A Message to the President on Aging Policy

Aging in America: an agenda for an era of new possibilities
Top of the Administration’s agenda: stem the rising cost of healthcare
Strengthening elder safety and security
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The Aging of America: A Positive Vision for the Future

With the outcome of the 2016 presidential election, America has seen the culmination of an election cycle like no other in the history of its democracy. Now, as the new President prepares to take office, one area of domestic policy calls for renewed vision and action—the substantial aging of the American population.

This is a crucial time for action on aging issues and a great opportunity to champion solutions that appeal not only to the powerful political constituency of America’s elders, but also to their families. We now can frame a positive message that reinforces core American values of individual responsibility and self-reliance, and supports the importance of family and social engagement in successful and healthy aging.

As Guest Editor of this issue of Generations, “A Message to the President on Aging Policy,” G. Lawrence Atkins believes that “the aging of our population presents our most significant challenge to the quality of life for older Americans and continued growth and economic prosperity for the country as a whole. We need to address it head on—in this Presidency.”

Atkins, the executive director of the Long-Term Quality Alliance (LTQA), is working hard to advance person-centered, high-quality, integrated long-term services and supports (LTSS). He has gathered an impressive group of experts to write for this issue, asking them to offer observations and policy recommendations on aging demographics and their impacts, and the most crucial economic, policy, healthcare, safety net, housing, and caregiving issues America now faces in its aging society, plus frame the challenges faced by coming generations.

Atkins anticipates “the new Administration will be more focused on undoing than on doing, and that the attention of our most talented citizens and respected institutions will for the next few years be focused on limiting the damage wrought by impulsive and careless decisions and actions.” His plan to counter this scenario is to bolster state and local leadership and citizens to continue innovative programming that is already transforming aging.

Thus, the LTQA has recently begun work on a study to measure the value of integrated LTSS, by measuring its impact on healthcare spending. It expects that study to establish a business case for integrated LTSS and financing.

Atkins began his career in an urban community organization in Kentucky, where he ran a strategic social planning initiative; he then earned a doctorate in social policy. In the 1980s, he worked on the Senate Aging Committee for Chairman John Heinz, playing a key role in the National Commission on Social Security Reform, the 1983 Social

During the 1990s, Atkins ran a benefits policy practice in a law firm, launched a health policy firm in Washington, D.C., and founded and ran a coalition of twenty-five of the largest U.S. companies laboring to advance healthcare reform in the Clinton years. He directed U.S. public policy in the 2000s for global pharmaceutical manufacturer Merck & Co., Inc., before he retired in 2009.

As an encore career, Atkins returned to work in aging policy, as staff director for the Commission on Long-Term Care, assuming executive directorship in 2014. “The way we [currently] provide LTSS is inefficient and expensive. Family caregivers provide most of the care today, without adequate support, and the paid workforce is undertrained and underpaid,” he says. “There is an opportunity for technology and service delivery reform to transform how care is provided—to make care managers available and improve efficiency in how care is delivered, enabling better training, certification, higher pay, and career ladders for direct care workers.”

Atkins stresses three changes that must occur to sustain and improve quality of life for older Americans. The first, and most important, is to change how we practice healthcare. “Twenty years from now, the U.S. cannot afford to provide the level of intensive, expensive medical treatment we offer today for an older population nearly doubled in size,” he says. America must lessen its costly medical, clinical, and institutional interventions and improve supports that families can provide in the home, community, and workplace.

Second, the United States needs to build a person- and family-centered approach to providing medical and non-medical care. The goals of older Americans and their families must be synchronized with those of healthcare professionals, Atkins says.

Third, Atkins knows the challenges of financing Social Security, Medicare, and LTSS must be addressed: “The President will need to propose legislation to the Congress that can enable Social Security and Medicare to serve a much larger retired and disabled population in the next two decades and can remain sustainable for future generations.”

Faced with the uncertain terrain of this Presidency, Atkins thinks the best course is to better use existing resources to shape a more proactive, preventive strategy for aging—one that engages and supports people in their homes and communities to reduce or delay the onset of cognitive and functional limitations, and the reliance on clinical and institutional care.

Atkins’ mandate is to act locally to achieve a better quality of life for America’s elders on a national scale. Perhaps if our new President reads the “message” in this issue of Generations, we can also have hope for action at the federal level.

—Alison Biggar and Alison Hood
Aging in America: An Agenda for an Era of New Possibilities

By G. Lawrence Atkins

A proposed policy agenda to guide America’s new President in championing and advocating for America’s aging population—now and in the future.

Our nation has survived an unusually bitter and contentious presidential campaign that has tested American democracy and raised concerns about our government’s capacity to address complex problems and chart pathways for improving the lives of our citizens. In the early days of the new President’s tenure, Americans need a clear agenda that can begin to unite us in common purpose for a better future.

In this issue of Generations, we propose a policy agenda for the most important unmentioned domestic policy issue during the recent campaign—the challenge and opportunity created by the aging of the U.S. population. Over the next fifteen years, the proportion of the population ages 65 and older and ages 85 and older will rise dramatically (Ortman, Velkoff, and Hogan, 2014), though at its peak in 2030, the proportion of elderly people in the U.S. population will only reach levels already evident today in Germany, Italy, and Japan (He, Goodkind, and Kowal, 2016).

The sheer magnitude and pace of this demographic transformation will present both challenges and opportunities for federal aging policy.

The Challenges and Opportunities of an Aging Population

The last fifty years have seen a revolution in the perception of aging and the well-being of America’s older adults. Today’s retiring generation will have, on average, higher levels of education, better health, and greater financial resources than any previous generations, but it also will have much greater disparities within its ranks with respect to income, wealth, and health, and there will be many more elders who are medically, financially, and socially

This new Presidency faces a major test: Can it champion policy changes and Administration initiatives that can transform the aging experience?

⇒ ABSTRACT This article overviews the Winter 2016–17 issue of Generations, which proposes a policy agenda to address the challenges and opportunities created by U.S. population aging. The first set of proposals concern preserving retirement income, slowing healthcare spending growth, financing long-term services and supports, and securing the safety net. The second set addresses enabling older adults to remain connected, active, and engaged for as long as possible in community. A final set visualizes how to best prepare for the future by forging person-centered and forward-thinking policy. | key words: retirement income, healthcare spending, long-term services and supports, safety net, aging in community
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vulnerable. Today’s retirees also will be more diverse than previous retirees; and each succeeding generation will have a higher percentage of African, Asian, and Hispanic Americans, as well as foreign-born residents.

The fundamental challenges of an aging population lie in the efforts to sustain the government programs that provide economic security in old age, ensure promised benefits are delivered, and restore public confidence for younger generations in these programs’ sustainability. Retirement of the Baby Boom Generation, already five years underway, will by 2030 nearly double the number of Social Security and Medicare recipients, with consequences for our nation’s retirement income programs, healthcare spending, long-term-care financing, and economic growth.

An aging population and the demand it creates for innovation in products and services can drive economic growth. If greater numbers of new older adults can remain in better health, delay retirement, pursue encore careers, and otherwise remain active and engaged, it can help temper the fiscal pressure of an older population. But economists disagree on whether this will be enough to overcome the dampening effects of this kind of demographic shift: slower growth in the labor force, declining labor force participation, and slowed growth in productivity.

**The Challenges Facing a New President**

This Presidency at its inception faces a major test:

- Can it **champion** the policy changes and administration initiatives that can transform the aging experience—promoting a more engaged, more productive, and healthier older population?

- Can it **finance** the services and supports to enable older people to remain in their homes and communities, with the support of their families, and reduce the reliance on expensive medical facilities and interventions?

- Can it **stimulate** the innovation needed to transform how we live and work in older age so as to reduce the pressure on retirement and healthcare programs?

The incoming President inherits a federal debt at levels higher than any period since the end of World War II, and a federal budget already set on a course to increase that debt. If our leaders do nothing, demography-fueled growth in public expenditures and in the federal revenues needed to fund them will only exacerbate our national proclivity to borrow for current consumption (retirement benefits, health-

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**Baby boomer retirement will by 2030 nearly double the number of Social Security and Medicare recipients—with consequences for America’s retirement income programs, healthcare spending, LTC financing, and economic growth.**

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care and long-term-care spending) at the expense of investment in the engines for future growth (education, infrastructure development, healthy children and families).

Behind the Baby Boom Generation are younger generations now in the workforce—cohorts that face a future exhilarating for its more fluid opportunities and challenging in the dizzying array of hurdles to be overcome to prepare adequately for that future. The President has an equal duty to restore the confidence of coming generations in the availability of opportunities to create a secure old age, and to strengthen the protections that today guard against unexpected catastrophes and enable each successive generation to take the risks that drive a productive and growing economy.

Legislation to put Social Security and Medicare on sounder footing can no longer be avoided, but moving legislation through a divided Congress will require compromise. In a debt-neutral policy environment, choices to fully fund benefits must be balanced with investments need-
ed for future growth. As unattractive as these tradeoffs may be, the consequences of a further postponement of action will be worse. Pursuing well-crafted policy on one of the central domestic issues of our time can only help restore public confidence in the fairness and competence of our system of governance.

A Proposed Action Agenda on Aging

The articles in this issue of Generations propose a straightforward and ambitious agenda for action. The first set of proposals tackles the major domestic policy challenges posed by an aging population: financing retirement income, slowing growth in healthcare spending, financing long-term services and supports, and securing the safety net. The second set of proposals addresses the conditions and circumstances that most directly relate to these policy challenges: enabling older adults to remain connected, physically active, and purposefully engaged for as long as possible in the home and community they prefer; creating opportunities for continued work; protecting the most vulnerable elders; and supporting family and paid caregivers. These endeavors all contribute to healthier aging, which can result in an older population less dependent on expensive institutionally focused care. A final duet of proposals poses a vision of how we can best prepare for the future by forging person-centered and forward-thinking policy that supports today’s retirees and the coming generations of future retirees.

This is the right time for action on aging issues, and a great opportunity to champion solutions that appeal not only to the powerful political constituency of America’s older adults, but also to their families, who often share their burdens and who, themselves, face a future of old age. We now have the opportunity to frame a positive message reinforcing core American values of individual responsibility and self-reliance, while underscoring our national commitment to the social contract and the programs that protect families and individuals from the economic consequences of old age and disability.

G. Lawrence Atkins, Ph.D., is executive director of the Long-Term Quality Alliance in Washington, D.C.

References


The Challenges and Opportunities of the American Demographic Shift

By James H. Johnson, Jr., and Allan M. Parnell

Our nation’s population will change dramatically through 2040: Is our new Administration ready to meet the realities of an aging America?

We are living in an era of disruptive demographics (Johnson and Kasarda, 2011). Major shifts in the size, composition, and geographic distribution of the U.S. population are dramatically transforming our social, economic, and political institutions, creating challenges and opportunities along the way. Nowhere are these shifts more apparent than in the aging of America (Ortman, Velikoff, and Hogan, 2014; Thompson, 2016).

The aging of the native-born population is driven in part by the maturing of the Baby Boom Generation, which began turning age 65 in 2011 and will continue to do so at the rate of more than 8,000 per day for the next twenty years (Johnson and Kasarda, 2011). This demographic shift is also a function of major advances in healthcare and in the behaviors of older adults, which include more active living and healthier eating habits, both of which contribute to increased longevity in this cohort (Wheeler, 2010).

This article presents a contemporary snapshot of our nation’s older adult population and projections of how this population will likely change through the year 2040. We also identify critical areas in which policy prescriptions are required to address some of the most daunting challenges and to take advantage of the most propitious opportunities that underlie the aging of America.

A Contemporary Snapshot of Aging

In 2014, the U.S. population of people ages 65 and older totaled 46.2 million. It is a fairly homogeneous population. In comparison to the total population, in the older population, non-Hispanic whites (78 percent, or 36 million) are over-represented. Blacks (8.8 percent, or 4.1 million), Hispanics (7.6 percent, or 3.5 million), and other non-white groups are under-represented in the older population. Between 2010 and 2014, the older adult population grew at a rate that was nearly five times the rate of growth experienced by the total population (14.8 percent versus 3.1 percent); the leading edge of the baby boomer cohort (i.e., those between ages 65 and 69) grew seven times as fast as the total population (22.4 percent versus 3.1 percent); and the ages 85 and older population, the oldest old, grew nearly four times as fast as the total pop-
The nation’s older adult population grew by roughly 6 million between 2010 and 2014, concentrated in Southern and Western states.

At the regional level, older adults have been moving from the Northeast and Midwest to the West and especially to the South for at least the past fifteen years. Irrespective of region of origin, older adults are leaving primarily large urban centers or the principal cities of major metropolitan areas in the Northeast and Midwest and settling mainly in suburban communities of large metropolitan and smaller micropolitan areas in the West and the South. These destinations are mostly amenity-rich and-or planned retirement communities, which benefit from relatively small but significant net flows of older adult migrants from non-metropolitan or rural communities (U.S. Census Bureau, 2015b).

Considerable aging in place occurs outside of these older adult migration-magnet communities (Johnson and Parnell, 2013). The phenomenon is most apparent in the nation’s rural counties, where young people have left and continue to leave in search of better economic opportunities elsewhere. These counties are typically left with high older-age dependency ratios, where there are not enough prime working age adults to care for the retired population.

Nationally, in 2014 the old-age dependency ratio was .232. That is, there were twenty-three people ages 65 or older for every 100 individuals between the ages of 18 and 64. But across the country, dependency ratios range from .06 (almost no older adult dependents) to 1.33 (more older adult dependents than prime working age individuals). Some migration-magnet communities have high dependency ratios (i.e., greater than .40). But the majority of communities with high dependency ratios are located in our nation’s rural heartland (U.S. Census Bureau, 2015a).

It is not uncommon for these rural aging-in-place counties with large dependency ratios to have high concentrations of older women who typically live alone (Johnson and Parnell, 2013). These concentrations emerge because older adults are much more likely than the total population to be widowed, separated, or divorced (40 percent versus 18 percent in 2014). And older women are more likely than men to find themselves in this situation (51.7 percent versus 24.5 percent in 2014). This disparity exists because women typically live longer and are less likely than men to remarry following the death of a spouse, a legal separation, or a divorce (U.S. Census Bureau, 2015a).

In these so-called widow hot spots, many women live in older homes that are not age friendly; this puts them at risk for life-threatening falls. And because the dependency ratio is high, they also often lack the caregiver support that is required to successfully age in place (Johnson and Parnell, 2013).

Population Growth as We Look Ahead
Over the next quarter century, older adult population growth is projected to continue to outpace total population growth. Between 2015 and 2040, according to the Census Bureau’s National Population Projections, the U.S. total population is projected to increase by 18 percent—from 321 million to 380 million. During this period, the ages 65 and older population is expected to increase much more rapidly—from 47.8 million to 82.3 million, an increase of 72 percent. And because life expectancy at birth is projected to increase significantly for both
genders and all races and ethnic groups, the oldest-old cohort is forecasted to grow even faster than the ages-65-and-older population (132 percent versus 72 percent) over the next quarter century. By 2040, the ages-85-and-older population is projected to reach 14.6 million, up from 6.3 million in 2015. Outpacing both groups, the ages-100-and-older population is projected to increase by 168 percent between 2015 and 2040. According to Census Bureau projections, there will be an estimated 193,000 centenarians living in the United States by 2040, up from 72,000 in 2015 (U.S. Census Bureau, 2014).

Moreover, because of an increasing number of immigrants in U.S. society, the older adult population will become far more diverse over the next quarter century. In all three older adult age groups—ages 65 and older, ages 85 and older, and ages 100 and older—the foreign-born population will increase more rapidly than the native-born population. While native-born older adults in these three age groups are projected to increase by 57 percent, 123 percent, and 163 percent, respectively, the corresponding numbers for foreign-born older adults in these age groups are 173 percent, 200 percent, and 200 percent, respectively. By 2040, there will be an estimated 64.9 million native-born and 17.5 million foreign-born older adults living in the United States (U.S. Census Bureau, 2014).

