferred long-term care savings accounts;
* High quality standards for nursing homes;
* Tough standards for long-term care insurance;
* Support for hone health care and other support services;
* Assistance to families providing long-term care;
* Congregate housing and home sharing options; and
* Home equity conversion financing for long-term care services.

Witnesses were divided into four panels to discuss the long-term care issues from the perspectives of government, providers of care, consumers of care, insurers and employers. It was pointed out that factors which impact the long-term care issue include services and assistance programs, such as health, social, housing and income, are needed over an extended period of time by the chronically ill and physically disabled of all ages.

The Social Security Notch: Justice or Injustice? Washington, D.C., February 22, 1988, Hon. John Melcher, Chairman, Presiding

Witnesses

Senator Terry Sanford, North Carolina
J. Daryl Cooper, president, Notch Committee to Correct Inequities in Social Security and Medicare, Inc
Michael C. Carozza, Deputy Commissioner for Policy and External Affairs, Social Security Administration
Mary Alice Magness, Anaconda, MT, aide to the elderly at Home Health.
Anthony Purcell, Sr., chairman, Notch Babies Organization
Arthur Flemming, co-chairman, Save Our Security
James Roosevelt, Jr., National Committee to Preserve Social Security and Medicare, accompanied by: G. Allen Johnston, director, Grassroots Activities and Membership Services; Edith Detviler, member; and Audrey Webb, member

Issues Raised and Testimony Summary

The purpose of the hearing was to examine the inequities in the Social Security "notch" issue and attempt to assist Congress in reaching a fair solution to the problem, while maintaining the integrity of the system and ensuring the continued solvency of the trust funds.

Senator Terry Sanford of North Carolina discussed his bill, the "Social Security Notch Adjustment Act" (S. 1830), which is designed as a compromise proposal. It increases benefits for individuals born between 1917 and 1929 and would correct the notch in a gradual manner. Sanford testified that while the legislation would increase Old Age Survivors Insurance (OASI) expenditures by 2 1/2 percent, it would save $4 billion over a 10-year period by eliminating future double indexed benefit increases to babies born before 1917 that have been denied to notch babies. The Act would allow those individuals born between 1917 and later to use four additional years of earnings, through age 65, in calculating their retirement benefits. It also

includes a one-time retroactive payment limited to not more than $1,000.

The Social Security Platform Resolutions adopted by the "Notch Babies Grass Roots Coalition" across the United States were presented to the Committee by Anthony Purcell, Sr.

Dr. Arthur Flemming, co-chairman of Save Our Security, emphasized that if Congress decides to remedy the notch controversy and increase benefits, then it also must find additional revenue.

Adverse Drug Reactions: Are Safeguards Adequate for the Elderly? Washington, D.C., March 25, 1988, Hon. John Melcher, Chairman, Presiding

Witnesses

Ms. Ann Little, Gray, TN
Ms. Wilda Henry, Golden Gate, FL
J.W Colinger, Jr., M.D., medical director, Life Care Center Nursing Home, Erwin, TN
Jerry Avorn, M.D., director, Program for the Analysis of Clinical Strategies, Department of Social Medicine and Health Policy, Harvard Medical School
William Simonson, Pharm.D., associate professor of pharmacy, College of Pharmacy, Oregon State University

Issues Raised and Testimony Summary

The hearing was convened to highlight the numerous health and cost concerns related to adverse drug reactions within the elderly population and to explore ways of reducing serious and costly adverse drug reactions and interactions in this particularly vulnerable group.

It was pointed out that although older Americans represent only 12 percent of the population, they consume one-third of all prescription drugs and also, are far more vulnerable, physically and psychologically, to adverse drug reactions and interactions. Chairman Melcher offered several options that should be considered by Congress to address the special needs and problems of the drug-consuming elderly public. It also was noted that the Surgeon General's "Workshop on Health Promotion and Aging," has issued 33 recommendations concerning education, service, research and policy. These were included in the record.

Dr. Jerry Avorn cited examples of programs that have been put into place by the Harvard Medical School on a demonstration basis and have been verified as being effective in reducing the "informational deficit" that hits the elderly patients the hardest. These include using pharmacists as outreach educators of physicians, and "unadvertisements" as tools to reach out into the communities and reduce excessive drug use. Data published in the medical literature confirms that these programs save money, reduce a great deal of illness and suffering, but can save the health care system money by paying for itself.

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Vanishing Nurses: Diminishing Care, Philadelphia, PA, April 6, 1988, Hon. John Heinz, Presiding

Witnesses

Marie W., R.N., CCRN, staff nurse/charge nurse, intensive care
Joann B., R.N.
Richard Loughery, Special Assistant to the Secretary, Department of Health and Human Services
Patricia Prescott, BSN, Ph.D., University of Maryland
Perry Pepper, president, Chester County Hospital, chairman of the board, Hospital Association of Pennsylvania, and delegate, American Hospital Association
Mary Naylor, Ph.D., F.A.A.N., R.N. asoociate dean and director of undergraduate studies, University of Pennsylvania, School of Nursing
Paul Willging, Ph.D., executive director, American Health Care Association
George McNeal, M.D., chief of staff, VA Medical Center, Philadelphia, PA

Issues Raised and Testimony Summary

The hearing was held to review the perceived shortage of qualified nursing staff across the country. Testimony from witnesses underscored the fact that while there are more nurses today than there have been at any time during the past, the demand has never been greater. It was implied in the statement from Dr. Willging that the reason for the shortage may, in part, be due to the greater number of career opportunities available to women than in the past. The majority of the panel concurred that the exodus from the nursing profession might be stemmed if the financial reward and esteem accorded to nurses was raised to a scale in proportion to the level of work involved. It was suggested that this level might be arrived at by means of a comparable-pay formula with respect to jobs generally held by men.

Adult Day Health Care: A Vital Component of Long-Term Care, Washington, D.C., April 18, 1988, Hon. John Melcher, Chairman, Presiding

Witnesses

Gretchen Meinke, administrative director, San Francisco Adult Day Health Network
George and Jean Glakas, Falls Church, VA
Lou Glasse, president, Older Women's League, accompanied by Laurie Shields, co-founder, Older Women's League
Don Peterson, executive vice president, St John's Lutheran Home, Billings, MT
Kay Larmer, chairperson, National Institute on Adult Daycare, National Council on Aging

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Ellen Shillinglaw, director, Office of Legislation and Policy, Health Care Financing Administration
Carol Kurland, administrator, Office of Home Care Programs, New Jersey Department of Human Services

Issues Raised and Testimony Summary

The hearing was held to examine the role of adult day health care as a vital component of long-term care. Testimony focused on how adult day care programs around the country assist frail elderly and disabled adult participants and their family caregivers, as well as how effective they are in saving costs and delaying or preventing the elderly from having to enter a nursing home.

Over the past 10 years, more than 1,400 programs have grown rapidly at the grassroots level around the country. Most are financed by a patchwork of public and private funds, philanthropic donations and private client fees. For the most part, however, they lack a stable base of funding.