In part, as a function of these projected changes in the absolute size and composition of the older adult population, the elder share of the total population is projected to increase from 14.9 percent in 2015 to 21.7 percent in 2040. This shift will be evident in both sexes. Older men are projected to comprise 19.7 percent of the male population in 2040, up from 13.3 percent in 2015. The older adult share of the female population is projected to increase from 16.4 percent to 23.6 percent of the total between 2015 and 2040 (U.S. Census Bureau, 2014). Paralleling these increases in the older adult share of the total male and female populations, there will be corresponding declines in the group that is younger than age 18 and the ages 18 to 64 shares of the U.S. population—a potential problem, given that the demand for caregivers for older adults will increase along with the projected growth of the older population (Redfoot, Feinberg, and Houser, 2013).

**Responding to the Challenges and Opportunities of an Aging Society**

Foremost among the challenges created by the current and projected older adult population growth is to figure out how to cover the additional costs of social safety programs for older adults. Due to the aging of baby boomers and the increased longevity of older adults, Social Security, Medicare, and Medicaid obligations will increase sharply. These fiscal impacts are addressed elsewhere in this issue of *Generations*. Suffice it to cite here one specific example of the fiscal challenge that aging will pose in the years ahead—an example that is not widely known. Medicaid covered 62.5 percent of the $207.9 billion expended on long-term services and supports (LTSS) in 2010. LTSS expenditures are projected to grow to $346 billion by 2040 (The SCAN Foundation, 2013).

Notwithstanding these fiscal and other challenges (e.g., the need for both caregiver support and succession-planning programs in public- and private-sector organizations), aging can be, in our view, a new engine for innovation, business development, and employment growth. Opportunities abound in this space to support and facilitate healthy and active aging on the one hand, and to care for the frail elderly on the other (Johnson and Parnell, 2013).

Everything in both the person-centered (i.e., residential) and the built environments (i.e., all public, private, and commercial spaces) must...
change to accommodate an aging population (Bergal, 2016a, 2016b; Goneya and Hudson, 2015; Guzman and Harrell, 2015; Hudson, 2015; Lawler, 2015; Phillipson, 2015). New ideas and innovations, including assistive technologies and the digital literacy training required to use them, are needed to support older adults as they strive to age successfully in their homes and communities. New models of care also are required to address the needs of the oldest old, the segment of elders that is growing most rapidly (Johnson and Parnell, 2013).

Efforts to create an age-friendly U.S. society and economy must reflect and build upon the following considerations.

First, it must be recognized that most older adults are not obsessing over arthritis, incontinence, or dementia. Rather, many are working past age 65 and a significant number are launching encore careers in either a traditional business venture or as social entrepreneurs (Peterson, 2014; Stangler, 2014; PR Newswire, 2016). In 2014, 24.2 percent of the 65-to-74-year-old population and 6 percent of the ages-75-and-older population were still working (U.S. Census Bureau, 2015a). And these so-called encore entrepreneurs reportedly not only start new business ventures at a higher rate, but also their businesses have a higher five-year survival rate than those of any other group, including businesses run by people in their twenties. Encore entrepreneurs are alleged to have double ESP, that is, experience, expertise, seasoned judgment, and proven performance, which they leverage to launch and grow their businesses (Peterson, 2014).

To build upon and expand these mature and highly valuable human capital assets, federal workplace polices will have to be revised to accommodate aging workers, as well as their younger co-workers who have eldercare responsibilities. The latter group includes more than 10 million Millennials. Also, federal programs designed to promote or advance encore entrepreneurship must be expanded in the years ahead.
Second, the baby boomer segment of the older adult population has enormous consumer purchasing power—far more than the Millennials. According to Bloomberg Businessweek, baby boomers constitute a $15 trillion market opportunity globally and $3 trillion here in the United States (Boyle, 2013). But to leverage this market opportunity, businesses must design, label, and package products and services that are age friendly; and to do so successfully, they must understand the aging consumer paradox: older adults do not like to be singled out and reminded that they are old.

As Bloomberg Businessweek’s Matthew Boyle (2013) put it, “[t]he company that does a great job of making products for seniors takes great pains not to make products for seniors.” Firms that successfully tap into this burgeoning baby boomer market must design products and services that are equally accessible for all age groups, not just older adults. This will, in all likelihood, necessitate a comprehensive review of the rules undergirding the Fair Packaging and Labeling Act, which was enacted in 1967.

Third, the challenges of aging, including diminished hearing, vision impairments, and other chronic disabilities, will require that all public, private, and commercial spaces are redesigned to be age-friendly. Emblematic of the nature and magnitude of the problem, one-quarter of older adults between ages 65 and 74 had one or more disabilities and, in 2014, 16 percent of all older adults had independent-living constraints. As one might expect, the percentages with disabilities and independent-living constraints were much higher for the ages 75 and older population than for the ages 65 to 74 population (U.S. Census Bureau, 2015a).

Despite these types of infirmities, most older adults prefer to age in place—in their homes and their communities. In order for them to do so, we must redesign existing communities, plus design new ones that substantially reduce the likelihood of costly and possibly life-threatening slips and falls, as well as frequent trips to hospital emergency rooms, extended hospital stays, and long-term placements in institutionalized care settings. Among other characteristics, age-friendly communities house institutions that are easy to visit, provide easy access to transport systems, offer pedestrian crosswalks with extended walk times, have street signage that is large and readable, and feature older adult or multi-generational playgrounds and fitness parks (Bergal, 2016a, 2016b; Goneya and Hudson, 2015; Guzman and Harrell, 2015; Hudson, 2015; Lawler, 2015; Phillipson, 2015).

If we are to scale existing efforts to build age-friendly communities, we must implement policies that do the following (Lawler, 2015):

• Ensure that transportation investments at the federal and state levels of government reflect the realities of longevity;

• Allow older adults to safely access the equity in their homes while they remain in place, increase the availability of affordable rental housing, better coordinate between health services and housing supports, and integrate aging-in-place concerns across a range of federal programs; and

• Leverage the power of public–private partnerships and creative financial products and incentives that integrate older adults into the economic development strategies of cities, counties, and states.

In addition to creating an age-friendly infrastructure, we must build a sustainable eldercare support network, especially for communities where there are high concentrations of older adults living alone, with multiple disabilities, and-or having independent-living constraints (Johnson and Parnell, 2013; Redfoot, Feinberg, and Houser, 2014). To do so, we must enact
comprehensive immigration reform legislation, and vigorously enforce the recent U.S. Department of Labor ruling stipulating that homecare workers benefit from the same labor protections as other employees (The Editorial Board, 2016). These are strategic imperatives because, as Thompson notes (2016), immigrants will perform most homecare and institutional care.

Finally, addressing racial disparities in the socioeconomic well-being of older adults must be a strategic imperative. Although in 2014 they made up a relatively small share of the older population, the poverty rate for black older adults was more than twice as high as the poverty rate for all older adults (22.5 percent versus 9.5 percent), and it was three times as high as the poverty rate for white older adults (22.5 percent versus 7.8 percent) (U.S. Census Bureau, 2015a). This issue must be high on the nation’s policy agenda, not solely for social or moral reasons, but also as a key driver of the overall health and socioeconomic well-being of our nation in a hyper-competitive global economy. Moreover, getting a handle on this problem is vitally important because, as previously noted, the older adult population will become increasingly diverse over the next quarter century.

If policy prescriptions are implemented in these domains, we are convinced that our nation will be a far more attractive place in which to live and do business in the years ahead—especially for our rapidly growing older adult population.

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The Economic, Fiscal, and Financial Implications of an Aging Society

By G. William Hoagland

Demography is our destiny, so it would behoove the new Administration to pay close attention to the aging of our nation and the opportunities it presents.

When the 45th President of the United States is sworn into office on January 20, 2017, the inaugural address will undoubtedly emphasize increasing U.S. economic growth with expanded opportunities for all Americans. But the one factor that the new President and the new 115th Congress will not be able to change is that a key to future economic growth will be demographics. On inauguration day 2017, almost exactly ten years after the first wave of baby boomers has already retired, the President and policy makers will no longer be able to ignore the economic, fiscal, and financial impacts of an aging U.S. population.

While economists have searched for reasons why recent growth in the United States has been disappointing—citing fiscal austerity, regulatory burdens, and a weak global economy—many are now coming to realize that one of the stiffest headwinds is also one of the hardest to overcome. What has become obvious to many analysts is the simple fact that the economic, fiscal, and financial challenges of the near future relate directly to the aging of the U.S. demographic profile (Maestas, Mullen, and Powell, 2016).

Demographics may rule in the decades ahead and past policies may not have prepared us for today’s aging profile, but it is also true that where there are challenges, there are opportunities. A dynamic economy will find new models for delivering services to a less mobile population, new opportunities for innovation in housing construction and personalized healthcare, new products and services for older adults, and, significantly, a transformed employment market.

In the 1930s, as U.S. population growth slowed, Harvard University economist Alvin Hansen said the decline in population growth would cause businesses to invest less capital due to fewer workers to equip, and because older adult consumption patterns would favor personal services over capital-intensive and durable goods. Hansen’s 1938 presidential address to the Ameri-
can Economic Association coined the term “secular stagnation,” resulting from demographic changes he thought would be the permanent U.S. landscape going forward. Secular stagnations would produce “sick recoveries which die in their infancy and depressions which feed on themselves and leave a hard and seemingly immovable core of unemployment” (Hansen, 1939).

Hansen spoke too soon. He could not foresee in 1938 a forthcoming global war that would fundamentally change the economic, social, and fiscal landscape for years to come. World War II led to an explosion in government spending restoring full employment, and a post-war baby boom that would reverse the declining population of the 1930s. The U.S. fertility rate leapt from 2.3 in the 1930s to a peak of 3.8 in 1957.

But beginning in the 1960s, cultural changes resulted in the fertility rate declining significantly and more women joining the labor force. Between 1957 and 1980, the birth rate for women dropped from 3.8 to 1.8 (a 53 percent reduction)—resulting in a rate lower than the estimated replacement rate of 2.1, which the Office of the Chief Actuary of the Social Security Administration no longer expects the United States to achieve in their long-range intermediate estimates to 2090. The result: the baby boom of the 1940s and 1950s, adding in the baby bust of the 1960s, has combined to create a completely altered labor force for the early decades of this new millennium.

Economic Impacts Stemming from the Altered Demographics of the 21st Century

Economists develop estimates of potential growth for an economy based on two important variables: labor force and labor force productivity.

**Labor force**

The first critical variable is the size of the labor force and the second is the productivity level of that labor force. A declining or slower rate of population growth results in a decline or a slower rate of growth in the labor force.

Economists today predict that the population that is employed will remain roughly unchanged over the next few years, but then decline markedly over the next decade, along with reduced participation rates. While various factors contribute to this decline, going forward, the major factor is the aging of the Baby Boom Generation as more working people move into retirement. From 1950 to 2015, the potential U.S. labor force grew annually by 1.5 percent. Critically, over the next decade, the potential labor force will grow annually by only 0.5 percent (Congressional Budget Office [CBO], 2016). Short of changing immigration policies, American presidents and policy makers will find it impossible to reverse this trend—one that has been effectively baked in the cake since the 1960s.

‘A dynamic economy will find new models for delivering services to a less mobile population.’

In addition, the labor force participation rate—the share of people older than age 15 either working or looking for work—has slumped to 62.6 percent (in May 2016)—the lowest level in nearly forty years—and is expected to continue to decline over the next several years (CBO, 2016). Some analysts have attempted to explain this phenomenon as the lingering effects of the 2008–2009 recession that resulted in the long-term jobless giving up the hunt for work and dropping out of the labor force. But economists at the Federal Reserve in 2006 predicted this would happen because of long-range structural factors: aging baby boomers would start retiring; the number of working women would level off; young adults would stay in school longer; and some unskilled workers would bow out of the market. Those economists now predict the participation rate will fall to nearly 60 percent by 2022 (CBO, 2016).

Growth theories today assume that firms need a given stock of capital per worker—
equipment, buildings, land, and intellectual property—to produce output. Fewer workers require less capital, and a vicious circle of stagnation, if not declining growth, results. The growth rate of capital stock slowed from 3.1 percent a year from 1994 to 2003, to 1.2 percent since 2009 (CBO, 2016). As Greg Ip of The Wall Street Journal said, “Simply put, companies are running out of workers, customers or both. In either case, economic growth suffers. As a population ages, what people buy also changes, shifting more demand toward services such as health care and away from durable goods such as cars” (Ip, 2015).

**Labor force productivity**

Productivity, the second critical factor, lies at the heart of economic growth. Increasing productivity for those remaining in a shrinking workforce could offset the negative effects of a declining and aging workforce. Unfortunately, recent estimates from The Conference Board suggest productivity is set to fall for the first time in three decades. By one measure, Americans are producing about 0.2 percent less Gross Domestic Product (GDP) per hour than they were in 2015. Further, most economists today do not project any major increase in worker productivity over the next decade.

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*The new budget director will present the new President with estimates of exploding deficits and debt.*

By another measure, the annual rate of growth in potential labor force productivity is expected to grow slowly over the next decade—1.4 percent—compared to previous decades. When combined with a 0.5 percent annual labor force growth over the same time period, the overall economy’s potential growth would be less than 2 percent (0.5 percent labor plus 1.4 percent productivity equals 1.9 percent GDP). To offset the given slowdown in the labor force over the next decade, and to achieve a gold standard of 4.0 percent annual real growth reached in the 1950 to 1974 time period, worker productivity would have to nearly double to 3.5 percent (CBO, 2016).

The most recent peaks in the productivity cycle came in the 1990s when computer technology displaced the typewriter and secretarial pools. Annual growth in worker productivity grew more than 2 percent in the last decade of the twentieth century (CBO, 2016). The poor productivity figures of today are surprising given the breakneck pace of digital innovation from such places as Silicon Valley. It may mean that government statistics cannot measure the fruits of a digital and service economy as easily as they measure a widgets and manufacturing economy, but nonetheless, the benefits of technology by themselves appear not to offset a slowing, aging workforce that requires much less capital per worker.

If the new President and 115th Congress seek to focus on restoring economic growth to levels necessary to increase families’ incomes broadly and restore confidence that families’ futures will be bright with opportunities, any policy solutions are constrained by the economics and politics of an aging population profile.

But at least two direct approaches to increase growth seem obvious, if difficult—one politically difficult and one structurally difficult. First, the politically difficult approach would be to increase the workforce through delaying retirement for current workers, while increasing immigration, particularly of high-skilled technical workers. While there are recent indications that some workers are delaying retirement largely for personal hardship reasons, recent Social Security statistics still find that three-fourths of individuals claim Social Security benefits before their full retirement age (Social Security Administration, 2015).

Second, there is the structurally difficult policy of increasing worker productivity through regulatory reforms, skill development, training,
The Fiscal Landscape and 21st Century Demographics

It is well understood that as people age, their consumption habits change. Younger households spend more on homes, cars, and their children’s education, while older households spend more on prescription drugs, leisure items, and healthcare. A typical American between ages 35 and 44 spends nearly 10 percent of their income toward a mortgage, compared to less than 4 percent for someone older than age 65. A person older than age 65 spends an average of nearly 15 percent of their income on healthcare, and the younger person less than 6 percent. But these changing consumption patterns also provide employment opportunities for professional and lower-skilled healthcare and homecare services workers (U.S. Bureau of Labor Statistics, 2016).

The distribution of federal and state budgets’ expenditures reflects the younger and older family comparisons. Public expenditures, particularly federal expenditures, are skewed toward older constituents whose ranks will only grow in the future. The result will be an ever-increasing demand for additional services and benefits serving this aging population. The rising demand for aging services also could provide an opportunity for substantial increases in productivity, enabled by the disruptive application of technology to an area of service that has been extremely labor-intensive and “high touch.”

But if these additional demands remain on their current trajectory, there will be a debate over the sources and allocation of additional revenues to pay for these benefits if the country is to avoid exploding public deficits and debt. Alternatively, the U.S. government could rely on even greater borrowing from investors both at home and around the globe who might be willing to purchase Treasury bonds. Unfortunately, obtaining additional tax revenues from a less than robust economy, marked by a declining workforce, means additional downward pressure on family incomes; but relying on additional borrowing only transfers the tax burden to future generations to pay the interest on the borrowed money.

The budget outlook

The 45th President will arrive in Washington, D.C., with economic and budget forecasts based on the underlying labor force and productivity factors similar to those outlined above. Those factors suggest the economy will grow at a very modest annual rate of 2 percent over the course of the President’s first term in office. Such modest growth will be a significant slowdown from the growth activity of the 1980s, 1990s, and 2000s, also resulting in projections of weak revenue growth. When such revenue projections are combined with increasing spending for public programs that would serve an aging population, the first day the President enters the Oval Office, the new budget director will present the new occupant with estimates of exploding deficits and debt. Welcome to the White House!

With no change in policies, annual federal deficits are projected to more than double from $560 billion in 2017 to nearly $1.4 trillion in 2026. Similarly, the cumulative debt held by the public would nearly double from $14.0 trillion (76 percent of GDP) to $27.7 trillion in 2026 (86 percent of GDP) (CBO, 2016). Critically important, within two months of being sworn into office, the new President and Congress will also face having to increase the country’s $18.4 trillion statutory borrowing limit, which has been suspended through March 15, 2017, or subject the country to its first-ever default. (While the limit will be breached on March 15, 2017, the Department of the Treasury is authorized to use “extraordinary measures” that could postpone any federal government default until later in the year (CBO, 2016).
Federal spending between 2016 and 2026 will increase from $3.9 trillion to $6.4 trillion. What will account for this $2.5 trillion in increased spending over this period? Simply stated, programs serving an aging population—Social Security and major healthcare programs—will account for 60 percent of the $2.5 trillion increase in spending. And this is not including the increase in interest payments. If interest costs associated with additional debt from increased spending on these programs are included, nearly three-quarters (73.8 percent) of the growth in spending could be attributed to federal aging programs (CBO, 2016).

The fiscal challenge for the new Administration and policy makers going forward is daunting. They must directly address existing commitments to current and future older adults, while avoiding the debt burden that will be similarly placed on future generations. Further, it also is critical that a balance in the government’s spending and revenue portfolio be found to ensure resources remain available to focus on the economy’s “productivity” growth variable.

Social Security

The most visible impact of an aging population reveals itself in both the growth of beneficiaries and the challenging finances facing the Social Security program (OASI) over the next several years. At the time of the inauguration in January 2017, nearly 52 million retired workers and their survivors will be receiving benefits totaling nearly $800 billion. By the end of the new President’s first term, beneficiaries will have grown to more than 59 million and benefits to be paid out will exceed $1 trillion (CBO, 2016).

Unfortunately, due in part to a declining labor force, the revenues paid into the system beginning in 2017 will not cover the level of benefits paid out and the program’s net cash flow will turn negative. The last time this occurred was early in the 1980s, leading to the creation of the Greenspan Commission to address the program’s financial crisis. Ten years from now, more than 65 million people will receive OASI benefits, 25 percent more than in 2017. Continuing net negative cash flows will erode the assets of the OASI trust fund until they are gone sometime between 2030 and 2034, requiring a 23 percent reduction in scheduled benefits unless changes are made in the program to avoid such significant benefit reductions (Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, 2016).

Candidates for public office, whether for the presidency or Congress, often choose to avoid discussing changes to the Social Security program for fear of electorate retribution. The facts, however, are indisputable: an aging population is a given and changes to the program are necessary to avoid major reductions in benefits. Also given increasing longevity, it is likely that a significant number of that first wave of baby boomers who retired at age 62 in 2007 could be subject to significant reductions at the vulnerable age of 85. The issue is no longer theoretical; it is real. Delaying action will only make the required changes even more difficult.

Medicare and Medicaid

It is well understood that an aging population exerts upward pressure on federal spending for healthcare, especially Medicare. In the new

### Table 1. Components of the Total Increase in $2.5 Trillion Spending from 2016 to 2026

<table>
<thead>
<tr>
<th>Component</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Other Programs</td>
<td>(17%)</td>
</tr>
<tr>
<td>Net Interest (Total 23%/SS &amp; Healthcare 14%)</td>
<td></td>
</tr>
<tr>
<td>Social Security</td>
<td>(28%)</td>
</tr>
<tr>
<td>Major Healthcare Programs</td>
<td>(32%)</td>
</tr>
</tbody>
</table>

Source: Congressional Budget Office, 2016 (author’s calculation).
President’s first term, the number of Medicare beneficiaries will grow by 10 million, from 57 million to nearly 67 million. Further, many low-income older adults will also qualify for Medicaid benefits funded both by federal and state revenues. In 2017, federal and state expenditures for these two programs alone will exceed $1.3 trillion, increasing to $1.9 trillion by the end of the new President’s first term (CBO, 2016). This would be an annual rate of growth of 10 percent.

As the population ages, total Medicare and Medicaid expenditures are affected by changes in relative per-beneficiary spending for beneficiaries of different ages. Recent analyses have estimated the spending per beneficiary for the older adult population (people between ages 65 and 105) enrolled in the traditional fee-for-service Medicare program between 1999 and 2012 (Niu, Buntin, and Manchester, 2015).

These analyses have found that over the entire period, the average annual growth rate of Medicare spending per beneficiary for people ages 65 to 74 was about half of that for those ages 85 to 94. A faster decline in the use of acute inpatient hospital care among younger beneficiaries than among older beneficiaries contributed to the slower growth of spending per beneficiary for the 65- to 74-year-old age group; while rapid growth in spending on care provided in skilled nursing facilities and hospice care contributed to the faster growth in spending per beneficiary among the older groups.

Not only is our nation’s population aging, but also the age profile of older adults is getting older. The total population ages 90 and older is projected to more than quadruple from 2010 to 2050, compared to a doubling of the population ages 65 to 89 (He and Muenchrath, 2011). This segment of our population risks outliving their retirement savings, but equally as important, this demographic will place increased demands on long-term supports and services (LTSS).

Most Americans are not aware that Medicare does not cover the costs of LTSS. Medicaid is the primary payer of LTSS, and LTSS spending accounts for at least a quarter, possibly a third, of total Medicaid spending today. The Office of the Actuary of the Centers for Medicare & Medicaid Services (CMS) estimates that spending for LTSS will grow annually an average of 6 percent through 2021 (end of the new President’s first term). It is further estimated that 70 percent of individuals older than age 65 will need LTSS sometime in their lives, doubling the number of Americans needing such care over the next several years (CMS, 2012). The collision course is set—the demand for LTSS will substantially outpace the U.S. economy’s growth rate, with significant increases in both federal and state Medicaid expenditures.

The total population of people ages 90 and older is projected to more than quadruple from 2010 to 2050.

The fiscal challenges facing the new Administration, the new Congress, and states, created by publically funded healthcare services, will only increase as the baby boom population ages across the next decade.

The Horns of a Dilemma: Current Consumption vs. Future Investment

The final challenge to the new Administration and Congress comes down to simple math. With limited resources, how should American taxpayers’ dollars be allocated between current consumption programs serving an aging population and investments in programs not geared toward older adults that are necessary to achieve long-term economic growth? What resources, if any, can or should government provide to secure our national defense, while investing in those areas that will increase productivity and economic growth in the future? As our society ages and spending programs such as Social Security and Medicare consume a growing portion of the federal budget, it has and will become even more
difficult for policy makers to maintain important investments in our future. An aging society will dictate that many of these investments will be directed at older adults through new products. Broader societal investments in education, infrastructure, science, and technology also will be needed to increase productivity and growth to ensure basic benefits remain available to an older adult population.

Hansen spoke too soon in 1938 because he could not predict a world turned upside down in just a few years by a world war. Analysts today also cannot be omniscient. But absent the power to predict a future of many unknowns, what we know is America is aging and will continue to do so for the foreseeable future. Policy makers cannot risk the country’s future by ignoring the economic and fiscal impact of an aging future. They also cannot risk short-changing the opportunities the shifting demographics provide that will help to confront this future head on. The next President will have “an appointment with destiny.”

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Author's Note

Disclaimer: The views expressed herein are those of the author and should not be assumed to reflect policy positions, views, or options of the Bipartisan Policy Center, its staff, or Board members.
Restoring Public Confidence in Retirement Income

By Alicia H. Munnell

A five-part proposal to restore retirement security.

The new President will have an opportunity to take the lead in solving the nation’s brewing retirement income crisis. This article presents a five-part proposal that offers a comprehensive solution, which includes maintaining Social Security, making 401(k) plans fully automatic, providing all workers with access to an employer-based retirement plan, encouraging the use of home equity for retirement income, and promoting longer work lives.

Components of the Five-Part Proposal

The following five actions are recommended to restore retirement security for older Americans.

Maintain Social Security

Given that Social Security replacement rates are already shrinking under current law, it is important to maintain benefit levels rather than cut them further to close the projected seventy-five-year deficit. Instead of cuts, Congress should increase revenues. Traditional options for raising revenues include increasing payroll tax rates and-or raising the cap on taxable payroll above today’s ceiling. Note that Congress temporarily cut employees’ portion of payroll taxes by two percentage points in 2011 and 2012, and then in 2013, restored the cut with little controversy. So changes in this range are certainly feasible.

Other non-payroll-tax ideas for increasing revenue are shifting the burden of financing Social Security’s start-up costs (the legacy debt) to general revenues and investing a portion of the trust fund in equities. These ideas are more complicated and controversial, but could be part of a financing package.

Make 401(k)s fully automatic

The 401(k) is not currently an effective savings vehicle for many workers, but its shortcomings can largely be overcome by mandating that all 401(k)s be fully automatic, while continuing to allow workers to opt out. Plans should be required to automatically enroll all of their workers (not just new hires); enroll them at a meaningful default contribution rate; and automatically increase that rate until the combined employee contribution and employer match reach 12 percent of wages. The default investment option should be a target-date fund composed of a portfolio of low-cost

Abstract

Today’s workers face a brewing retirement income crisis. Economic and demographic changes have transformed the retirement landscape, systematically shifting risk and responsibility away from government and employers to individuals. As a result, about half of working-age households are “at risk” of being unable to maintain their pre-retirement standard of living in retirement. Fortunately, Americans have the tools to fix the problem. And the sooner we act, the easier it will be to shore up the nation’s retirement security. | key words: retirement income crisis, retirement security, Social Security, 401(k) plans, home equity
index funds. Also, to prevent people from running out of money in retirement, plans should establish either a single premium annuity or an advanced life deferred annuity as a default withdrawal mode for some portion of 401(k) balances. Separately, the problem of 401(k) leakages (which occur when individuals withdraw their savings before retirement) needs to be addressed.

**Cover those without a plan**
More than half of private-sector workers are not covered by any form of retirement plan—neither defined benefit nor 401(k). To close this coverage gap, Congress should mandate that employers without a retirement plan auto-enroll their employees in an IRA that is invested in a low-cost target date fund. To dissuade lower-income workers from opting out, Congress should expand the Savers Credit and make it refundable, which would provide a matching contribution from the government.

**Encourage the use of home equity for retirement income**
Retirees generally think of their home equity more as an emergency reserve than as a source of retirement income. However, because they may not have enough from Social Security and 401(k)s, they should consider downsizing or taking a reverse mortgage. Downsizing provides extra funds that can generate retirement income and also cuts expenses. A reverse mortgage allows retirees to stay in their home while accessing their equity; and the loan does not have to be paid back until the homeowner moves, sells the house, or dies. These options should be widely recognized as viable planning strategies for individuals nearing retirement. Specifically, the government should educate people about the possibility of using their home equity in retirement, and regulatory agencies should make clear to all financial professionals who provide retirement products or advice that they are acting within their fiduciary responsibilities if they suggest that a reverse mortgage be part of a financial plan for retirement.

**Encourage longer work lives**
Policy makers should encourage people to work longer and claim Social Security later, through an educational campaign highlighting the fact that Social Security’s monthly benefits are highest at age 70 and are reduced actuarially for each year they are claimed prior to age 70. Such a shift away from emphasis on the statutory Full Retirement Age—along with a clear explanation of the benefits of working longer—could have a significant impact over time on the way Americans think about retirement. Working longer makes an enormous difference because it increases an individual’s monthly Social Security check by 7 percent to 8 percent for each year of delay; it allows an individual to contribute more to a 401(k), and provides more time for the assets to grow; and it shrinks the number of years over which an individual needs to stretch his retirement nest egg. While it is not realistic to think that everyone will work until age 70—the current average retirement age for men is only 64—even working a few additional years will go a long way to boosting retirement security.

**How These Proposals Address the Problem**
Baby boomers—and the generations that follow them—will face a much different retirement landscape than did their parents: they will need more retirement income and they will receive less support from the traditional sources of Social Security and employer-sponsored plans. And today, as in the past, half of private-sector workers do not participate in any retirement plan at a given point in time. In addition, most people do not recognize that their house is a major retirement asset, and many retire too early.

**The need for retirement income is growing**
Today’s workers will need more income when they retire because retirement spans are getting
longer, healthcare costs are rising, and interest rates are very low.

- The number of years spent in retirement is rising because people are living much longer and continuing to retire at relatively young ages. The retirement period has increased from thirteen years in 1960 to about twenty years today (Ellis, Munnell, and Eschtruth, 2014), which means that people need income to support themselves for many more years than in the past.
- Despite Medicare, retirees still face substantial out-of-pocket costs for healthcare premiums, deductibles, co-payments, and uncovered services. Out-of-pocket costs are eating up an increasing portion of the average Social Security benefit. Long-term-care costs are a looming additional expense for many. These rising costs mean that people need more retirement income to maintain their standard of living.
- Real interest rates continue to hover around historic lows of 1 percent, which means that retirees need a much bigger nest egg than in the past to generate a given amount of income.

Traditional sources of retirement income are providing less support

At the same time that people need more retirement income, traditional sources for that income are shrinking. Both Social Security and employer-sponsored retirement plans will provide less support than in the past. This trend is especially worrisome because people save virtually nothing outside of these two vehicles.

- Social Security benefits—the foundation of the retirement income system—are shrinking in their ability to replace pre-retirement income for three reasons. First, under current law, the gradual rise in the program’s Full Retirement Age from age 65 to age 67 is cutting benefits across the board. For those who continue to retire at age 65, this cut takes the form of lower monthly benefits; for those who choose to work longer, it takes the form of fewer years of benefits. Second, Medicare premiums, which are automatically deducted from Social Security benefits, are rising faster than benefit levels. Third, more benefits will be subject to taxation under the personal income tax because the tax thresholds are not indexed for inflation or wage growth. These three factors will reduce Social Security replacement rates for the average worker retiring at age 65 by nearly a quarter—from a net 40 percent in 1985 to 31 percent by 2030 (Ellis, Munnell, and Eschtruth, 2014).

- Employer-sponsored plans are not doing the job. For those lucky enough to work for an employer providing a retirement plan, the nature of these plans has changed dramatically from defined benefit plans to 401(k)s. This shift means that employees rather than employers make all the decisions and bear all the investment risks during the accumulation phase and face the risk that they will exhaust their assets in retirement.

In 2006, policy makers—through the Pension Protection Act (PPA)—encouraged 401(k) plan sponsors to adopt automatic mechanisms that have proven effective at boosting participation (auto-enrollment) and contribution rates (auto-escalation). However, the effects of the PPA appear to have played themselves out, and today fewer than half of participants have access to auto-enrollment (Vanguard Group, 2016), and a much smaller fraction have auto-escalation (Plan Sponsor Council of America, 2014). Also, provisions to encourage auto-annuitization—which would make annuities the default distribution method for a portion of 401(k) assets—have never been enacted.