Advances in Aging Research, Washington, D.C., May 11, 1988, Hon. John Melcher, Chairman, Presiding

Witnesses

Daniel Perry, executive director, Alliance for Aging Research, Washington, D.C.
Allan L. Goldstein, Ph.D., professor and chairman, Department of Biochemistry, George Washington University, Washington, D.C.
Trudy L. Bush, Ph.D., MHS, assistant professor, the Johns Hopkins University School of Hygiene and Public Health, Department of Epidemiology, Baltimore, MD
Carl W. Cotman, Ph.D., professor, University of California, Irvine, School of Medicine, Department of Psychobiology, Irvine, CA
David Kritchevsky, associate director, Wister Institute of Anatomy and Biology, Philadelphia, PA
George G. Glenner, M.D., professor, University of California, San Diego, School of Medicine, Department of Pathology, La Jolla, CA
Takashi Makinodan, Ph.D., director, Geriatric Research, Education and Clinical Center, VA Wadsworth Medical Center, Los Angeles, CA
Gino Doria, M.D., Euratom Biological Division, Laboratory Radiobiology Animal CSN., Casaccia, Rome, Italy
Dr. William B. Ershler, director of gerontology, associate professor of Medicine, University of Wisconsin Medical Sciences Center, Madison, WI

Issues Raised and Testimony Summary

The purpose of the hearing was to investigate the recent advances in medical research and to see what dividends the elderly will reap from such progress. Witnesses emphasized the necessity of coordinating national and international efforts in fighting disabling diseases such as Alzheimer's and cancer.

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A recurring theme brought up in testimony targeted the fact that funding for research is not commensurate with the amount of money needed to care for individuals afflicted with the diseases affecting the elderly. While the cost of treating Alzheimer's disease alone costs approximately $50 billion a year, total annual federal funding for research in all areas of dementia is little more than one one-thousandth of that figure. Yet, the problems posed by diseases that characteristically afflict the elderly were found to have vast implications for younger generations as well. For example, Dr. Glenner testified that recent findings indicated that Alzheimer's is "irrevocably linked" to Down's syndrome, and it was generally agreed that more discoveries would breach old notions about the generational exclusivity of certain maladies.

Kickbacks in Cataract Surgery, Philadelphia, PA, May 23, 1988, Hon. John Heinz, Presiding

Witnesses

Glenn Pomerance, M.D., Ooltewah, TN
Charles Wright, M.D., Kinston, NC
Isabella McGee, Salt Lake City, UT
Mary Sugarmann, Pittsburgh, PA
Bryan Mitchell, Deputy Inspector General, U.S. Office of Inspector General, Washington, DC
Hunter Stokes, M.D., Secretary for Government Relations, American Academy of Opthamology, Washington, DC
Harvey Hanlen, O.D., Chairman, Federal Relations Committee, American Optometric Association, Washington, DC
Charles Booth, Director, Office of Reimbursement Policy, Health Care Financing Administration, Washington, DC
Eric Kriss, President and Chairman, MediVision, Inc., Boston, MA

Issues Raised and Testimony Summary

The purpose of the hearing was to examine the role of patient referrals in the relationship between opthamologists and optometrists. Opthamologists are surgeons who specialize in diseases of the eye and who rely, in large part, on optometrists for patient referrals. Optometrists do vision screening and testing, prescribe corrective lenses, and with the advent of legislative changes in 1980 and 1986, may provide and charge Medicare for services provided to cataract patients after surgery -- services only opthamologists were paid for in the past. The hearing was convened as a result of the concern expressed that the result of the current referral procedure is based on financial reward instead of good patient care.

Testimony focused on the managers, brokers, and other middlemen who help assemble and operate these networks and the effect of such networks upon the cost of care for the elderly. Under discussion was the degree to which Congress and the Health Care Financing Administration may have contributed to the problem of kickbacks. In 1986, Congress enacted legislation that permitted reimbursement of

optometrists as physicians for any procedures they were licensed by the State to perform.

Information from patients, surgeons and a panel of experts revealed that recent legislation may have opened the door to highly questionable referral agreements and kickbacks between willing surgeons and optometrists. It was suggested that Congress make changes in the reimbursement of cataract surgery and set standards as conditions for Medicare reimbursement.

The Rural Health Care Challenge, Part I, Washington, D.C., June 13, 1988, Hon. John Melcher, Presiding

Witnesses

Sam M. Cordes, Ph.D., member, National Advisory Committee on Rural Health; professor, University of Wyoming, Laramie, WY
Michael E. Cooper, administrator, Richland Parish Hospitals, Rayville, LA, accompanied by John Jurovich, vice president, Louisiana Hospital Association
Jim Oliverson, trustee, Montana Hospital Association; administrator, St. Luke's Community Hospital, Ronan, MT
J. Patrick Hart, Ph.D., director, Office of Rural Health Services, Center for Rural Health Services, Grand Forks, ND
Timothy K. Size, board member, National Rural Health Care Association; executive director, Rural Wisconsin Hospital Cooperative, Sauk City, WI
C. Ross Anthony, Ph.D., Associate Administrator for Program Development, Health Care Financing Administration, Washington, DC

Issues Raised and Testimony Summary

There were two hearings convened in order to look at the problems facing rural health care. The first, held on June 13, 1988, looked at the problems the current status of rural hospitals and their ability to provide adequate care. One of the main issues confronting the panel was the disparity in Medicare and Medicaid reimbursement rates between rural health care providers and their urban counterparts.

Witnesses testified that under the Prospective Payment System (PPS), rural hospitals were reimbursed at a rate at least 20% lower than urban hospitals, even though rural providers had to compete with urban facilities that could afford the profitable but expensive technologies, such as CAT scans. The PPS is a formula that pays care providers according to their efficiency. Submitted testimony affirmed that it was seldom possible for a rural hospital to be as efficient as a metropolitan one because of the nature of the locale, both geographically and financially. In a related disclosure, of the 289 hospitals that lost money under the prospective payment system for fiscal years 1984-86, 241 of those hospitals were located in rural areas.

It was proposed the Health Care Financing Administration (HCFA) restructure the wage index used to formulate the Prospective Payment

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System (PPS) so that reimbursement rates for rural and urban hospitals would be more equitable.

The EEOC's Performance in Enforcing the Age Discrimination in Employment Act, Washington, D.C., June 23 and 24, 1988, Hon. John Melcher, Chairman, Presiding

Witnesses

Joseph Bennett, Director, Office of Human Rights, Alexandria, VA, former Director, EEOC, Region II
Lynn Bruner, Director, St. Louis District Office, EEOC
Donald Muse, Director, Birmingham District Office, EEOC
Hermilio Gloria, Director, Phoenix District Office, EEOC
Vanessa Hannah, Investigator, Birmingham District Office, EEOC
Levi Morrow, Senior Investigator, Dallas District Office, EEOC
Michael O'Dell, social science analyst, General Accounting Office Detailee
Howard Rhile, Associate Director, Information, Management and Technology Division, General Accounting Office
Harriet J. Ehrlich, Director, Houston District Office, EEOC
R. Edison Elkins, Director, Charlotte District Office, EEOC
Clarence Thomas, Chairman, EEOC, accompanied by James Troy, Director, Office of Program Operations

Issues Raised and Testimony Summary

The purpose of these hearings was threefold: (1) to determine to what extent the Equal Employment Opportunity Commission (EEOC) had failed to enforce the Age Discrimination in Employment Act (ADEA); (2) to determine the causes of the EEOC's failure; and (3), to explore potential preventative measures in order to guard against further failure on the part of the EEOC.

A year-long investigation, including three hearings conducted in September 1987 and June 1988, established that the EEOC had permitted as many as 8,800 ADEA charges to exceed the Act's two-year statute of limitations over a four year period, beginning in 1984. Consequently, thousands of charging parties had been deprived of their right to seek legal remedy in their age discrimination cases.

Testimony of EEOC investigators and managers indicated that the agency's failure was due primarily to a lack of adequate resources, a faulty computerized charge tracking system and mismanagement.

The investigation led to enactment of the Age Discrimination Claims Assistance Act (ADCAA) in April 1988. The Act required the EEOC to identify and notify all individuals whose ADEA charges had been filed beginning on January 1, 1984, and had been permitted to exceed the statute of limitations prior to resolution. The Act further provided that these charging parties and the EEOC would be given an additional 18 months from the date of enactment of the ADCAA to resolve these expired charges. The Committee also requested the General Accounting Office to evaluate the EEOC's computerized charge tracking system and make recommendations on what improvements are

needed to ensure efficiency, effectiveness and economy in its operations.

The Rural Health Care Challenge, Part II, Washington, D.C., July 11, 1988, Hon. John Melcher, Chairman, Presiding

Witnesses

Sandral Hullett-Robertson, M.D., director, West Alabama Health Services, Eutaw, AL
James L. May, executive director, Northwest Health Services, Mound City, MO
Pat Nessland, R.N., director of nursing, Frances Mahon Deaconess Hospital, Glasgow, MT
Kevin M. Fickenscher, M.D., director, Center for Rural Health Services Research and Services Administration, U.S. Department of Health and Human Services, accompanied by Jeffrey Human, Director, Office of Rural Health Policy
David N. Sundwall, M.D., Administrator, Health Resources and Services Administration, U.S. Department of Health and Human Services, accompanied by Jeffrey Human, Director, Office of Rural Health Policy

Issues Raised and Testimony Summary

The purpose of the second of the two hearings on rural health care was to investigate the issues facing rural health care personnel in their effort to provide adequate services to residents in sparsely populated areas. Witness testimony highlighted the need to recruit health care professionals into the rural setting and it was suggested that a decrease in support for the National Health Service Corps would adversely affect the plight of rural health providers. The National Health Service Corps was instituted in order to deal with the shortage of physicians in less populated regions across the Nation by offering medical school scholarships to those who, among other stipulations, agree to dedicate a specified time in their practice to rural areas immediately after graduating. While much testimony was in support of the program, some Members believed that more money alone would not make the program more effective. What was needed, it was felt, was an enhanced system of distribution of the participating physicians.

The American Indian Elderly: The Forgotten Population, Pine Ridge, SD, July 21, 1988, Hon. Larry Pressler, Presiding

Witnesses

David Merwin, acting administrator, Bennett County Hospital, Martin, SD
Francis Swift Bird, director, Felix S. Cohen Home, Pine Ridge, SD
Geraldine Janis, director, Oglala Sioux Tribe's Community Health Representative Program, Pine Ridge, SD
Iyonne Garreau, director, Sioux Nation Commission on Aging

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Elaine Quiver, director, Foster Grandparent Program, Pine Ridge, SD
Frank Marshall, Fifth Member, Oglala Sioux Tribe
Chief Oliver Red Cloud, chairman, Eight Reservation of Old People
Vernon Ashley, Pierre, SD, former State program director, ACTION
Royal Bull Bear, Kyle, SD
Marie Randall, Wamblee, SD
Cecelia Montgomery, Wa Wo Kiye Os-piyea Elderly Program, Rapid City, SD

Issues Raised and Testimony Summary

The purpose of the hearing was to gather recommendations from individuals and Native American community groups in order to develop comprehensive legislation that would address the needs of elderly Native Americans. Representatives of area nursing homes, health programs, and state and Federal agencies submitted testimony outlining concerns and proposals to meet those concerns. Witnesses indicated the need for reservations to have greater access to health care facilities, as well the need for those facilities to be adequately staffed. Yet, concerns were not limited to the conditions of health care facilities on reservations. Testimony indicated that even in metropolitan areas, the health status of the Native American elderly was generally lower than the rest of the elderly population.

Rural Health Care Delivery in Arkansas: Impact on the Elderly, Pine Bluff, AR, August 30, 1988, Hon. David Pryor, Presiding

Witnesses

Joycelyn Elders, M.D., director, Arkansas Department of Health, Little Rock, AR
Roger Busfield, M.D., president, Arkansas Hospital Association, Little Rock, AR
Jerry Campbell, administrator, Johnson County Regional Hospital, Clarksville, AR
Franklin Montgomery, former administrator, Lee Memorial Hospital, Marianna, AR
Jerry Campbell, administrator, Johnson County Regional Hospital, Clarksville, AR
Mary O'Rourke, retired schoolteacher/volunteer with Area Agency on Aging, DeValls Bluff, AR
Hon. Tom Catlett, county judge, Monroe County; president, Mid-delta Rural Health Clinic, Clarendon, AR
DeWayne Nash, M.D., physician, National Health Service Corps, M & S Clinic, Camden, AR
Wayne Waller, M.D., physician, National Health Service Corps, director, Jefferson Comprehensive Care Center, Pine Bluff, AR
Betty Bradshaw, director, Southeast Arkansas Area Agency on Aging, Pine Bluff, AR
Herb Sanderson, director, Office of Aging and Adult Services, Arkansas Department of Human Services, Little Rock, AR
Wayne Sanders, owner, Hempstead County Ambulance Service, Inc., Hope, AR

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Gary L. Hughes, administrator, Arkansas Home Health Agency; president, Arkansas Association of Home Health Agencies, Little Rock, AR
Frank M. Butts, CPA, partner, Frost & Co., Little Rock, AR

Issues Raised and Testimony Summary

The hearing convened in order to explore the reasons for the disparity in health service between rural and metropolitan areas in Arkansas. While 58 of the 75 counties in Arkansas have been designated as rural, only 31% of the physicians in Arkansas practice in those regions. With Arkansas second only to Florida in terms of the per capita elderly population, access to adequate health care in the less populated areas of the State was considered essential.

The hearing focused on a broad range of issues, including the closing of hospitals and the shortage of manpower in sparsely populated areas. Witnesses from the health care profession complained that Medicare reimbursement for services was often hindered by the nature and amount of paperwork required under the Prospective Payment System. It was found that many forms were unclear in their requests, and those that were readily understood asked for redundant information. Administrators testified that, on occasion, Medicare/Medicaid reimbursement did not justify the time it took to process the information required for the forms. Several witnesses also questioned the wage index as an adequate criterion by which to construct the PPS for rural areas.

In terms of services rendered, testimony pointed to the short supply of ambulances and other transportation needed to afford access to health care for elderly residents in rural areas. In general, testimony reinforced the notion of a two-tier health care system; one for urban and one for rural residents. The consensus of the hearing was that Congress must act quickly to eradicate the urban/rural differential.

Cost of Living Adjustments and the CPI: A Question of Fairness, Washington, D.C., October 5, 1988, Hon. John Melcher, Chairman, Presiding

Witnesses

Janet Norwood, Commissioner, Bureau of Labor Statistics, U.S. Department of Labor
Harry Ballantyne, Chief Actuary, Social Security Administration, U.S. Department of Health and Human Services
Gorham L. Black, national legislative council, American Association of Retired Persons
Mary Jane Yarrington, senior policy analyst, National Committee to Preserve Social Security and Medicare

Issues Raised and Testimony Summary

The purpose of the hearing was to examine the shortcomings of the currently used Consumer Price Index (the CPI-W) as a basis for determining the cost-of-living adjustments (COLAs) for the elderly and other recipients of Federally-financed COLAs. The questions posed to

the witnesses by the Committee focused primarily on the desirability of moving to another inflation index, already in use by the Federal Government -- the CPI-U, for the purpose of calculating COLAs. The use of the CPI-U was viewed as preferable to the CPI-W because it includes elderly retirees in its sample, while the CPI-W does not. While the desirability of an entirely separate index for the elderly was considered, it was felt that budget and time considerations would argue for the use of the already-in-place CPI-U.