As a result, 401(k)s are still far short of being a broadly effective retirement savings vehicle. For example, about 20 percent of those eligible...
Half of private-sector workers do not participate in a plan
Unfortunately, those workers covered by a 401(k) plan are the lucky ones. Only about one-half of private-sector workers—at any given time—are participating in an employer-sponsored plan, and this share has remained relatively constant across almost four decades (Ellis, Munnell, and Eschtruth, 2014). The uncovered often work for small employers or in specific industries, such as retail sales. The lack of universal coverage means that many American workers move in and out of plan participation and a significant percentage will end up with nothing but Social Security.

The house is rarely considered as a source of retirement income
For most families, their house is their major asset. Generally, though, older people only think of their house as a reserve in case they face major health-related expenses, such as the need for long-term care. In the absence of a precipitating event, such as the death of a spouse or entry of a family member into a nursing home, most households continue to own their own home well into their eighties. Even when a financial shock occurs, it is rare for older adults to sell their house. Those who do sell their house are likely to purchase another and increase, rather than reduce, their home equity. Homeowners can access their equity either by downsizing to a less expensive house or by taking out a reverse mortgage, but only 2 percent of those eligible for a reverse mortgage select the option (Moulton, Haurin, and Shi, 2016).

People are retiring too early
While life expectancy has increased dramatically over many decades, the average retirement age declined from the 1880s to the mid-1980s. This long-run trend toward earlier retirements began with Civil War pensions and continued with the enactment of Social Security and the expansion of employer pensions. The downward trend got a further boost from Medicare’s introduction in 1965, the sharp increase in Social Security benefits in 1972, and the spread of early retirement benefits in pension plans (Costa, 1998). The downward trend stopped in the mid-1980s and, since then, the average retirement age for men has increased by two years (from age 62 to age 64) (Ellis, Munnell, and Eschtruth, 2014). But the increase has not been enough to prevent a substantial rise in the ratio of retirement years to working years.

Overall impact is a retirement income crisis
The combined effect of increasing needs, declining resources, the enormous coverage gap, and the failure to recognize the house as a retirement asset means that more than half of today’s working households will fall short in retirement. Thus, Americans are facing a retirement income crisis.

Who Cares?
Those most directly affected are today’s workers and future retirees. This looming challenge is particularly acute for those with low to moderate incomes. These households are heavily dependent upon Social Security, with the bottom third receiving nearly 90 percent of their retirement income from the program and the middle third receiving about 70 percent (author’s calculations from U.S. Census Bureau, Current Population Survey) (U.S. Census Bureau,
Thus, the current reductions in Social Security benefits hurt them more.

More strikingly, low- and moderate-income households are less able to respond effectively to the retirement challenge than their higher-income counterparts. First, it is harder for them to save because they have less access to workplace savings plans. Second, it is harder for these households to work longer because they tend to be in worse health and to have skills and abilities that erode more quickly relative to the needs of their jobs. As a result, they are more likely to retire in their early 60s and claim Social Security right at age 62, with a reduction in their benefits for early claiming. Third, it is harder for them to access the financial resources that they do have, because most of their assets are tied up in home equity, which requires knowledge of and access to products that are not currently in widespread use.

The retirement plight facing today’s low- and moderate-income workers will also crimp the economic opportunities and retirement prospects of their children and grandchildren. Traditionally, part of the ethos of the older generation is to lend a hand to younger generations by helping them get started financially. However, those who are scrambling to piece together their own retirement will not be in a position to invest in their families; in fact, they might even end up draining resources from them. The younger family members are then less likely to achieve their own financial security. In this way, today’s retirement income crisis creates ripple effects from generation to generation.

Although many employers do not recognize the fact, they too should care that today’s workers have inadequate retirement incomes. With the shift to 401(k)s and the increased mobility of older workers, retirement has become a much messier process than in the past. With mandatory retirement, both parties knew that, as of a certain age, the relationship would end. Employers also used defined benefit plans to structure an orderly departure. No such structure exists in a 401(k) environment. Employers face the prospect of workers with declining productivity and inadequate 401(k) balances hanging on much longer than desirable.

Finally, government officials should care whether their citizens have adequate resources, not only for humanitarian reasons, but also for the potential drain that unprepared retirees will impose on public coffers. No one has yet documented it, but initiatives by states to expand coverage likely reflect concerns about future costs, such as Medicaid, associated with a large impoverished older adult population.

**The Politics of a Solution**

The good news is that a solution to the retirement income crisis is feasible; we have the ability and the financial infrastructure to meet the challenge. Solving the problem does not pit the old against the young, grandparents against grandchildren. Americans belong to families that care about the generations ahead of and behind them. All that is required is the political will, and the required changes—with the exception perhaps of maintaining Social Security—are not politically charged.

The bad news is that more saving during the work life, either through employer plans or Social Security, means less consumption. There is no silver bullet. Some people talk of contributions from employers as if such funding were free money, but economists believe that employers think in terms of total compensation, so a dollar paid in fringe benefits means a dollar less paid in wages. Thus, the culture needs to change so that people recognize that as they build up assets for retirement they need to control spending. Such a trade-off is painful in a world where middle-class households have not seen any increase in their real incomes for decades.
Two major components of the required changes should be relatively easy politically. The first is making 401(k) plans automatic. Republicans may argue for trying to accomplish the goal through more safe harbors or tax credits. But this approach has been exhausted; a mandate is required. Financial services firms should support a mandate because it increases assets under management. In fact, at least one CEO of a major financial services firm has come out in support of such an approach. Some employers may resist because auto-enrollment increases the required match, which increases costs. Two points could be made here. First, the cost increase is a short-run issue because, in the long run, they can recoup that money by slowing wage growth and-or raising prices. Second, employers benefit from having workers prepared for retirement who can choose to stop working when their productivity declines.

The Auto-IRA proposal to expand coverage will meet with some resistance from those who oppose any mandate but, given the huge gap in coverage, compromise should be possible. Moreover, state initiatives to set up their own plans highlight the inefficiencies of a state-by-state approach. Interestingly, anecdotal evidence suggests that opposition toward a national plan among some financial services companies may be softening, as they would prefer a uniform plan to fifty different state plans. On the other hand, both Republicans and Democrats appear to support expanding the Savers Credit and making it refundable.

Preserving Social Security will be harder because the notion of a 50-50 split between tax increases and benefit cuts sounds fair. And that is the pattern established in 1983 and suggested by a recent report from a Bipartisan Policy Center commission. On the other hand, a seismic shift has occurred in the politics of Social Security; while previously, all the pressure was on the side of cutting benefits, enthusiasm for expanding benefits has gained a lot of momentum. Holding steady might emerge as a nice compromise between cuts and expansion.

Encouraging people to work longer and to use their home equity are essentially messaging initiatives that involve no legislation and relatively few resources. In terms of reverse mortgages, the regulatory agencies have to make clear to financial professionals who provide retirement products or advice that they are acting within their fiduciary responsibilities if they suggest using reverse mortgages as part of a financial plan for retirement.

Conclusion

The bottom line is that a long retirement is expensive; it is difficult to prepare for because Americans are increasingly on their own when it comes to ensuring sufficient retirement income; and, without making changes, most families are not going to have enough in savings. Federal policymakers need to take the lead in ushering in the necessary changes that will promote more saving—through maintaining Social Security, automating 401(k) plans, expanding coverage, encouraging the use of home equity in retirement, and promoting longer work lives. The proposals described above involve doable adjustments that build on our existing retirement systems. Restoring confidence in retirement income should be a high priority for the new President.

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References


COMING UP IN
Spring 2017

When Goals of Life Begin to Change: Driving Improvement in End-of-Life Care

William Novelli and Raca Banerjee, Guest Editors

As the United States is slated to have 18 million adults older than age 80 by 2050, it is time to address what sort of care this cohort will receive at the end of life. Many will have multiple chronic conditions and functional impairments, as well as a range of complex spiritual, emotional, and physical needs. Yet currently, these individuals receive care that is uncoordinated, fragmented, and unable to meet their evolving needs, goals, values, and preferences. The Spring 2017 issue of *Generations* will discuss a paradigm shift in the thinking around end-of-life care, focusing on how goals of life begin to change, rather than on a series of clinical conditions and interventions. Articles will identify current challenges and future opportunities to reform end-of-life care in America, and discuss how public opinion, provider discussion, and political dialogue around end of life care have evolved over time.
The rising cost of healthcare is one of the greatest economic, fiscal, and moral challenges facing the United States, not just for the next four years, but also for coming generations. Successful efforts to simultaneously improve quality and outcomes while “bending the curve” of healthcare spending must be a top national priority.

Where We Stand Today
Despite substantial progress reforming the health insurance market and reshaping healthcare delivery in the past six years, current trends are not promising for America’s older adults, or the population as a whole.

Undoubtedly, the United States has benefited from an unexpected slowdown in health spending growth and the fact that more than 90 percent of the population is currently insured. But that fortuitous slowdown has largely ended, with spending climbing again at a rate well above inflation and wage growth, albeit not as high as historical norms. The reality is that the cost of Medicare and Medicaid will consume increasing shares of our economy and our federal budget in the years and decades ahead. Any resurgence of healthcare spending growth will only accelerate the impact of an aging population on health spending. And as Medicare costs grow, so will the premiums paid by beneficiaries, a development which will negatively affect their ability to afford care—with the greatest immediate impact on the 5 percent of beneficiaries, who generate 50 percent of healthcare spending.

In the non-Medicare population, the situation is no better. Recent analyses of the employer market and the non-group market show rising premiums and rapidly climbing deductibles. On this trajectory, future generations of Americans will find it increasingly difficult to afford the care they need. Faced with these affordability barriers, Americans will experience higher rates of illness, disability, and early
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mortality than they otherwise might. Unless we act, this combination of poor health and the increasing cost of care will gradually erode our standard of living—until the security provided today by programs like Medicare, and the American dream of generational progress, both vanish under the growing burden of healthcare costs.

The Path Forward

Difficult as it will be, our health system requires major additional reforms to change its cost trajectory. There are three broad strategies with the power to accomplish this goal without sacrificing quality or access, but only if they are pursued aggressively: reform healthcare delivery and benefits to better care for the chronically ill; make prescription drugs more affordable; and reduce demand for healthcare through public health initiatives.

This article outlines a series of targeted policies that would implement these strategies.

The root causes of our healthcare spending problem have been known for years, if not decades: poor quality often is due to failures of care coordination, inefficient and uncompetitive markets for prescription drugs, and high rates of preventable chronic disease. The United States can no longer afford to leave these root causes unaddressed. And with strong leadership from the new Administration, they need not be.

Efficient, Effective Care for the Chronically Ill

The U.S. Agency for Healthcare Research and Quality estimates that people with multiple chronic conditions (representing 5 percent of the population) account for 66 percent of total healthcare spending (Agency for Healthcare Research & Quality, 2016). Yet our healthcare system too often furnishes these patients with inefficient, ineffective, and uncoordinated care. While there is no silver bullet, several steps, if taken together, can meaningfully improve Americans’ experience of care and outcomes, while also saving money.

Restore primary care’s central role

Historically, primary care clinicians have been trained to see the needs of the whole person and design a care plan accordingly. Nowhere is this more important than among older adults and disabled Americans.

A broader embrace of medical homes and other advanced primary care models, particularly for high-cost populations, could help bring our healthcare system back to this holistic model. The concept of a medical home conveys both the assurance to the patient that their full range of needs are recognized, and also conveys the responsibility of the physician to coordinate with a range of specialists, when appropriate, to provide more efficient care.

The evidence is clear that local markets, states, or even nations with stronger primary care sectors have lower healthcare spending (Starfield, Shi, and Macinko, 2005). For lower costs in Medicare and the United States as whole, primary care must be a top priority.

Within Medicare, advanced primary care models like Independence at Home and Geriatric Resources for Assessment and Care of Elders (GRACE) have been shown to improve care quality, outcomes, and curb costs for the most challenging Medicare beneficiaries (Centers for Medicare & Medicaid Services [CMS], 2015). In both cases, the models applied long-standing principles of geriatric care, emphasizing functional assessment, care for multiple chronic conditions, non-clinical needs, provision of services in the home, and care driven by patient and caregiver preferences and values.

Two immediate steps for fostering such models would be to enact legislation converting Independence at Home to a permanent part of the Medicare program, available nationwide, and to integrate geriatric care principles into ongoing multi-payer medical home initiatives like the Comprehensive Primary Care Plus...
model as well as Accountable Care Organization (ACO) programs.

Training and educating for team-based care
Physicians are not the only trained professionals who can deliver top-quality care. Other professionals—physician assistants, nurses, home health aides, social workers, and community health workers—often can provide more responsive and more efficient care and services to those with multiple chronic conditions. That is why smart providers and plans, including physician practices, are increasingly relying on teams that embrace a wide range of healthcare and social service professionals.

The new Administration should work with Congress to support broader embrace of team-based care in three ways.

First, all federally supported education and training programs must train every health profession to work collaboratively in interdisciplinary teams to care for the chronically ill, particularly the highest-cost, highest-need patients.

Second, because traditional fee-for-service payment is ill-suited to support interdisciplinary teams, the Administration should press forward with the transition away from fee-for-service toward alternative payment models sparked by the Affordable Care Act’s payment reform provisions and the Medicare Access and CHIP Reauthorization Act (MACRA; goo.gl/2eqXa4).

Finally, current funding levels lapse in 2017 for Federally Qualified Health Centers, the Teaching Health Center program, and the National Health Service Corps, threatening the healthcare sector with a primary care funding cliff. Beyond their important role in improving access for underserved communities, these programs will be crucial if we are to effectively train the next generation of team-focused, primary care clinicians. The new Administration should work with Congress to substantially expand federal funding for each of these programs and make that funding permanent.

Social service interventions to reduce medical costs
Studies have demonstrated the value of social services such as nutrition, in-home support services (Holland, Evered, and Center, 2012), and supportive housing services (Dohler et al., 2016) in reducing downstream medical costs for older adults and disabled beneficiaries. Capitated and integrated health plans that serve Medicaid enrollees and beneficiaries dually eligible for Medicare and Medicaid are using their flexibility to provide some of these services today (Philip, Kruse, and Soper, 2016).

However, current law and regulations generally prohibit spending Medicaid dollars on housing. And if a beneficiary is not enrolled in Medicaid, neither Medicare providers nor plans are permitted to deploy in-home support or nutritional interventions—even when these interventions could forestall disability or institutionalization. The new Administration should insist that federal healthcare programs allow providers and plans the flexibility to better serve high-cost, high-need beneficiaries. It is time to work with Congress to update the existing Stark (goo.gl/9haJkx) and anti-kickback statutes, overhaul rules governing supplemental benefits in Medicare Advantage (MA) and ensure that Medicare-Medicaid Plans, MA plans, and advanced Alternative Payment Models (APM) like the Next Generation ACO Model (goo.gl/wBFvRb) have the flexibility to provide services and supports not covered by either program whenever they would help lower overall costs and improve outcomes.

Paying for value: next steps
Transitioning healthcare reimbursement away from paying for the volume of services and toward paying for the value of care is now a
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consensus-backed, bipartisan strategy. We can see it in the enthusiastic embrace of Health and Human Services Secretary Burwell’s payment goals by stakeholders, and the enormous show of bipartisan support for recently enacted legislation overhauling physician payment (MACRA) and Medicare post-acute care (the IMPACT Act; goo.gl/mb4EtP).