Supplement 2

COMMITTEE PRINTS AND REPORTS PRINTED BY THE SPECIAL COMMITTEE ON AGING IN 1988

Helping Older Americans To Avoid Overpayment of Income Taxes, committee print, January 1988, Serial No. 100-D.
Publications List, committee print, February 1988, Serial No. 100-E.
Developments in Aging: 1987 - Volume 1 - Report No. 100-291, February, 1988.
Developments in Aging: 1987 - Volume 2 - Report No. 100-291, February, 1988.
Developments in Aging: 1987 - Volume 3 - Report No. 100-291, February, 1988.
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.
Health Insurance and the Uninsured: Background and Analysis, joint committee print, May 1988, Serial No. 100-I.
Legislative Agenda for an Aging Society: 1988 and Beyond, joint committee print, June 1988, Serial No. 100-J.
Medicare Physician Reimbursement: Issues and Options, committee print, September 1988, Serial No. 100-L.
Medicare's New Prescription Drug Coverage: A Big Step Forward, But Problems Still Exist, committee print, October 1988, Serial No. 100-M.
Rural Health Care Challenge, committee print, October 1988, Serial No. 100-N.
Insuring the Uninsured: Options and Analysis, joint committee print, December 1988, Serial No. 100-O.
Cost and Effects of Extending Health Insurance Coverage, joint committee print, December 1988, Serial No. 100-P.
EEOC Headquarters Officials Punish District Director for Exposing Headquarters Mismanagement, committee print, December 1988, Serial No. 100-Q.

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Supplement 3

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100TH CONGRESS, SECOND SESSION

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Supplement 4

PUBLICATIONS LIST

HOW TO ORDER COPIES OF COMMITTEE HEARINGS, REPORTS, AND COMMITTEE PRINTS

The Special Committee on Aging, under the direction of its Chairman, publishes committee prints, reports, and transcriptions of its hearings each year. These documents are listed chronologically by year, beginning with reports and committee prints, and followed by hearings.

Copies of committee hearings and reports are available from the committee and from the Government Printing Office. The date of publication and the number of copies you would like generally determine which office you should contact in requesting a publication.

The following are guidelines for ordering copies of committee publications:

—Single copies of publications printed after January 1985 can be obtained from the committee.

—Any publication printed before January 1985 should be ordered from the Government Printing Office.

—If you would like more than one copy of a publication, they should be ordered from the Government Printing Office.

*If the committee supply has been exhausted—as indicated by one asterisk—contact the Government Printing Office for a copy of the publication. If all supplies have been exhausted-contact your local Federal "Depository Library," which should have received a printed or microformed copy of the publication.

While a single copy of a publication is available, free of charge, from the committee, the Government Printing Office charges for publications.

ADDRESSES FOR REQUESTING PUBLICATIONS

Documents
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Government Printing Office
Washington, D.C. 20402
(202) 783-3238

REPORTS AND COMMITTEE PRINTS

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.*
Developments in Aging, 1967, Report No. 1098, April 1968.*
Developments in Aging, 1968, Report No. 91-119, April 1969.*
Developments in Aging, 1969, Report No. 91-875, May 1970.*
Developments in Aging, 1970, Report No. 92-46, March 1971.*
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.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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.*
Developments in Aging: 1982—Volume 2, Report No. 98-13, February 1983.*
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.*
Developments in Aging: 1985—Volume 1, Report No. 99-242, February 1986.
Developments in Aging: 1985—Volume 2—Appendixes, Report No. 99-242, February 1986.*
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.*

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.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

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.*

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.*
Health Insurance and Related Provisions of Public Law 89–97, The Social Security Amendments of 1965, committee print, October 1965.*
Major Federal Legislative and Executive Actions Affecting Senior Citizens, 1965, committee print, November 1965.*

1966

Services to the Elderly on Public Assistance, committee print, March 1966.*
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.*

NOTE: When requesting or ordering publications in this listing, it is important that you first read the instructions on page 1.

Tax Consequences of Contributions to Needy Older Relatives, Report No. 1721, October 1966.*
Detection and Prevention of Chronic Disease Utilizing Multiphasic Health Screening Techniques, committee print, December 1966.*

1967

Reduction of Retirement Benefits Due to Social Security Increases, committee print, August 1967.*
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]
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]
The Stake of Today's Workers in Retirement Security, committee print, April 1970.* [1]
Legal Problems Affecting Older Americans, committee print, August 1970.* [1]
Income Tax Overpayments by the Elderly, Report No. 91-1464, December 1970.*
Older Americans and Transportation: A Crisis in Mobility, Report No. 91-1520, December 1970.*
Economics of Aging: Toward a Full Share in Abundance, Report No. 91-1548, December 1970.*

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.*
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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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Elderly Cubans in Exile, committee print, November 1971.*
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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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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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1977

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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.

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1982

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The Proposed Fiscal Year 1983 Budget: What It Means for Older Americans, committee print, March 1982.*
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1985

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Fifty Years of Social Security: Past Achievements and Future Challenges, committee print, Serial No. 99-C, August 1985.
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1986

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The Impact of Gramm-Rudman-Hollings on Programs Serving Older Americans: Fiscal Year 1986, committee print, Serial No. 99-H, February 1986.*
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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.
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1987

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Older Americans Act Amendments of 1987: A Summary of Provisions, committee print, December 1987, Serial No. 100-C.
Helping Older Americans To Avoid Overpayment of Income Taxes, committee print, January 1988, Serial No. 100-D.

1988

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Publications List, committee print, February 1988, Serial No. 100-E.
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The President's Fiscal Year 1989 Budget Proposal: How it Would Affect Programs for Older Americans, committee print, April 1988, Serial No. 100-G.
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- 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:*
- Part 1. Washington, D.C., August 23 and 24, 1961.
- 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.
- Part 7. Boise, Idaho, November 15, 1961.
- Part 8. Spokane, Wash., November 17, 1961.
- Part 9. Honolulu, Hawaii, November 27, 1961.
- Part 10. Lihue, Hawaii, November 29, 1961.
- Part 11. Wailuku, Hawaii, November 30, 1961.
- Part 12. Hilo, Hawaii, December 1, 1961.
- Part 13. Kansas City, Mo., December 6, 1961.

Nursing Homes:*
- Part 1. Portland, Oreg., November 6, 1961.
- 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.
Part 6. San Francisco, Calif., December 7, 1962.
Frauds and Quackery Affecting the Older Citizen:*
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Part 2. Washington, D.C., January 16, 1963.
Part 3. Washington, D.C., January 17, 1963.
Housing Problems of the Elderly:*
Part 1. Washington, D.C., December 11, 1963.
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:*
Part 1. Washington, D.C., December 19, 1963.
Part 2. Los Angeles, Calif., January 10, 1964.
Part 3. San Francisco, Calif., January 13, 1964.
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Part 1. San Francisco, Calif., January 13, 1964.
Part 2. Washington, D.C., March 9, 1964.
Part 3. Washington, D.C., March 10, 1964.
Part 4A. Washington, D.C., April 6, 1964 (morning).
Part 4B. Washington, D.C., April 6, 1964 (afternoon).
Services for Senior Citizens:*
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Part 2. Boston, Mass., January 20, 1964.
Part 3. Providence, R.I., January 21, 1964.
Part 4. Saginaw, Mich., March 2, 1964.
Blue Cross and Other Private Health Insurance for the Elderly:*
Part 1. Washington, D.C., April 27, 1964.
Part 2. Washington, D.C., April 28, 1964.
Part 3. Washington, D.C., April 29, 1964.
Part 4A. Appendix.
Part 4B. Appendix.
Deceptive or Misleading Methods in Health Insurance Sales, Washington, D.C., May 4, 1964.*
Nursing Homes and Related Long-Term Care Services:*
Part 1. Washington, D.C., May 5, 1964.
Part 2. Washington, D.C., May 6, 1964.
Part 3. Washington, D.C., May 7, 1964.
Interstate Mail Order Land Sales:*
Part 1. Washington, D.C., May 18, 1964.
Part 2. Washington, D.C., May 19, 1964.
Part 3. Washington, D.C., May 20, 1964.
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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Part 3. Los Angeles, Calif., February 17, 1965.
Part 4. Denver, Colo., February 23, 1965.

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- Part 5. New York, N.Y., August 2 and 3, 1965.
- Part 6. Boston, Mass., August 9, 1965.
- Part 7. Portland, Maine, August 13, 1965.

Extending Private Pension Coverage:*
- Part 1. Washington, D.C., March 4, 1965.
- Part 2. Washington, D.C., March 5 and 10, 1965.

The War on Poverty As It Affects Older Americans:*
- Part 1. Washington, D.C., June 16 and 17, 1965.
- Part 2. Newark, N.J., July 10, 1965.
- Part 3. Washington, D.C., January 19 and 20, 1966.

Services to the Elderly on Public Assistance:*
- Part 1. Washington, D.C., August 18 and 19, 1965.
- Part 2. Appendix.

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.*

Retirement and the Individual:*
- Part 1. Washington, D.C., June 7 and 8, 1967.
- Part 2. Ann Arbor, Mich., July 26, 1967.

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- Part 1. Washington, D.C., June 22 and 23, 1967.
- 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.*

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- Part 1. Washington, D.C., July 23, 1968.
- Part 2. Seattle, Wash., October 14, 1968.
- Part 3. Ogden, Utah, October 24, 1968.
- Part 4. Syracuse, N.Y., December 9, 1968.
- Part 5. Atlanta, Ga., December 11, 1968.
- Part 6. Boston, Mass., July 11, 1969.
- Part 7. Washington, D.C., October 14 and 15, 1969.

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: *
- Part 1. Los Angeles, Calif., December 17, 1968.
- Part 2. El Paso, Tex., December 18, 1968.
- Part 3. San Antonio, Tex., December 19, 1968.
- Part 4. Washington, D.C., January 14 and 15, 1969.
- Part 5. Washington, D.C., November 20 and 21, 1969.

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 1. Washington, D.C., July 30, 1969.
- 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.
- Part 5. Washington, D.C. (Marietta, Ohio, fire), February 10, 1970.
- Part 6. San Francisco, Calif., February 12, 1970.
- Part 7. Salt Lake City, Utah, February 13, 1970.
- Part 8. Washington, D.C., May 7, 1970.
- Part 9. Washington, D.C. (Salmonella), August 19, 1970.
- Part 10. Washington, D.C. (Salmonella), December 14, 1970.
- Part 11. Washington, D.C., December 17, 1970.
- Part 12. Chicago, Ill., April 2, 1971.
- Part 13. Chicago, Ill., April 3, 1971.
- Part 14. Washington, D.C., June 15, 1971.
- Part 15. Chicago, Ill., September 14, 1971.
- Part 16. Washington, D.C., September 29, 1971.
- Part 17. Washington, D.C., October 14, 1971.

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Part 18. Washington, D.C., October 28, 1971.
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Part 19B. Minneapolis-St. Paul, Minn., November 29, 1971.
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Part 24. New York, N.Y., February 4, 1975.
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Older Americans in Rural Areas:*
Part 1. Des Moines, Iowa, September 8, 1969.
Part 2. Majestic-Freeburn, Ky., September 12, 1969.
Part 3. Fleming, Ky., September 12, 1969.
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Part 5. Greenwood, Miss., October 9, 1969.
Part 6. Little Rock, Ark., October 10, 1969.
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Part 10. Washington, D.C., June 2, 1970.
Part 11. Dogbone-Charleston, W. Va., October 27, 1970.
Part 12. Wallace-Clarksburg, W. Va., October 28, 1970.
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Part 1. Ocean Grove, N.J., April, 18, 1970.
Part 2. Washington, D.C., June 8 and 9, 1970.
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Part 2. Boston, Mass., April 30, 1971.
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Part 1. Washington, D.C., March 25, 1971.
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Part 7. Des Moines, Iowa, May 13, 1971.
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Part 9. Casper, Wyo., August 13, 1971.
Part 10. Washington, D.C., February 3, 1972.
Cutbacks in Medicare and Medicaid Coverage:*
Part 1. Los Angeles, Calif., May 10, 1971.
Part 2. Woonsocket, R.I., June 14, 1971.
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Unemployment Among Older Workers: *
- Part 1. South Bend, Ind., June 4, 1971.
- Part 2. Roanoke, Ala., August 10, 1971.
- Part 3. Miami, Fla., August 11, 1971.
- Part 4. Pocatello, Idaho, August 27, 1971.

Adequacy of Federal Response to Housing Needs of Older Americans:*
- Part 1. Washington, D.C., August 2, 1971.
- Part 2. Washington, D.C., August 3, 1971.
- Part 3. Washington, D.C., August 4, 1971.
- Part 4. Washington, D.C., October 28, 1971.
- Part 5. Washington, D.C., October 29, 1971.
- Part 6. Washington, D.C., July 31, 1972.
- Part 7. Washington, D.C., August 1, 1972.
- Part 8. Washington, D.C., August 2, 1972.
- Part 9. Boston, Mass., October 2, 1972.
- Part 10. Trenton, N.J., January 17, 1974.
- Part 11. Atlantic City, N.J., January 18, 1974.
- Part 12. East Orange, N.J., January 19, 1974.
- Part 13. Washington, D.C., October 7, 1975.
- Part 14. Washington, D.C., October 8, 1975.

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:*
- Part 1. Washington, D.C., October 18, 1971.
- Part 2. Washington, D.C., October 19, 1971.
- Part 3. Washington, D.C., October 20, 1971.

Death With Dignity: An Inquiry Into Related Public Issues:*
- Part 1. Washington, D.C., August 7, 1972.
- Part 2. Washington, D.C., August 8, 1972.
- Part 3. Washington, D.C., August 9, 1972.