However, if this transition is going to succeed, there is much work left to do: improving the accuracy of value metrics, risk-adjusting for patient populations, and calibrating incentives to reward the highest quality care are just three of the challenges ahead. Additionally, despite the spread of alternative payment models like ACOs and episodic bundling, fee-for-service remains the predominant payment approach. Even most APMs continue to rely on fee-for-service billing or payment to some degree.

Federal policy should begin supporting payment models that decouple provider reimbursement from the fee-for-service chassis. On the regulatory front, the Center for Medicare and Medicaid Innovation (CMMI) can encourage Next Generation ACOs in fee-for-service Medicare to move toward capitation (also known as global payment) and ensure that MACRA’s 5 percent Advanced APM participation incentive is available to clinicians participating in the capitated models now used by some MA plans. But the new Administration should also capitalize on bipartisan congressional interest in legislation to establish global payment options within traditional Medicare for well-qualified provider organizations.

**Improving end-of-life care**

Today, 32 percent of Medicare expenditures go to care and services for beneficiaries who are in their last two years of life, according to the Dartmouth Atlas of Healthcare (2016). But much of this money is spent on overuse of procedures, often subjecting patients to pain and discomfort, with little chance of improving their quality of life. We know palliative care is associated with improved experience for the patient and their caregivers (Smith et al., 2014)—as well as lower costs (Morrison et al., 2011).

The movement to respect patients’ care choices and broaden the availability of palliative care has made great progress—most notably with Medicare’s recent decision to reimburse for advanced-care-planning discussions with patients. But more could be done to integrate support for caregivers into all federal healthcare programs, and expand additional training and continuing education in palliative care for health professionals. The new Administration should also work with Congress and the states to pursue the regulatory and statutory changes necessary to ensure all Americans’ advanced care plans are properly documented, accessible, and transferable across time and care setting.

**The Need for More Affordable Prescription Drugs**

The rising cost of prescription drugs represents an immediate threat to efforts to constrain healthcare costs. Prescription drugs have the power to dramatically improve outcomes, even cure deadly and disabling disease. This is particularly true for the nation’s Medicare beneficiaries, who use more prescription drugs than does the overall population. But today’s rapid rate of increase in drug spending means that fewer and fewer patients can afford the drugs they need and prescription drug costs are now the single largest driver of increases in the overall cost of care.

The failures of our prescription drug market are numerous. New medications often are priced very high, without regard to their clinical value. Existing medications have their prices increased frequently, again without regard to value. And even some generic drugs have experienced very high price increases when the manufacturer finds itself the sole remaining producer. The market for prescription drugs is clearly broken, and needs a series of steps to repair it. Restoring a balance between affordability and rewards for
innovation will be critical to the sustainability of federal healthcare programs and the Administration’s overall efforts on healthcare policy.

Transparency
For a market to function, information relevant to value must be transparent. Currently, there is little relevant information available about the value of a new medication. FDA approval is based on demonstration that a medication is safe and effective compared only to a placebo. Information on comparative effectiveness between medications is lacking, and purchasers have no basis for a negotiation based on value.

The new Administration should insist that both price and effectiveness information is broadly available so consumers and payers can fully evaluate the value of the drugs for which they are paying. Requiring manufacturers to disclose pricing information in conjunction with a product launch, or in conjunction with price increases above general inflation, is a necessary first step toward a functioning market. Also the new Administration should work with Congress to require manufacturers to submit studies comparing new treatments to existing therapies as part of the approval process—similar to requirements in the European Union and other nations.

Competition
The FDA today does not take competition into account when considering new drug applications for either brand or generic compounds. But its actions have a great deal of impact on whether competition can exist. The substantial backlog in approving generics, long waits for approval of competitors to expensive drugs, and the FDA’s failure to provide even draft guidance on interchangeable biologic medicines all are factors that limit effective competition. If we are going to be able to rely on competition to keep drugs affordable, the FDA must act to address these limitations. Also the new Administration should work with Congress to bring down statutory barriers to competition, including the excessively long, twelve-year period in which new brand-name biologic drugs are entirely protected from generic competition and the Risk Evaluation and Mitigation Strategies loopholes that allow brand-name manufacturers to deny competitors access to samples needed to develop lower-cost, generic versions.

Pay for Value
Ultimately, a functioning market should be able to reward value in a way that encourages innovation but keeps overall cost increases sustainable. To achieve this, there needs to be transparency, competition, and comparative effectiveness information. Paying for results is one way to reward value—by tracking patients who take certain drugs and rewarding the manufacturer for good outcomes. The industry is beginning to explore such tactics, but more aggressive policies are needed. Payers, including government programs, could base reimbursements on agreed upon measures that assess how well the medication works in practice.

One approach would be to base initial pricing with reference to the existing standard of care prior to launch, with incentive payments post-launch based on clinical and economic results. Reimbursements also could be based on the findings of the independent and highly respected work of the Institute for Clinical and Economic Review (ICER). In addition, manufacturers of drugs priced in conformity with ICER standards of affordability could receive incentive awards designed to support additional investments in research and development.

Public Health: Curbing Demand for Healthcare Services Through Behavior
The United States has the highest healthcare costs in the world, in part because of the demands placed on the health system by individuals’ unhealthy behaviors. If we are to keep healthcare affordable in the United States, the new Administration’s strategy must priori-
tize not just delivering healthcare more efficiently, but also keeping Americans healthier, thus lowering demand. We must fight against the epidemics of tobacco use, alcohol abuse, obesity, and opioid abuse, which are taking lives and driving up health costs for Americans in all age cohorts.

Tobacco
Tobacco use today is the single biggest cause of preventable death and costs the healthcare system an estimated $170 billion a year (Xu et al., 2015). About one in every five deaths (almost 500,000 every year) is associated with tobacco use, including 42,000 from exposure to secondhand smoke. Measures that effectively deter tobacco use include social media campaigns directed at teens, raising tobacco taxes (Campaign for Tobacco-Free Kids, 2016), and raising the age for purchase to 21 (Institute of Medicine, 2015). The new Administration should work with Congress to bolster funding for effective federal tobacco prevention programs, while pursuing incentives for states that increase the tobacco age of purchase to 21 and an improved, strengthened federal excise tax on all tobacco products.

Sugar-sweetened beverages and obesity
Medical costs for obesity-related health conditions are estimated to be $190 billion, with roughly half these costs paid for publicly through the Medicare and Medicaid programs (Harvard University, T.H. Chan School of Public Health, 2016b). Rising consumption of sugary beverages has been a major contributor to the obesity epidemic (Harvard University, T.H. Chan School of Public Health, 2016a). Thus, one measure to curb the obesity and diabetes rate is a sugar-sweetened beverage tax. Taxing sugar-sweetened beverages would reduce the adverse health and cost burdens of obesity, diabetes, and cardiovascular diseases (Wang et al., 2012), and the resulting increase in revenues could provide resources to support broad implementation of the most cost-effective obesity prevention interventions available.

Alcohol
Alcohol abuse contributes to an estimated $27.5 billion in healthcare costs annually, in addition to substantial costs due to lost productivity, car insurance claims, and criminal justice expenses (Stahre et al., 2014). The Centers for Disease Control and Prevention (CDC) estimates that excessive drinking accounts for one in ten deaths among working age adults, and is the fourth leading preventable cause of death (CDC, 2015). Enhanced enforcement of retailer compliance regarding the sale of alcohol to minors and higher taxes on alcohol have each been shown to be effective (Community Preventative Services Task Force, 2007). Both should be on the new Administration’s policy agenda.

Opioid abuse
The U.S. Department of Health and Human Services estimates that the abuse of opioids generates an estimated $72 billion in medical costs each year, which is comparable to the costs of major chronic conditions, such as asthma and HIV. Opioid overdoses killed more than 28,000 people in 2014—more than any year on record, and an alarming 14 percent increase from the previous year (CDC, 2016). To effectively address this epidemic, the new Administration should challenge Congress to back up its talk with meaningful action. The Administration can begin by insisting on robust appropriations for substance abuse prevention and treatment, along with stronger standards and funding for the community behavioral health centers that serve patients facing both addiction and other mental health disorders.
These initiatives, taken together, would have a very substantial impact on the cost of healthcare, benefitting both families and the economy by lowering premiums and burdensome cost-sharing. They would also save lives. Given the imminent threat that rising health costs represent, we should not delay acting. While no single magic bullet can fix healthcare, the combination of reforms focused on high-cost, high-need patients, measures to keep prescription drugs affordable, and successful public health initiatives would constitute the single most important set of actions that the incoming Administration could take to put Medicare, as well as our broader health system, on a more sustainable course and to benefit all Americans.

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References


The Summer of Love

W. Andrew Achenbaum, Erlene Rosowsky, and Mercedes Bern-Klug, Guest Editors

The Summer of Love in 1967 stands as a seminal moment in U.S. history, when the counter-culture entered the mainstream and the rest of America saw firsthand the power of anti-war activism, free love, feminism, and drug- and music-fueled optimism. The Summer 2017 issue of Generations will explore how this group of current baby boomers are experiencing later life. How is this cohort, which broke traditions in the 1960s, faring now as they are long past the age they said was not to be trusted? The issue will address generational dichotomies, women’s roles, global violence and the impact of military conflicts, love in older age, retirement, pressures to remain “young,” friendship, caregiving, and general post-1968 expectations, illusions, and disillusionments.
A bold new proposal to counter the potentially devastating costs of long-term care to older Americans and their families.

A Proposal for LTSS Financing Reform

We recommend that the President announce a bold legislative package to significantly expand coverage for LTSS benefits. The package would begin the transition to integrating LTSS coverage with existing health insurance coverage for Americans of all ages. The goal ultimately would be to provide coverage for LTSS at little or no incremental cost within the existing health insurance system. Access to well-managed home- and community-based care would reduce the reliance on expensive hospital and institutional care over time.

The legislative changes would amend the Medicare program to establish a new program of fully integrated care—care that would include LTSS—in place of Medicare Advantage (MA). Medicare beneficiaries also eligible for Medicaid (i.e., dual eligible beneficiaries) would receive the expanded benefit package at no additional cost. Other Medicare beneficiaries would pay an increase in the enrollee premium based on the net increment of per capita cost in the program. Plans with this new integrated benefit would have their exposure to “catastrophic” LTSS expenses capped through a federal reinsurance program, backed by a federal guarantee.

Finally, the legislative package would include a series of pilot projects to test the impact on non-Medicare health insurance premiums of a requirement to incorporate LTSS benefits within

→ABSTRACT  Americans remain at risk for potentially devastating costs for LTSS that are not covered by Medicare or private health insurance. This article proposes a legislative package to finance LTSS, offering LTSS coverage in the context of existing integrated health plans. Building on current federal demonstrations, LTSS coverage would initially be integrated with Medicare Advantage plans. The goal is to provide coverage for LTSS at little or no incremental cost within the existing health insurance system, relying on well-managed home- and community-based care to reduce the use of expensive hospital and institutional care. | key words: long-term services and supports, LTSS, LTSS integration, integrated plans, Medicare, Medicaid, functional limitations, home- and community-based care
the package of essential health insurance benefits for the non–Medicare-eligible population. The pilot projects would include broad risk pools, risk adjustment, and other features now found in the MA program that spread risk. The integrated LTSS package would only be available through health insurance plans (in Medicare, the plans that are now MA plans) and would not be available to beneficiaries who remain in traditional Medicare, or through Medicare supplemental plans. The integrated package would be the standard package for new enrollees in MA plans. The goal would be to encourage beneficiaries to enroll in fully integrated plans to gain LTSS coverage. Current MA enrollees could remain in grandfathered plans for up to five years. Private long-term-care insurers could amend benefits to wrap around the new plans (paying co-insurance and deductibles) or to pay the premium increment.

The Message to Americans: Ease Families’ Financial Burden and Bend the Cost Curve

The President would announce this financing reform program as a bold new path forward in meeting the needs of all Americans and their families to protect against unanticipated and devastating costs of a prolonged need for assistance with daily living activities, due to an illness or disability. Such reforms would protect the retirement income and assets of Americans in their old age.

This new approach to care, combining medical and home-based care, would enable older Americans to safely remain in their homes and communities for as long as possible, support overburdened family caregivers, and reduce the failures of in-home support that result in unnecessary and expensive emergency room visits and hospital and nursing home admissions. As well, it would:

- Substantially reduce medical spending for the small portion (5 percent) of the population that today accounts for half of all medical spending (Stanton and Rutherford, 2005);
- Reduce the impact on state budgets of Medicaid long-term-care spending; and
- Help individuals and families make informed decisions about end-of-life care, and reduce the substantial amount of Medicare spending on unwanted medical treatment.

What Is the Problem?

Twelve million Americans need LTSS, about half of them are ages 65 and older, and the other half are people with disabilities who are younger than age 65. This cohort of 12 million people will double over the next thirty-five years (Commission on Long-Term Care, 2013). A person turning age 65 today has a 70 percent chance of needing some amount of assistance with activities of daily living; 52 percent will need a substantial amount of assistance—and 14 percent of this group will need assistance for more than five years. Nearly all of these people will need some paid in-home care or nursing home care, and will spend an average of $266,000—half of it out of pocket (Favreault and Dey, 2016). Few families reach old age with resources to cover these costs, and many will exhaust their resources and become eligible for Medicaid.

Care provided in the home often is inadequate—particularly protracted care for Alzheimer’s disease and dementia. Families are poorly equipped to handle the considerable responsibilities in caring for individuals who are cognitively impaired. All too often, care for older adults is arranged and provided piecemeal, with poor to no coordination between medical providers and in-home caregivers. This results in adverse effects on the person receiving care: lack of compliance with therapies, adverse drug inter-
actions, and other inadequacies of in-home support—all of which leads to unnecessary emergency room visits, hospitalizations, and other institutional care, at substantial cost to Medicare and Medicaid.

As older adults age and develop LTSS needs, they and their families should have access to care management that would help them assess their needs, plan, arrange, and coordinate their care, and provide a single point of contact and accountability for outcomes. Outside of Medicaid, however, financing for most people is neither available nor practical. Private LTSS insurance today serves only 10 percent of the potential market of persons ages 50 and older—and is not growing (Commission on Long-Term Care, 2013). New individual insurance products could expand coverage slightly, but individual insurance as a solution is limited.

The strong relationship between providing integrated and effective supports and services, and reducing healthcare spending provides an opportunity to fund LTSS for people through savings from reduced healthcare spending. Now, half of states integrate care through managed care plans for Medicaid participants, but not for dual eligible older adults, except through a handful of “Duals Demos” and special needs MA plans.

What Is Driving the Problem?
The financial and emotional burden on American families of caring for an aging or disabled family member (or loved one) has been exacerbated by the transformation of the workforce to two-worker families, placing more emphasis on paid formal care and support services.

Medicaid’s role as a payer for institutional care has changed in recent years with the movement to “rebalance,” i.e., reduce institutionalization by providing more support for persons remaining in their own homes and communities. While the shift away from institutional care has been dramatic in some states for younger adults with disabilities, it has not to the same degree affected care for older adults. Most states have capped their support for home-based care to control expenditures. Without broader financial support for LTSS outside of the context of Medicaid, states will be overwhelmed with the doubling in LTSS demand as the already aging baby boomers grow older and more frail.

The more recent state Medicaid movement to managed LTSS, however, has provided states with a way to make home-based care a viable alternative to institutional care. Integrating medical and LTSS coverage for elders, and combining Medicare and Medicaid per capita payments to health plans, states, and federal programs can finance the added costs of in-home care with savings from reduced medical and institutional costs. These reductions can be significant for people with complex care needs, who are the highest users of expensive medical care. Net savings over time from the reduction in hospital and nursing home use can help states offset the impacts of the aging demographic upon state healthcare expenditures.

Why we should care about the problem: personal and fiscal costs

Nearly every adult of middle age and older can understand on a personal level the problems and burden of arranging and paying for LTSS for an older or disabled relative. Awareness and concern about this issue transcends party lines. Despite any understanding of the problems and burden one might have on a personal level, many people wrongly believe Medicare covers LTSS, and relatively few people appreciate the threat of their own exposure to LTSS costs. With education, however, there potentially is a large constituency (including most members of Congress) who would value LTSS coverage on a personal level, and who would advocate for reform.