Future Directions in Social Security:*
- Part 1. Washington, D.C., January 15, 1973.
- Part 2. Washington, D.C., January 22, 1973.
- Part 3. Washington, D.C., January 23, 1973.
- Part 4. Washington, D.C., July 25, 1973.
- Part 5. Washington, D.C., July 26, 1973.
- Part 6. Twin Falls, Idaho, May 16, 1974.
- Part 7. Washington, D.C., July 15, 1974.
- Part 8. Washington, D.C., July 16, 1974.
- Part 9. Washington, D.C., March 18, 1975.
- Part 10. Washington, D.C., March 19, 1975.
- Part 11. Washington, D.C., March 20, 1975.
- Part 12. Washington, D.C., May 1, 1975.
- Part 13. San Francisco, Calif., May 15, 1975.
- Part 14. Los Angeles, Calif., May 16, 1975.
- Part 15. Des Moines, Iowa, May 19, 1975.
- Part 16. Newark, N.J., June 30, 1975.
- Part 17. Toms River, N.J., September 8, 1975.
- Part 18. Washington, D.C., October 22, 1975.

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Future Directions in Social Security—Continued
Part 19. Washington, D.C., October 23, 1975.
Part 20. Portland, Oreg., November 24, 1975.
Part 21. Portland, Oreg., November 25, 1975.
Part 22. Nashville, Tenn., December 6, 1975.
Part 23. Boston, Mass., December 19, 1975.
Part 24. Providence, R.I., January 26, 1976.
Part 25. Memphis, Tenn., February 13, 1976.
Fire Safety in Highrise Buildings for the Elderly:*
Part 1. Washington, D.C., February 27, 1973.
Part 2. Washington, D.C., February 28, 1973.
Barriers to Health Care for Older Americans:*
Part 1. Washington, D.C., March 5, 1973.
Part 2. Washington, D.C., March 6, 1973.
Part 3. Livermore Falls, Maine, April 23, 1973.
Part 4. Springfield, Ill., May 16, 1973.
Part 5. Washington, D.C., July 11, 1973.
Part 6. Washington, D.C., July 12, 1973.
Part 7. Coeur d'Alene, Idaho, August 4, 1973.
Part 8. Washington, D.C., March 12, 1974.
Part 9. Washington, D.C., March 13, 1974.
Part 10. Price, Utah, April 20, 1974.
Part 11. Albuquerque, N. Mex., May 25, 1974.
Part 12. Santa Fe, N. Mex., May 25, 1974.
Part 13. Washington, D.C., June 25, 1974.
Part 14. Washington, D.C., June 26, 1974.
Part 15. Washington, D.C., July 9, 1974.
Part 16. Washington, D.C., July 17, 1974.
Training Needs in Gerontology:*
Part 1. Washington, D.C., June 19, 1973.
Part 2. Washington, D.C., June 21, 1973.
Part 3. Washington, D.C., March 7, 1975.
Hearing Aids and the Older American:*
Part 1. Washington, D.C., September 10, 1973.
Part 2. Washington, D.C., September 11, 1973.
Transportation and the Elderly: Problems and Progress:*
Part 1. Washington, D.C., February 25, 1974.
Part 2. Washington, D.C., February 27, 1974.
Part 3. Washington, D.C., February 28, 1974.
Part 4. Washington, D.C., April 9, 1974.
Part 5. Washington, D.C., July 29, 1975.
Part 6. Washington, D.C., July 12, 1977.
Improving Legal Representation for Older Americans:*
Part 1. Los Angeles, Calif., June 14, 1974.
Part 2. Boston, Mass., August 30, 1976.
Part 3. Washington, D.C., September 28, 1976.
Part 4. Washington, D.C., September 29, 1976.
Establishing a National Institute on Aging, Washington, D.C., August 1, 1974.*
The Impact of Rising Energy Costs on Older Americans:*
Part 1. Washington, D.C., September 24, 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.
- Part 4. Washington, D.C., April 5, 1977.
- Part 5. Washington, D.C., April 7, 1977.
- Part 6. Washington, D.C., June 28, 1977.
- Part 7. Missoula, Mont., February 14, 1979.

The Older Americans Act and the Rural Elderly, Washington, D.C., April 28, 1975.*

Examination of Proposed Section 202 Housing Regulations:*
- Part 1. Washington, D.C., June 6, 1975.
- Part 2. Washington, D.C., June 26, 1975.

The Recession and the Older Worker, Chicago, Ill., August 14, 1975.*

Medicare and Medicaid Frauds:*
- Part 1. Washington, D.C., September 26, 1975.
- Part 2. Washington, D.C., November 13, 1975.
- Part 3. Washington, D.C., December 5, 1975.
- Part 4. Washington, D.C., February 16, 1976.
- Part 5. Washington, D.C., August 30, 1976.
- Part 6. Washington, D.C., August 31, 1976.
- Part 7. Washington, D.C., November 17, 1976.
- Part 8. Washington, D.C., March 8, 1977.
- Part 9. Washington, D.C., March 9, 1977.

Mental Health and the Elderly, Washington, D.C., September 29, 1975.*

Proprietary Home Health Care (joint hearing with House Select Committee on Aging), Washington, D.C., October 28, 1975.*

Proposed USDA Food Stamp Cutbacks for the Elderly, Washington, D.C., November 3, 1975.*

The Tragedy of Nursing Home Fires: The Need for a National Commitment for Safety (joint hearing with House Select Committee on Aging), Washington, D.C., June 3, 1976.*

The Nation's Rural Elderly:*
- 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.
- Part 5. Sioux Falls, S. Dak., August 18, 1976.
- Part 6. Rockford, Iowa, August 18, 1976.
- Part 7. Denver, Colo., March 23, 1977.
- Part 8. Flagstaff, Ariz., November 5, 1977.
- Part 9. Tucson, Ariz., November 7, 1977.
- Part 10. Terre Haute, Ind., November 11, 1977.
- Part 11. Phoenix, Ariz., November 12, 1977.
- Part 12. Roswell, N. Mex., November 18, 1977.
- Part 13. Taos, N. Mex., November 19, 1977.
- Part 14. Albuquerque, N. Mex., November 21, 1977.
- Part 15. Pensacola, Fla., November 21, 1977.
- Part 16. Gainesville, Fla., November 22, 1977.
- Part 17. Champaign, Ill., December 13, 1977.

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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.
Part 2. Washington, D.C., May 17, 1977.
Part 3. Washington, D.C., June 15, 1977.
Part 4. Cleveland, Ohio, July 6, 1977.
Part 5. Washington, D.C., September 21, 1977.
Part 6. Holyoke, Mass., October 12, 1977.
Part 7. Tallahassee, Fla., November 23, 1977.
Part 8. Washington, D.C., April 17, 1978.
Senior Centers and the Older Americans Act, Washington, D.C., October 20, 1977.*
The Graying of Nations: Implications, Washington, D.C., November 10, 1977.*
Tax Forms and Tax Equity for Older Americans, Washington, D.C., February 24, 1978.*
Medi-Gap: Private Health Insurance Supplements to Medicare:*
Part 1. Washington, D.C., May 16, 1978.
Part 2. Washington, D.C., June 29, 1978.
Retirement, Work, and Lifelong Learning:*
Part 1. Washington, D.C., July 17, 1978.
Part 2. Washington, D.C., July 18, 1978.
Part 3. Washington, D.C., July 19, 1978.
Part 4. Washington, D.C., September 8, 1978.
Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units, Washington, D.C., July 25, 1978.*
Vision Impairment Among Older Americans, Washington, D.C., August 3, 1978.*
The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and "Alternatives," Chicago, Ill., August 30, 1978.*
Condominiums and the Older Purchaser:*
Part 1. Hallandale, Fla., November 28, 1978.
Part 2. West Palm Beach, Fla., November 29, 1978.
Older Americans in the Nation's Neighborhoods:*
Part 1. Washington, D.C., December 1, 1978.
Part 2. Oakland, Calif., December 4, 1978.
Commodities and Nutrition Program for the Elderly, Missoula, Mont., February 14, 1979.*
The Effect of Food Stamp Cutbacks on Older Americans, Washington, D.C., April 11, 1979.*
Home Care Services for Older Americans: Planning for the Future, Washington, D.C., May 7 and 21, 1979.*
Federal Paperwork Burdens, With Emphasis on Medicare (joint hearing with Subcommittee on Federal Spending Practices and Open Government of the Senate Committee on Governmental Affairs), St. Petersburg, Fla., August 6, 1979.*

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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.*
Energy Assistance for the Elderly:*
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.
Medicare Reimbursement for Elderly Participation in Health Maintenance Organizations and Health Benefit Plans, Philadelphia, Pa., October 29, 1979.*
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.
Rural Elderly—The Isolated Population: A Look at Services in the 80's, Las Vegas, N. Mex., April 11, 1980.*
Work After 65: Options for the 80's:*
Part 1. Washington, D.C., April 24, 1980.
Part 2. Washington, D.C., May 13, 1980.
Part 3. Orlando, Fla., July 9, 1980.
How Old Is "Old"? The Effects of Aging on Learning and Working, Washington, D.C., April 30, 1980.*
Minority Elderly: Economics and Housing in the 80's, Philadelphia, Pa., May 7, 1980.*
Maine's Rural Elderly: Independence Without Isolation, Bangor, Maine, June 9, 1980.*
Elder Abuse (joint hearing with House Select Committee on Aging), Washington, D.C., June 11, 1980.*
Crime and the Elderly: What Your Community Can Do, Albuquerque, N. Mex., June 23, 1980, stock No. 052-070-05517-1—$5.*
Possible Abuse and Maladministration of Home Rehabilitation Programs for the Elderly, Santa Fe, N. Mex., October 8, 1980, and Washington, D.C., December 19, 1980.*
Energy Equity and the Elderly in the 80's:*
Part 1. Boston, Mass., October 24, 1980.
Part 2. St. Petersburg, Fla., October 28, 1980.
Retirement Benefits: Are They Fair and Are They Enough?, Fort Leavenworth, Kans., November 8, 1980.*
Social Security: What Changes Are Necessary?:*
Part 1. Washington, D.C., November 21, 1980.
Part 2. Washington, D.C., December 2, 1980.

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Social Security—Continued
Part 3. Washington, D.C., December 3, 1980.
Part 4. Washington, D.C., December 4, 1980.
Home Health Care: Future Policy (joint hearing with Senate Committee on Labor and Human Resources), Princeton, N.J., November 23, 1980.*
Impact of Federal Estate Tax Policies on Rural Women, Washington, D.C., February 4, 1981.*
Impact of Federal Budget Proposals on Older Americans:*
Part 1. Washington, D.C., March 20, 1981.
Part 2. Washington, D.C., March 27, 1981.
Part 3. Philadelphia, Pa., April 10, 1981.
Energy and the Aged, Washington, D.C., April 9, 1981.*
Older Americans Act, Washington, D.C., April 27, 1981.*
Social Security Reform: Effect on Work and Income After Age 65, Rogers, Ark., May 18, 1981.*
Social Security Oversight:*
Part 1 (Short-Term Financing Issues). Washington, D.C., June 16, 1981.
Part 2 (Early Retirement). Washington, D.C., June 18, 1981.
Part 3 (Cost-of-Living Adjustments). Washington, D.C., June 24, 1981.
Medicare Reimbursement to Competitive Medical Plans, Washington, D.C., July 29, 1981.*
Rural Access to Elderly Programs, Sioux Falls, S. Dak., August 3, 1981.*
Frauds Against the Elderly, Harrisburg, Pa., August 4, 1981.*
The Social Security System: Averting the Crisis, Evanston, Ill., August 10, 1981.*
Social Security Reform and Retirement Income Policy, Washington, D.C., September 16, 1981.*
Older Americans Fighting the Fear of Crime, Washington, D.C., September 22, 1981.*
Employment: An Option for All Ages, Rock Island, Ill., and Davenport, Iowa, October 12, 1981.*
Older Workers: The Federal Role in Promoting Employment Opportunities, Washington, D.C., October, 29, 1981.*
Rural Health Care for the Elderly: New Paths for the Future, Grand Forks, N. Dak., November 14, 1981.*
Oversight of HHS Inspector General's Effort To Combat Fraud, Waste and Abuse (joint hearing with the Senate Finance Committee), Washington, D.C., December 9, 1981.*
Alternative Approaches To Housing Older Americans, Hartford, Conn., February 1, 1982.*
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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Problems Associated With the Medicare Reimbursement System for Hospitals, Washington, D.C., March 10, 1982.*
Impact of the Federal Budget on the Future of Services for Older Americans (joint hearing with House Select Committee on Aging), Washington, D.C., April 1, 1982.*
Health Care for the Elderly: What's in the Future for Long-Term Care?, Bismarck, N. Dak., April 6, 1982.*
The Impact of the Administration's Housing Proposals on Older Americans, Washington, D.C., April 23, 1982.*
Rural Older Americans: Unanswered Questions, Washington, D.C., May 19, 1982.*
The Hospice Alternative, Pittsburgh, Pa., May 24, 1982.*
Nursing Home Survey and Certification: Assuring Quality Care, Washington, D.C., July 15, 1982.*
Opportunities in Home Equity Conversion for the Elderly, Washington, D.C., July 20, 1982.*
Long-Term Health Care for the Elderly, Newark, N.J., July 26, 1982.*
Fraud, Waste, and Abuse in the Medicare Pacemaker Industry, Washington, D.C., September 10, 1982.*
Social Security Disability: The Effects of the Accelerated Review (joint hearing with Subcommittee on Civil Service, Post Office, and General Services of the Senate Committee on Governmental Affairs), Fort Smith, Ark., November 19, 1982.*
Quality Assurance Under Prospective Reimbursement Programs, Washington, D.C., February 4, 1983.*
Combating Frauds Against the Elderly, Washington, D.C., March 1, 1983.*
Energy and the Aged: The Impact of Natural Gas Deregulation, Washington, D.C., March 17, 1983.*
Social Security Reviews of the Mentally Disabled, Washington, D.C., April 7, 8, 1983.*
The Future of Medicare, Washington, D.C., April 13, 1983.*
Life Care Communities: Promises and Problems, Washington, D.C., May 25, 1983, stock No. 052-070-05880-3, $4.50.*
Drug Use and Misuse: A Growing Concern for Older Americans (joint hearing with the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging), Washington, D.C., June 28, 1983.*
Community Alternatives to Institutional Care, Harrisburg, Pa., July 6, 1983.*
Crime Against the Elderly, Los Angeles, Calif., July 6, 1983.*
Home Fire Deaths: A Preventable Tragedy, Washington, D.C., July 28, 1983.*
The Role of Nursing Homes in Today's Society, Sioux Falls, S. Dak., August 29, 1983.*
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.*
Social Security Disability Reviews: The Human Costs:
Part 1. Chicago, Ill., February 16, 1984.
Part 2. Dallas, Tex., February 17, 1984.
Part 3. Hot Springs, Ark., March 24, 1984.
Meeting the Present and Future Needs for Long-Term Care, Jersey City, N.J., February 27, 1984.
Energy and the Aged: Strategies for Improving the Federal Weatherization Program, Washington, D.C., March 2, 1984.
Medicare: Physician Payment Options, Washington, D.C., March 16, 1984.
Reauthorization of the Older Americans Act, 1984 (joint hearing with the Subcommittee on Aging of the Senate Committee on Labor and Human Resources), Washington, D.C., March 20, 1984.*
Long-Term Care: A Look at Home and Community-Based Services, Granite City, Ill., April 13, 1984.*
Medicare: Present Problems—Future Options, Wichita, Kans., April 20, 1984.
Sheltering America's Aged: Options for Housing and Services, Boston, Mass., April 23, 1984.*
Protecting Medicare and Medicaid Patients from Sanctioned Health Practitioners, Washington, D.C., May 1, 1984.*
A 10th Anniversary Review of the SSI Program, Washington, D.C., May 17, 1984.
Long-Term Needs of the Elderly: A Federal-State-Private Partnership, Seattle, Wash., July 10, 1984.*
Low-Cost Housing for the Elderly: Surplus Lands and Private-Sector Initiatives, Sacramento, Calif., August 13, 1984.*
The Crisis in Medicare: Exploring the Choices, Rock Island, Ill., August 20, 1984.*
The Cost of Caring for the Chronically Ill.: The Case for Insurance, Washington, D.C., September 21, 1984.
Discrimination Against the Poor and Disabled in Nursing Homes, Washington, D.C., October 1, 1984.*
Women In Our Aging Society, Columbus, Ohio, October 8, 1984.*
Healthy Elderly Americans: A Federal, State, and Personal Partnership, Albuquerque, N. Mex., October 12, 1984.
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.*