Budget hawks in particular, and taxpayers in a more general sense both should appreciate the problems with Medicare financing and the potential that an integrated approach to LTSS could have for managing Medicare costs. Medicare faces a substantial financing challenge over
the next thirty-five years and, at the outset of the new Administration, will present a major fiscal challenge for elected officials. Failing to address this challenge will put the Medicare program at risk.

The overemphasis in the American healthcare system on expensive institutions, technologies, and medical procedures is as much a driver of spending as the aging of the population. A solution to address Medicare’s financing challenge is one that could shift care away from expensive, intensive medical care toward filling gaps in LTSS to achieve better outcomes. This should be more politically palatable to both sides of the aisle than approaches that simply raise taxes or cut benefits.

This new approach to care, combining medical and home-based care, would enable older Americans to safely remain in their homes for as long as possible.

Nearly 50 percent of Medicare expenditures annually are attributable to the 5 percent of beneficiaries with the most complex care needs. This spending is generated by multiple emergency room visits and hospital admissions, intensive treatments, and post-acute skilled nursing home stays. The best predictor of who in any year will be in this 5 percent group is their functional incapacity, i.e., their need for long-term services and supports (Rodriguez et al., 2014).

Contracting with health plans to take on risk for the full cost of care for an individual—including medical care, LTSS, and behavioral health care—makes it possible and advantageous for the plans to manage high-risk individuals more effectively in their homes and communities, reducing unnecessary emergency room use and hospital admissions, and reducing or delaying admission to institutional settings. Availability of palliative and hospice care can help members and their families avoid unwanted medical treatment at the end of life. This approach can help meet the LTSS needs of elders and adults with disabilities, support family caregivers and help keep them in place, and address peoples’ functional needs in a proactive, preventive manner rather than in a more reactive, crisis-oriented, and costly manner.

The Consequences of Inaction

The current inadequacies in LTSS financing leave most Americans and their families exposed to the risk of impoverishment due to a protracted need for expensive care in old age. Despite a clear preference to remain in their own homes and communities for as long as possible, many older adults end up in institutional settings when family caregivers are unsupported and overwhelmed, and financial resources are not available for in-home services. The result is an unwieldy and expensive financing approach that leaves most people unprotected—one that will be sorely challenged as the size of America’s older and disabled population doubles over the next three decades.

The issue is not merely that there is an absence of government coverage for LTSS, because Medicaid now is the coverage of last resort for low-income families and for those who exhaust their resources on health and LTSS expenses (and it accounts for 60 percent of all LTSS expenditures) (O’Shaughnessy, 2014). The issue also is families’ inability to access coverage for these expenses without wiping out their resources.

Another big concern is that the financial support that is available—largely through Medicaid—still favors institutional care in much of the country. Medicaid, originally a payer only for nursing home long-term care, has only in recent years allowed the states waivers to pay for home- and community-based services (HCBS) (Commission on Long-Term Care, 2013). States substantially limit how much they cover—and there are waiting lists for care in many states,
People and their families who need LTSS, and who have resources, would benefit from the reduced financial risk of consuming their own resources and-or “spending down” to Medicaid eligibility. The Medicaid program and state budgets would benefit from a reduced reliance on Medicaid as the payer of last resort.

Providers would benefit from a more sustainable and reliable source of payment for LTSS, which currently is underfunded: state rates for custodial care in nursing homes are low, many states have capped HCBS, and community-based organizations have suffered from dwindling federal appropriations. Growth in integrated LTSS and a greater reliance on managed care organizations would stimulate rebalancing and bring additional resources to HCBS. Integrated and well-managed LTSS would create efficiencies in how care is provided and free up resources, providing an opportunity to improve training, certification, career ladders, and pay for the direct care workforce.

Finally, a financing solution relying on coverage through integrated plans would enable more immediate coverage of the LTSS needs of the younger disabled population as well as the current generation of retirees. Most other financing approaches would require younger generations to start saving or insuring for their future LTSS needs, and do little to help already retired and disabled individuals and their families.

The healthcare industry would suffer from the slowed growth in healthcare spending that would result from integrating LTSS and capitalizing a full array of healthcare, behavioral healthcare, and LTSS and the resulting shift in

Inadequate LTSS financing now leaves most Americans and their families at risk of impoverishment, due to a protracted need for expensive care in old age.

The long-term-care crisis will develop as this expensive and inefficient jumble of unpaid and paid services and supports is pushed to its limits by the growing numbers of elders with significant functional limitations living longer in their homes, fewer family caregivers available and able to manage their care, and limited private resources that are quickly exhausted in paying for that care.

The Politics of a Solution
A large-scale, creative solution that can help the current generation of older Americans is needed to better finance what will otherwise become, within only a decade or two, a huge strain on state and federal budgets.

Who wins, who loses
An LTSS financing solution of any kind would benefit not only those with LTSS needs who need help paying for care, but also the organizations and industries that now provide LTSS.

despite the fact that well-managed home- and community-based care can be less expensive.

Finally, the coverage and care that are available form a confusing patchwork that is unintelligible and overwhelming for most families to access. Most of the existing LTSS coverage (Medicaid and private coverage) will pay for specified amounts of a laundry list of specific services and supports. Older adults and their families with this coverage, or no coverage, often are left to their own devices to identify needed services, select agencies or caregivers, arrange and manage the care, and negotiate payment. Most families do not have access to the one service that could be most effective: a qualified care manager able to identify the individual’s and his or her family’s goals and preferences, assess the individual’s functional capacity, develop with the individual a person-centered care plan, coordinate the medical and social service resources at hand to provide that care, and ensure the individual is safely supported, according to their preferences.

The long-term-care crisis will
resources to social services and community-based LTSS providers. Given the projected increase in America's aging population and anticipated shortages in trained medical personnel, though, the current medical care system could meet the coming demographic challenge with its current facilities and workforce only if the balance point in care was shifted away from medical and institutional treatment toward home- and community-based services and supports.

**Political risks and possible benefits**
Properly designed and negotiated, a relatively affordable LTSS financing solution that avoids creating a new product and policy infrastructure and promotes individual responsibility, dignity, and independence should be attractive to politicians of all stripes. The struggle to access and afford LTSS is so broadly based that members of Congress tend to encounter these issues first through their own experiences with family; as such, there should be a broad constituency among members of Congress for a fiscally sober financing solution that they can artfully sell to their constituencies.

However, there remains an element of fear and antipathy in the population to managed care. The main risk for the new Administration is that it could miss the opportunity to get ahead of any potential opposition and define the issue and the solution on its own terms with the American public. The concepts and language the Administration uses in describing the proposals should capture the themes that resonate with its ideological counterparts to create a safe space for leaders of both parties to communicate with their followers. It is important to create space and enable a broad range of members of Congress to be part of the process, take credit, and own the results.

An additional risk is the challenge of successful implementation. A broad constituency invested in the passage of the bill will translate into widespread ownership of the results, and a more collaborative environment for implementation. In any event, those involved in successfully charting a new direction for financing LTSS—one that would reduce Americans' exposure to potentially catastrophic LTSS expenses, and improve services and supports with better outcomes for frail and disabled persons and their families—should be able to reap substantial political benefits.

**Allies and opponents**
Enacting this ambitious proposal will require the assembly of a broad constituency of supportive stakeholders with the resources to mount and sustain an effective campaign. Legions of allies can be found in the organizations that represent and provide assistance to aging and disabled individuals and-or those that represent sectors of the long-term-care industry. While LTSS consumers and providers today do not wield the political influence of hospitals, physicians, and other medical providers, given U.S. population aging, the LTSS industry is set for major political and economic growth, and will produce more visible and effective advocates in the political arena in years to come.

The sector of the healthcare industry that is heavily invested in integrated care can be an important ally for any legislation that would expand the application or utility of that care. Large national health insurance companies have made major commitments to integrated health plans in Medicare, Medicaid, and in commercial markets. Managing population health risk and integrating care have also been a growing focus for hospitals and other healthcare providers, as evidenced by the advent of Accountable Care Organizations and other payment reforms in the Affordable Care Act.

Any major policy shift with big winners will also have losers who will need to be accommodated. Some existing providers will likely need to adapt their operating models in ways that would allow them to more readily participate in risk-sharing and population health–based models so as to enable them to benefit from
reductions in more expensive, intensive care and services.

Not all consumer groups support integrated care, and there is widespread suspicion in the U.S. population about the motives of managed care organizations. Those who serve and advocate for the population with intellectual and development disabilities (I/DD) have the greatest commitment to the status quo and uncertainty about managed care, and most states have carved services for I/DD out of managed LTSS, although this is changing. It will be important to reach out to these groups, incorporate them in developing policy options, and craft legislative solutions that are sensitive and responsive to their concerns.

Conclusion

The movement underway today toward integrated plans that include healthcare, behavioral healthcare, and LTSS offers the greatest hope and most practical solution for financing long-term care, as well as for reducing medical expenditures and the resulting fiscal pressure on state Medicaid programs and Medicare. It is an approach that marries the most effective care models with cost management and healthcare spending reduction and provides a platform for an innovative approach to financing long-term care.

It is not a perfect solution. Integrated LTSS will take time to fully implement and even then will only serve those who choose to enroll in fully integrated plans. Other models that can mirror the outcomes of integrated LTSS will be needed to expand its reach. The need for a safety net will remain, and other mechanisms that employ savings and insurance must still be encouraged to fill affordability gaps.

Nonetheless, the approach outlined here offers the best hope for an affordable solution for financing LTSS—one that can insure the greatest part of the at-risk, frailest population, deliver the most immediate value to today’s disabled and older populations, and yield significant benefits in America’s population health and quality of life.

A new Administration provides the best opportunity to introduce a bold concept like this and to start the process of education and coalition-building that will be necessary to yield an eventual successful result.

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A proposal to create a federally regulated electronic exchange for voluntary, private LTC insurance will relieve pressure on state and federal Medicaid budgets.

Few who have looked at the facts concerning the financing of long-term services and supports (LTSS) in this country will dispute the need for serious change. Neither the current private long-term-care insurance (LTCI) market, which is largely stagnant, nor the public sector, with its reliance on Medicaid as the payer of last resort, can solve the LTSS financing challenge alone. Consensus is building that both sectors must play an important role.

Like so many of us, I am personally acquainted with the stress of long-term care (LTC). My mother suffered terribly in the last seven years of her life from vascular dementia, and she had no private insurance to pay for the services she needed. This put a tremendous strain on my father, who took care of her at home until his health failed. My personal experiences with LTC have informed my ideas about its financing for more than thirty years, a span during which I have analyzed problems and proposals with many thought leaders in this field.

While some await the bill that may give us a basic mandated LTSS benefit, perhaps as an extension to Medicare, I believe it makes sense in the interim to improve private LTCI coverage by stimulating the private market. This article posits that the new Administration should send to Congress a proposal for legislation that will create a federally regulated national exchange for private LTCI coverage—an idea I first proposed in a paper submitted to the 2013 Federal Commission on Long-Term Care—to be called the American Long Term Care Insurance Program (ALTCIP) (Forte, 2013, 2014). Establishing such an exchange, as detailed in this article, would accomplish this.

Exchange as Solution to Private LTCI Market Challenges
Building on the American public’s appetite for accessing

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**ABSTRACT** This article recommends creating a federally regulated electronic exchange for private long-term-care insurance called the American Long Term Care Insurance Program (ALTCIP). ALTCIP would draw new consumers, while incentivizing insurers to participate by helping stabilize premiums and spreading risk. Offering a uniform program giving the middle class access to affordable coverage could increase LTCI take-up rates nationwide, relieving pressure on state and federal Medicaid budgets. If a tax-based social insurance plan offering catastrophic LTSS coverage were implemented, the ALTCIP would be complementary, either providing front-end coverage or filling in gaps. | key words: long-term care, long-term-care insurance, Medicaid
information and performing transactions online, the ALTCIP would provide a framework for private LTCI underwriters to offer approved HIPAA-tax-qualified private LTC insurance plans (see Figure 1, below) by means of a powerful electronic enrollment platform.

Beyond serving as an online marketplace for purchasing private LTC insurance, however, the ALTCIP also would create a mechanism designed to ensure true value and stability to policyholders over decades. It would do this by functioning as a national clearinghouse of reliable LTCI information and also as a vehicle for presenting and comparing products side by side—a format that would attract consumers (hence, carriers)—in greater numbers than anything that has taken place so far in the private LTC insurance market. This would in turn promote competition and keep prices reasonable as carriers jockey for a much larger market share.

The private market has thus far lacked pricing stability. This was caused by limited actual insured pricing data, revised actuarial assumptions, rich plan design, and other factors, including Federal Reserve actions to hold down interest rates for economic stimulus. The necessary data are now emerging, giving actuaries and underwriters greater insight into policyholder claims patterns. Unfortunately, a number of insurance companies have already stopped selling policies due to poor financial results, increased capital strain, and lackluster outlook.

The ALTCIP would offer affordable “basic” coverage for LTSS, which should be appealing to consumers and insurers alike. Policies would use standard triggers for benefit eligibility (i.e., a person’s inability to perform two of six daily activities).
activities of daily living and-or their cognitive impairment requiring close supervision). To allow for different price points, the ALTCIP would offer both comprehensive and home- and community-based care-only options on a reimbursement basis, with benefits reflecting local LTSS costs. Protections such as care coordination by credentialed nursing professionals, independent third-party review for disputed claims, and contingent non-forfeiture values (reduced “paid-up” benefits) would be built in.

**Informal care would be encouraged, but subject to controls to reduce duplicative services and fraud.**

Each approved ALTCIP insurance carrier would subscribe to an experience fund—an account segregated from that insurer’s general account assets. This fund would ensure that premiums paid are used solely to cover ALTCIP liabilities, not other insurer liabilities. Insurers would manage assets through a specialized investment strategy geared to long-dated liabilities and approved by the regulator. The regulator would supervise this strategy’s management, along with capped risk charges and expenses. Under this arrangement, any surplus not used for approved risk charges and allowable expenses would remain in the fund and belong to ALTCIP enrollees. The regulator would also issue regulations, certify ALTCIP carriers, select administrator(s) via a Federal Acquisition Regulation contract bid, approve plans, review carrier and administrator performance, determine profit charge awards, and conduct audits. This would improve on the current system of regulation by fifty-six separate states and territories, which, even with the National Association of Insurance Commissioners interstate compact, is cumbersome and expensive.

The ALTCIP administrator(s) would coordinate the program, develop and update the enrollment platform, market products, streamline application and underwriting (if applicable), expedite claims, and perform aggregate reporting. Of critical importance is the platform featuring a powerful website equipped with diagnostic and decision tools, self-service portals, and controls to protect personal and private data, which would facilitate informed decision-making, application submission, claims reimbursement, changes from qualified life events, and plan design modification. Those unwilling or unable to use Web portals could get help from a fully staffed and trained call center. Compliance for vision and hearing-impaired persons would be assured.

Carriers could handle claims themselves or with administrator help. Because most consumers prefer home- and community-based care— and informal providers are paid less than RNs, LPNs, and medically oriented facility caregivers—informal care would be encouraged, but subject to controls aimed at reducing duplicative services and fraud. LTSS costs would be pre-negotiated with service provider networks wherever possible. Performance metrics, including customer satisfaction ratings, would be linked to carrier and administrative profit charges to ensure fair and reliable service during the benefit eligibility and claims process.