The Closing of Social Security Field Offices, Pittsburgh, PA, September 9, 1985, Serial No. 99-8.

Quality of Care Under Medicare's Prospective Payment System, Volume I, Serial Nos. 99-9, 10, 11, stock No. 552-070-00161-1, $11.

Medicare DRG's: Challenges for Quality Care, Washington, DC, September 26, 1985.

Medicare DRG's: Challenges for Post-Hospital Care, Washington, DC, October 24, 1985.

Medicare DRG's: The Government's Role in Ensuring Quality Care, Washington, DC, November 12, 1985.

Quality of Care Under Medicare's Prospective Payment System, Volume II—Appendix, Serial Nos. 99-9, 10, 11, stock No. 552-070-00162-0, $21.

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.*

The Effects of PPS on Quality of Care for Medicare Patients, Los Angeles, CA, January 7, 1986, Serial No. 99-14, stock No. 552-070-00322-3, $4.75.

Gramm-Rudman-Hollings: The Impact on the Elderly, Washington, DC, February 21, 1986, Serial No. 99-15, stock No. 552-070-01479-9, $5.

Disposable Dialysis Devices: Is Reuse Abuse? Washington, DC, March 6, 1986, Serial No. 99-16, stock No. 552-070-00501-3, $19.*

Employment Opportunities for Women: Today and Tomorrow, Cleveland, OH, April 21, 1986, Serial No. 99-17, stock No. 552-070-00632-0, $3.*

The Erosion of the Medicare Home Health Care Benefit, Newark, NJ, April 21, 1986, Serial No. 99-18, stock No. 552-070-00633-8, $2.50.*

Nursing Home Care: The Unfinished Agenda, Washington, DC, May 21, 1986, Serial No. 99-19.

Medicare: Oversight on Payment Delays, Jacksonville, FL, May 23, 1986, Serial No. 99-20, stock No. 552-070-01372-5, $2.25.

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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Providing a Comprehensive and Compassionate Long-Term Health Care Program for America's Senior Citizens, New Haven, CT, July 7, 1986, Serial No. 99-23, stock No. 552-070-00849-7, $3.50.
The Crisis in Home Health Care: Greater Need, Less Care, Philadelphia, PA, July 28, 1986, Serial No. 99-24, stock No. 552-070-01503-5, $1.50.
Retiree Health Benefits: The Fair Weather Promise? Washington, DC, August 7, 1986, Serial No. 99-25.*
Health Care for Older Americans: Insuring Against Catastrophic Loss, Serial No. 99-26.*
Part 1. Fort Smith, AR, August 27, 1986.
Part 2. Little Rock, AR, August 28, 1986.
Continuum of Health Care for Indian Elders, Santa Fe, NM, September 3, 1986, Serial No. 99-27.
Catastrophic Health Care Costs, Washington, DC, January 26, 1987, Serial No. 100-1.
Catastrophic Health Costs: Broad Problems Demanding Equally Broad Solutions (joint hearing with House Select Committee on Aging), Washington, DC, Serial No. 100-2.
Proposed Fiscal Year 1988 Budget: What it Means to Older Americans, Washington, DC, March 13, 1987, Serial No. 100-3.
The Catastrophic State of Catastrophic Health Care Coverage, Birmingham, AL, April 16, 1987, Serial No. 100-4.
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.
Developing a Consumer Price Index for the Elderly, Washington, DC, June 29, 1987, Serial No. 100-7.
Reauthorization of the Older Americans Act, Casselberry, FL, July 2, 1987, Serial No. 100-8.
Prescription Drugs and the Elderly: The High Cost of Growing Old, Washington, DC, July 20, 1987, Serial No. 100-9.
The Medicare Home Care Benefit: Access and Quality, Lakewood, NJ, August 3, 1987, Serial No. 100-10.
Housing the Elderly, A Broken Promise?
Reno, NV, August 17, 1987.
Las Vegas, NV, August 18, 1987, Serial No. 100-11.
Prescription Drug Costs: The Growing Burden for Older Americans, Little Rock, AR, August 27, 1987, Serial No. 100-12.
20 Years of the Age Discrimination in Employment Act: Success or Failure? Washington, DC, September 10, 1987, Serial No. 100-13.
Examining the Medicare Part B Premium Increase, Washington, DC, November 2, 1987, Serial No. 100-14.
Medicare Payments for Home Health Services, Portland, ME (joint hearing with the Senate Finance Committee), November 16, 1987, Serial No. 100-15.

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Long-Term Care: From Housing and Health to Human Services, Minneapolis, MN, January 5, 1988, 100-16.
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.
Adult Day Health Care: A Vital Component of Long-Term Care, Washington, DC, April 18, 1988, Serial No. 100-20.
Advances in Aging Research, Washington, DC, May 11, 1988, Serial 100-21.
Kickbacks in Cataract Surgery, Philadelphia, PA, May 23, 1988, Serial No. 100-22.
The Rural Health Care Challenge:
Part 1--Rural Hospitals, Washington, DC, June 13, 1988,
Part 2--Rural Health Care Personnel, Washington, DC, July 11, 1988, Serial No. 100-23.
The EEOC's Performance in Enforcing the Age Discrimination in Employment Act, Washington, DC, June 23 and 24, 1988, Serial No. 100-24.
The American Indian Elderly: The Forgotten Population, Pine Ridge, SD, July 21, 1988, Serial No. 100-25.
Rural Health Care Delivery in Arkansas: Impact on the Elderly, Pine Bluff, AR, August 30, 1988, Serial No. 100-26.
Cost-of-Living Adjustments and the CPI: A Question of Fairness, Washington, DC, October 5, 1988, Serial No. 100-27.