**The ALTCIP: Further Advantages**

The ALTCIP would not eliminate the risk of LTC insurance premiums increasing altogether. But the provisions just described would make the need for significant premium increases less likely, while an ultimate premium increase cap could be negotiated and offered, depending on the terms secured from carriers, reinsurers, and government. The following elements would further reduce the net cost of insurance and provide far greater stability.
A Centralized, Uniform Platform. Creating a centralized, uniform enrollment platform would eliminate redundant systems and data processing costs for insurers, while using direct-to-consumer sales protocols would eliminate intermediaries and their expenses, including commissions, marketing support, promotional incentives, production leaders' conferences, and other premium uses that do not directly benefit the insured. The ALTCIP’s federal regulation would strengthen this platform by making the ALTCIP uniform from coast to coast, reducing legal and compliance costs, and facilitating plan submission approval and premium adjustment filings.

A Return to Risk-Sharing. Also needed are streamlined benefits that provide solid but sensible coverage and shift a portion of the risk back to the consumer. The ALTCIP would promote longer waiting periods, co-insurance, and other cost-sharing provisions. The ALTCIP could also offer variable policies that would periodically adjust enrollees’ maximum lifetime benefit pools in accordance with actual program results. These would largely automate the process by which benefits are currently adjusted to offset premium increases, aligning pricing risks such as morbidity, mortality, lapse, expense, and investment earnings with actual experience, while a guaranteed benefit floor would ensure that the final payout from a policy would continue to provide a meaningful ratio of benefits paid out to premiums paid in. Wellness incentives are another area that deserves investigation, as these would make a difference to LTC costs in the long run. The ALTCIP would aim to implement a new data-based wellness tool to track lifestyle and health choices, recognizing and rewarding those whose habits position them for better long-term-care outcomes.

Availability of Reinsurance. Reinsurers have not received adequate inducements to write LTCI coverage. The ALTCIP would pre-negotiate a standard reinsurance agreement with commercial reinsurers and make reinsurance mandatory for participating carriers. This would spread the risk of claims, even across international boundaries, to foreign capital markets, limiting potential carrier losses. Reinsurance premiums would be collected automatically by the administrator, though carriers could opt out in favor of a comparable separate reinsurance arrangement, or cede to unauthorized reinsurers via letters of credit, Regulation 114 Trusts, funds withheld, and other methods of collateralization.

Government Backstop. Some have questioned whether a strong reinsurance market would emerge in response to the ALTCIP. As an alternative (or perhaps a concomitant), the federal government could provide a financial backstop. If claims reach a certain level, whether on an individual policy or aggregate basis, the carrier would be able to access a federally generated claims-stabilization reserve. While funding such a reserve would not be lightly undertaken, the cost would certainly be less in the long run than continuing to expand Medicaid, the nation’s primary payer of LTSS (at a cost of nearly $152 billion in 2014) (Eiken et al., 2016), or shunting more long-term-care expenses into Medicare, which was not designed to cover LTSS. Such a backstop could be implemented either as a temporary measure to reinvigorate the private market or as a permanent solution.

Either way, a government backstop would reduce ALTCIP premiums considerably, while boosting carrier participation. Many precedents exist, including federal backstops introduced when the market could not effectively

The ALTCIP could implement a wellness tool to track and reward healthier lifestyle choices.
deal with a particular risk (e.g., the National Flood Insurance Program in the late 1960s), when losses exceeded anything imaginable, (e.g., the Terrorist Risk Insurance Program after 9/11), and when private markets simply failed (home mortgage market in the 1930s and again in 2008–2009).

Summary
Ascertaining cost and the probable take-up rates after underwriting for plans offered under the ALTCIP would require modeling. I estimate that the ALTCIP would attract at least 1 million policyholders in its first year of operation, and 5 million within three years. This would amount to some 60 percent of the total number of private insurance policies in force at the end of 2015, a number it has taken the industry some thirty years to reach.

Legislation will be needed—specifically, a congressional bill—to create the ALTCIP, and to authorize sponsorship of the agency that would regulate it. The new Administration should support such a bill. The ALTCIP’s many potential beneficiaries cut across partisan lines: the millions of baby boomers and Gen Xers who are financially unprepared to finance their own care out of pocket; their Millennial caregivers; state governments whose LTC Medicaid spending is crowding out other critical social needs; the insurance industry, whose talents and resources are underutilized; and the U.S. taxpayer.

Were a mandatory social insurance program implemented in the next five years offering catastrophic LTSS protection, the ALTCIP would be an ideal mechanism for delivering mainstream front-end coverage before the government benefit kicks in, or for topping off the government benefit, or both. If no such plan materializes, the ALTCIP could still help relieve pressure by offering an improved mechanism and regulatory environment for the purchase of reliable and affordable private coverage.

A program like the ALTCIP could have made a difference to my parents, and it could make a material difference in our nation’s collective future. Without something of the sort, the millions who will require LTSS services within the next few decades will continue to rely on government as the principal payer of LTSS, an unsustainable arrangement that will enervate our economy and put further strain on our social fabric. We can alter this course, but it will require leadership at the highest levels of government and industry.

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Author’s Note
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Securing the Safety Net for America’s Vulnerable Populations

By Cindy Mann, Carol Raphael, Stephanie Anthony, and Keith Nevitt

America’s population is aging rapidly as the Baby Boom Generation reaches retirement. By 2029, 75 million baby boomers will have reached age 65 and older adults will represent more than 20 percent of the U.S. population, up from 13 percent in 2010 (Cawthorne, 2008; U.S. Census Bureau, 2011). An aging population will increase pressure on the health and social service programs that are so vital to protecting its economic security and health. Particularly vulnerable is the means-tested Medicaid program, which provides a critical safety net for those who reach old age with low incomes, for growing numbers of older Americans with limited resources at retirement, and for those who outlive their resources or exhaust them to pay for medical expenses.

A Bleak Retirement Outlook for Older Americans

Many older Americans have insufficient retirement income and assets to protect them through retirement. They often rely on Social Security (SSA) for retirement income, but Social Security only provides an average of $16,000 per year for retired workers (SSA, 2016). Many do not qualify for Social Security or receive very small Social Security payments and rely on Supplemental Security Income (SSI), which provides monthly benefits well below the Federal Poverty Level (FPL) (in 2016, the FPL was $11,880 for an individual and $16,020 for a couple). In addition, almost half of retirees surveyed in the 2016 Retirement Confidence Survey reported having less than $10,000 in savings and investments, and more than a quarter reported having less than $1,000 saved (Helman, Copeland, and VanDerhei, 2016).

Lack of savings will present a major challenge for people as they age. As of 2013, the median savings held by those nearing retirement (between ages 55 and 65) was only $14,500; however, estimates show that couples who retire at age 65 will require an average of $260,000 for healthcare costs alone during retirement (Rhee and Boivie, 2015; Fidelity Investments, 2016).

Almost all older adults have Medicare coverage, but Medicare has gaps in coverage...
(most notably for LTSS) and substantial out-of-pocket costs. Those with low incomes are “dually eligible” for both Medicare and Medicaid; they receive healthcare coverage through Medicare, with Medicaid filling gaps in coverage, including LTSS, and paying out-of-pocket costs. Those who reach age 65 without enough work history to qualify for Medicare will rely on Medicaid for both their healthcare and LTSS coverage.

Older Americans living below 75 percent of the FPL (about $13,000 a year for a couple) automatically qualify for Medicaid in most states (though the eligibility levels vary somewhat by state) (Kaiser Family Foundation, 2015). Some of those not eligible for Medicaid when they turn age 65 become eligible as a result of spending down their savings or income to cover medical expenses. Nearly 13 percent of people ages 65 and older in 1998 spent down savings or income and became eligible for Medicaid within ten years, and more than half of these people did so to pay for LTSS (Redfoot and Fox-Grage, 2013).

In the absence of other public and private financing options for LTSS, Medicaid assumes the role of default payer of these costly services for more than 6 million elders. This is a role that reaches beyond providing health coverage to low-income families—and one the program was never intended to fill. In 2014, total federal and state Medicaid LTSS spending was $152 billion, or a third of total Medicaid spending. National estimates project the rate of LTSS spending growth to be more than three times that of Medicaid overall, and rising state expenditures for Medicaid LTSS over the next few decades will put substantial pressure on state budgets and threaten the quality of and access to all Medicaid services (Anthony, Nevitt, and Raphael, 2016).

Recommendations to the President: A Seven-Point Action Plan

The new President must address the looming challenges that increasingly threaten Medicaid’s ability to protect older adults, and fulfill the program’s assumed responsibilities for LTSS. Solutions must recognize the permanent role that Medicaid plays for low-income older Americans, and focus on strengthening and maintaining the existing program, while supporting efforts to develop alternative LTSS financing mechanisms that reduce the magnitude of Medicaid’s role in covering these services.

Below are seven actions the President can take to not only ensure greater economic and health security for our nation’s older Americans and their families, but also to preserve Medicaid as a critical safety net for our most vulnerable citizens.

Action 1: Ensure Medicaid is adequately funded and preserved as an entitlement program.

Today’s elders are living longer than ever before—the average life expectancy continues to rise steadily and the number of people ages 100 or older rose 43.6 percent between 2000 and 2014 (Xu, 2016). People are also living longer with chronic illnesses and various forms of dementia, including Alzheimer’s, increasing their need for costly LTSS. To preserve this program, the President must ensure sufficient funding for Medicaid and reject proposals that reduce or cap the federal government’s responsibility to share in financing the program.

Proposals to “block grant” or cap federal Medicaid spending on a “per capita” basis seek to change the fundamental nature of the Medicaid program from an entitlement program open to all who are eligible (including low-income elders), in which costs are jointly absorbed by the federal and state governments, to one that
limits federal contributions (typically based on historical Medicaid spending) with adjustments for growth that are not tied to actual costs and need. Block grants shift the risk of unanticipated spending increases (such as increased costs caused by new medical advances) squarely onto states, which must then balance their budgets by cutting Medicaid eligibility, services, or provider rates; redistributing state dollars; or increasing taxes to generate new revenue.

Such initiatives would destabilize a 50-year-old cost-effective health insurance program, threaten the financial and health security of millions of older people who rely upon Medicaid for LTSS not covered by other insurers, and increase pressure on states and the providers, health plans, and somewhat fragile workforce that depend on Medicaid reimbursement.

**Action 2: Advance proposals that automatically trigger an increase in the federal Medicaid contribution during economic downturns.**

Medicaid was intentionally designed as a safety net for people in need and as an entitlement program for people who satisfy eligibility requirements. Enrollment is expected to (and does) grow during recessions as people lose jobs, health insurance, and savings. For example, Medicaid monthly enrollment jumped 6 million, or 14 percent, during the middle of the Great Recession (Kaiser Commission on Medicaid and the Uninsured, 2011).

Increased federal Medicaid support is critical for states, especially during stressful economic times. As state revenues decline during such times, states struggle to meet rising Medicaid costs. Unlike the federal government, most states are required to balance their budgets, leaving them with two options: cut public program spending or raise taxes.

The federal medical assistance percentage (FMAP) is the percentage rate used to determine the federal matching funds allocated to states for Medicaid expenditures. The FMAP calculation is prescribed by federal law, but in general can be no lower than 50 percent and no higher than 83 percent, and varies based on the relative wealth of each state. Congress has enacted numerous exceptions to the regular FMAP calculation, authorizing higher FMAPs to states in up to twenty circumstances. In two instances, after the September 11, 2001, terrorist attacks and, more recently, during the Great Recession, Congress acted to temporarily increase states’ FMAP rates to stabilize the Medicaid program and state budgets in the face of severe economic downturns and large Medicaid enrollment increases (Snyder and Rudowitz, 2015).

While these temporary adjustments have had documented value, they are not guaranteed, and even when enacted, they may not be initiated early enough to prevent damage and may end too soon for many of the most affected states. The President should call for an FMAP formula that is automatically increased without congressional action during times of economic recession. The trigger for an increase could be based on the unemployment rate or a decline in wages, and could be structured to target states with the highest need. The automatic increase would ensure a more timely and predictable response to helping states in need than waiting for Congress to act (Yocom, 2016). Several proposals for automatic FMAP adjustments have been proposed and should be revisited. Instead of being forced to cut Medicaid programs during these times, continued federal and state spending would secure the critical LTSS that Medicaid provides, as well as stimulate the economy by keeping dollars in the healthcare system.

**Action 3: Increase awareness of LTSS needs and support creation of viable financing options.**

The explosion in demand for LTSS is due both to an aging population and to advances in medical research, new treatments, and new technologies that help people with disabilities and other chronic diseases live longer. The need for LTSS will be a fact of life for more than half of those retiring today, yet few people reach old
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age adequately prepared to deal with or pay for it. Only half of people ages 40 and older even know where to go for information (Commission on Long-Term Care, 2013). Most pay attention only when the need arises—as a result of a medical crisis, such as a fall, stroke, or accident.

Additionally, most people are not fully aware of their LTSS financing options. Many mistakenly assume Medicare will pay for their LTSS needs, even though it only covers short-term nursing, home health, and therapy services after a hospital stay. To complicate matters, the private insurance market for LTSS coverage is unraveling as premiums continue to rise while benefits shrink. This results in fewer people purs...
tional stress and financial strain and, as the population ages, the number of potential family caregivers is rapidly declining. Failure to adequately support family caregivers could result in increased pressure on Medicaid to provide this care in their place.

The President should spur the creation of a national family caregiver strategy by advancing reforms that not only recognize the important role family caregivers play, but also provide much needed financial and emotional support. To begin, the President should prioritize increasing awareness of existing tax incentives for family caregivers and explore strengthening such incentives or creating new ones, such as the Credit for Caring Act. Introduced in the House of Representatives in March 2016, the Act creates a $3,000 caregiver federal tax credit, which could help alleviate some of the financial burden. In addition, the President should promote the Family and Medical Leave Act and encourage employers to implement more comprehensive and supportive paid family leave programs.

Action 5: Support and enhance the direct care workforce.

Demand for LTSS is increasing so rapidly that it is estimated that the direct care workforce will add 1.6 million new jobs by 2020 and become the largest occupational group in the country (Khatutsky et al., 2011). However, direct care workers face many challenges, including low wages, lack of affordable housing, and lack of training, all of which have contributed to the rate of those leaving direct care occupations outpacing the rate of those entering (Frogner and Spetz, 2015). A strong workforce is key to providing quality care and helping individuals avoid expensive hospital visits and-or readmissions, particularly with older American’s increasing reliance upon and strong preference for community-based services.

At a minimum, the President could support proposals to articulate and ensure minimum training standards for direct care workers. Currently, no standard training thresholds exist, and while some states have taken it upon themselves to establish training requirements, many states have yet to act. Training should ensure that workers have proper clinical training, while respecting each care recipient’s individualized needs and preferences, and workers also should receive personal safety and finance training to ensure they are adequately protected. Training could also help these workers become even more valuable members of a care team, as they offer a cost-effective touchpoint uniquely attuned to an individual’s medical and socioeconomic needs. Articulating clear expectations for direct care worker training will not only better equip this workforce, but also could help lay out an attractive career path—one that begins with a personal care worker role and extends to a nurse practitioner certification, or beyond.
The President must support efforts to increase and stabilize direct care workers’ earnings. Even though direct care occupations are growing rapidly, median annual wages are quite low, ranging from about $21,000 to $26,000 (U.S. Bureau of Labor Statistics, 2015). Any advocacy to increase workers’ wages must also promote steady hours and more predictable work schedules.

**Action 6: Develop a core set of LTSS-specific quality metrics.**

Because LTSS span a multitude of care settings, provider types, and payment structures, the healthcare industry has struggled to create meaningful quality metrics. The lack of meaningful measures results in a lack of comparable information, which consumers and policy makers need to make informed decisions. These metrics will become increasingly important as payers implement value-based payment reforms.

While there have been efforts to create standardized quality metrics for LTSS, progress has been slow. CMS created the Nursing Home and Home Health Compare websites to display data in a straightforward fashion for consumers, but persistent issues due to unreliable sample sizes and contradictory results between consumer and government ratings render the results of any search as suspect, at best (Rau, 2016). Legislation such as the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 laid the groundwork for better reporting, collection, and analysis of enhanced and standardized patient quality and provider performance data, but more work needs to be done in this area.

The President should encourage consumer groups, providers, health plans, and other stakeholders to come together and develop a core set of meaningful quality metrics. These metrics must include both clinical and non-clinical measures, be standardized (to the extent possible), and connect to existing population health and hospital quality improvement efforts. It is imperative that the process include consumers and caregivers.

The President must also work with states to create a streamlined, straightforward, and regularly updated dashboard that includes a manageable number of publically accessible metrics on LTSS quality. Tracking and reporting on a consistent set of LTSS-related metrics will help increase transparency and awareness, and the dashboard would need to evolve as LTSS quality tracking and reporting systems become more advanced.

**Action 7: Challenge CMS and the private sector to develop care delivery innovations that include LTSS.**

To date, LTSS providers have generally been left to operate in a fee-for-service environment, largely disconnected from the rest of the health-care continuum. Care fragmentation continues even in states that have moved LTSS into broader Medicaid managed care arrangements. The President should challenge CMS and the private sector to develop innovative care delivery and payment models that improve care quality, while containing cost growth. Such innovations could include incentivizing LTSS integration with medical and behavioral health, by allowing reinvestment of savings generated through decreased inpatient hospital and emergency department use and increased use of community-based care. Innovations should target better integration of LTSS, both across payers and across the care continuum, with a particular focus on high-use, high-cost populations.

Additionally, the President would spur innovation in new technologies to support people in their homes, thus reducing the need for intensive, face-to-face visits. CMS could host a “code-a-palooza” challenge focused on developing LTSS solutions, like it has done to develop solutions for Medicare data visualization tools in the past (Health Data Consortium, 2014).

Finally, the President should encourage the development of new independent and supportive housing alternatives. This effort will require multiple agencies, plus the public and private sectors, to come together and craft viable
housing solutions. Innovators could be encouraged to analyze current nursing home capacity in the United States, to assess how nursing homes might be updated and-or converted for mixed use, and to consider how tax credits could incentivize innovative housing solutions.

**Conclusion**

Given that many older people approaching retirement find themselves in challenging economic circumstances, the new President must support proposals and initiatives that preserve and strengthen Medicaid, as it is the critical safety net and primary source of LTSS coverage for low-income elders. Solutions must include ways to enhance the existing program by optimizing how Medicaid provides LTSS, as well as efforts to promote viable alternative LTSS financing options that preserve people’s income and assets and, ultimately, minimize Medicaid’s role as the primary payer of LTSS. Doing so will give all older Americans health and financial security—and greater peace of mind.

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**References**


Promoting Healthy Aging: A Presidential Imperative

By Sarah Lenz Lock and Basia Belza

Let’s encourage Americans to exercise more and lead healthier lives in anticipation of living longer—capitalizing on longevity while reducing chronic disease and dementia.

Americans are living longer. In the next fifteen years, the proportion of the population ages 65 and older will grow from 15 percent to 20 percent (Colvy and Ortman, 2015). Today, people ages 85 and older are the fastest growing age demographic in the United States. Since 1900, our average life spans have increased by thirty years, a remarkable achievement (National Center for Health Statistics, 2015). We must take advantage of this longevity bonus by fostering active, healthy living that maximizes Americans’ quality of life and their contributions to society.

We must promote physical exercise through community design, smart housing, and transportation planning.

If we do not reduce the prevalence of chronic disease and disability now associated with aging, we will put a substantial strain on healthcare resources and future federal spending. Many changes will be needed soon to avoid an overload of demand for limited healthcare resources.

Preeminent among them are interventions to prevent disease and improve the health and functioning of the population that will begin turning age 85 in the next twenty years.

The United States needs an aggressive program to educate the populace that healthy lifestyles, healthy diet, and social engagement are vitally necessary for health and well-being in old age. We must transform American communities to systemically encourage healthy choices and change behaviors. Adopting healthy living is essential to improving overall health of the aging population, reducing complications in late life, and reducing attendant healthcare and long-term-care costs. The recommendations that follow would put such a program in place.

Numerous vehicles during the new President’s term in office can be used to align with healthy aging program objectives and amplify their impact. Among them will be the national health goals of the U.S. Department of Health and Human Services (HHS) Healthy People 2020 plan, the report from the National Alzheimer’s Project Act (NAPA) on the national

→ABSTRACT Healthy aging means working across all sectors to promote health, to reduce the risks and costs of chronic disease and disability, including those diseases that cause dementia. The 45th President can be instrumental in promoting healthy aging to benefit the quality of life for all as we age—a strategy that can boost our nation’s economic vitality. | key words: healthy aging, dementia, Alzheimer’s disease, physical exercise, chronic disease

A Message to the President

We recommend that the new Administration:

**Create a multi-sector strategy to promote healthy aging at home and in the community.**

The 2015 White House Conference on Aging, in its focus on healthy aging, stressed the importance of addressing health beyond the confines of the medical care system. The environment in which Americans live largely dictates how well they live and how healthy they will be as they age. We can foster a culture of health that maximizes opportunities for individuals to choose healthy behaviors throughout their lives—first and foremost by promoting physical exercise through community design, smart housing, and transportation planning, as well as supporting access to healthy foods, lifelong learning, and social engagement. These components—purpose, social engagement, healthy diet, mobility, exercise—become especially important as determinants of health in old age.

The new President should engage federal agencies and foster collaboration between private and public sectors to bring together experts from across the spectrum of federal activities: income, health, employment, housing, transportation, arts and humanities, education, and military and veterans affairs. This collaboration could yield a strategy to support and enable the determinants of healthy aging in communities across the country. This process should place special emphasis on responding to the needs of people aging in low-income communities, in which life expectancies are shorter than in cities having highly educated residents, with high incomes, and a history of local government investment in public health.

**Develop and launch an initiative to promote brain health.** Cognitive aging is a common phenomenon associated with growing older. Many adults worry about their brain health deteriorating as they age. Eighty-four percent of AARP members (adults ages 50 and older) say they are extremely or very concerned about “staying mentally sharp” (Hagerty, 2016). More than a third (37 percent) of adults say their ability to remember things has declined in the past five years, and for those ages 60 and older, 45 percent have noticed cognitive decline (Skufca, 2015).

Age is the single greatest risk factor for the neurological diseases causing dementia. Eleven percent of those ages 65 and older, 14 percent of those ages 71 and older, and 32 percent of those ages 85 and older are estimated to have dementia of one form or another, including Alzheimer’s disease (Alzheimer’s Association, 2016). While there is no effective cure for the many types of dementia, including Alzheimer’s, there are many activities that are believed to promote overall brain health and to postpone or slow cognitive decline.

A presidential initiative to promote brain health and delay cognitive decline should include:

- **Supporting** the bold vision of the National Alzheimer’s Project Act to cure and effectively treat diseases causing dementia by 2025, and proposing a substantial increase for research into the causes and treatment of Alzheimer’s disease and other dementias.
- **Proposing** increased funding for research, public education, and health promotion to demonstrate and communicate that regular physical activity and exercise are key to brain health. Almost a third of adults (32 percent) do not know that exercise can improve brain health, help maintain mental sharpness, and reduce the risks of chronic disease. Unfortunately, 67 percent of those reporting memory problems do not get the recommended amount of exercise (Rainville and Mehegan, 2016).

**Create a national program that supports communities’ efforts to become age- and dementia-friendly.** This program would focus,
in part, on providing localities with streamlined and coordinated access to federal resources across agencies to support promotion of healthy aging at the community level. Lifetime homes in age-friendly communities should incorporate inclusive design appropriate for people of all ages, including those who have both physical and cognitive impairments. Communities that increase access to safe places to exercise and that support walking have shown increases in older adults’ physical activity. Public–private partnerships can help create venues conducive to physical activities, such as mall-walking programs, in which older adults can walk in climate-controlled, accessible shopping malls.

Encourage and provide funding for programs that promote purposeful activity and social engagement for older Americans. Older adults have a wealth of skills and experience to contribute to their communities, to society, and to the nation’s well-being. Merrill Lynch and Age Wave estimate that retirees alone will provide $8 trillion—in combined value of volunteer hours and charitable giving—to America over the next two decades (Merrill Lynch and Age Wave, 2015). Loss of a sense of purpose, loneliness, and isolation contribute to a host of mental and physical health problems in older people. Programs should be funded to promote mutually beneficial intergenerational programs for people of all ages to remain connected and engaged. Programs also should foster access to lifelong learning so that older people can develop and maintain skills that keep them working and/or volunteering longer and connected in an ever increasingly technological world. We must realize that investments in older people have long-term economic benefits.

Support programs that promote health and help those living with chronic health conditions to better manage them. The adage to not only add years to life, but also add life to years is critically important if our population is to age well. Age usually correlates with increases in disability and chronic disease. Two simultaneous goals are achieved by managing chronic disease: individuals and society can make the most of the longevity bonus, and healthcare expenditures can be decreased for a growing population who will need health and long-term-care services.

‘Chronic conditions account for nearly 95 percent of the healthcare expenditures of older Americans.’

All federal health programs funding medical care for older Americans, especially Medicare, should adopt approaches that identify at-risk patients, and provide them with needed medical, preventive, and social supports to reduce costly acute and chronic institutional care and improve patients’ overall wellness. Finally, support the well-established national network of Area Agencies on Aging (AAA) and the Aging and Disability Resource Centers (ADRC) in a way that is proportionate to the burgeoning population they serve. AAAs and ADRCs help integrate healthcare and long-term services and support systems (LTSS) by coordinating social care needs and bridging acute care transitions, such as from hospitals to the older person’s home (Collins, 2015).

Propose increased funding for National Institute on Aging’s and the Centers for Disease Control’s research on the medical, social, and behavioral issues of older people. Research offers great potential for discovering the best means to improve health and lower costs. Funding should be increased for health research that demonstrates how to lower risks of chronic diseases, improves the care and treatment of individuals with chronic diseases, and translates successful interventions into healthcare practice. Developing evidence in these three areas may prove to have as much or more impact on chronic disease—associated health outcomes and healthcare costs than development of further evidence to support the creation of new...
pharmaceuticals. Additionally, research should be made more relevant by ending the underrepresentation of older adults from diverse populations in clinical trials: older adults often react differently to treatments and have different outcomes than younger adults. Better clinical data would improve treatment outcomes for older people, and reduce expenditures for inappropriate and unnecessary care.

A Message to Americans
Population aging and the increased longevity of the American people present a golden opportunity to employ the valuable skills, knowledge, and experience we will have with a healthy and engaged older population. First, we must do everything we can to ensure that the population retiring over the next twenty years and beyond is the healthiest older population on record.

We are proposing a package of initiatives to promote the social engagement, physical and mental health, and cognitive functioning of the population reaching age 65 today and into the future. We will seek to recruit all Americans into the effort on both a societal level—to create a healthier environment for old age—and on a personal level, to adopt healthy behaviors throughout life (and particularly in old age) that lower the risk of chronic disease and disability.

We face a serious challenge to our society and economy in the next twenty years from the prospect of an unhealthy aging population, if it carries the burden of chronic disease and disabilities at the same rates that have impacted previous generations. We can and must do everything possible, individually and collectively, to transform this challenge into an opportunity for economic growth and prosperity, and for upholding individual dignity and purpose in old age.

Many people say they know about the commonsense healthy behaviors to adopt in order to reduce risks or delay the onset of chronic diseases, but not enough of them act on this knowledge. Not only must we pledge to take individual responsibility for change in ourselves, we must work together across all ages and sectors of society—local and national, public and private—to create the environments that will foster healthy aging and build a more productive society.

Problems To Be Solved
By creating a strategy to promote healthy living across life spans, federal policy can help disrupt aging and tackle some of its biggest challenges: chronic disease, cognitive impairment, and iso-
lation. And by doing so, we toss out the stereotypes of what it means to grow old, while preserving resources and capitalizing on the vitality of older Americans.

**Impacts of chronic disease and disability**

Improving the health of our aging population requires addressing its high rates of chronic disease and disability. As of 2012, about half of all adults—117 million—had one or more chronic health conditions. One out of four adults had two or more chronic health conditions (Centers for Disease Control and Prevention [CDC], 2016). The prevalence of chronic conditions and disability increases dramatically with age from one-in-five (19.7 percent) in the ages 45 to 54 group, to seven-in-ten (70.5 percent) of people ages 80 and older, suggesting that interventions to promote healthier aging can have a substantial effect on overall healthcare spending (Redfoot, Feinberg, and Houser, 2013).

More than two-thirds of all healthcare costs go to treat chronic illnesses. Chronic conditions account for nearly 95 percent of the healthcare expenditures of older Americans (CDC, 2013). Changing the behaviors of Americans, particularly to increase physical exercise and activity, get recommended screenings and preventive services, and learn about self-managing chronic conditions, can help prevent or delay disabling conditions such as heart disease, cancer, and diabetes, and enable people who develop chronic diseases to manage them more effectively. Of course, if we reduce the burden of chronic disease for individuals, we simultaneously reduce the burden on their families and friends as caregivers, help retirement savings last longer, and make our communities more interesting and vital for people of all ages (Jenkins, 2016).

**Impacts of cognitive impairment**

Cognitive health is a significant concern for older Americans and a critical corollary to physical health. There are two challenges to cognitive health in old age: normal cognitive aging and corresponding decline, which affects individual independence and self-reliance; and chronic diseases causing dementia, which can trigger the need for intense levels of LTSS and high levels of medical use and cost.

**Cognitive aging.** A 2015 report from the Institute of Medicine (IOM) examining cognitive aging, the natural process associated with advancing years, documented remarkable variation in the way people experience cognitive aging, with people experiencing improvement in some cognitive categories with advancing age (IOM, 2015). The report called for a public health approach to help as many people as possible maintain their brain health. Of its ten recommendations, the IOM identified stimulating higher levels of physical activity as its highest priority action to aid individuals in protecting their cognitive health.

A third of adults ages 40 and older are exercise ‘contemplators’—they see the benefits and are considering exercising.

A 2016 AARP survey of adults, ages 40 and older, on barriers to their engaging in brain-healthy behaviors (including physical exercise) found that the primary barriers were lack of time and lack of knowledge about which activities are healthy for the brain (Rainville and Mehegan, 2016). The Global Council on Brain Health, a collaborative project of AARP and Age UK, is set up as an ongoing trusted source of information about the science around brain health and cognitive function, with the aim of empowering people to make informed decisions about achieving a brain-healthy lifestyle (AARP, 2016).

**Dementia caused by neurological disease.**

Cognitive decline resulting from neurological diseases that damage or destroy the nerve cells in the brain, manifesting as symptoms of dementia, presents a larger, more significant challenge to individual and family well-being—and government spending. Dementia is a neurocognitive
A Message to the President on Aging Policy

disorder most commonly caused by Alzheimer’s disease, resulting in memory decline, and affecting problem-solving capacity and other cognitive skills that govern people’s ability to perform everyday activities. The greatest risk factor for dementia is increasing age.

The growing prevalence of Alzheimer’s disease poses a substantial threat to the LTSS and medical care systems. By 2025, the number of people ages 65 and older with Alzheimer’s disease in the United States is expected to increase almost 40 percent, to 7 million. The cost of caring for people with dementia, while necessary, is expensive. For the 5 million people living with dementia in 2016, the annual cost of care is estimated to be $236 billion. Out-of-pocket spending for individuals with dementia is $44 billion. Currently, average per-person Medicare spending for people ages 65 and older with dementia is three times higher than for older adults without dementia (Alzheimer’s Association, 2016). Medicaid payments for dementia patients are nineteen times higher. Almost 65 percent of all nursing home residents have moderate-to-severe cognitive impairment. Absent the discovery of a prevention or cure for dementia, the cost of providing care for those with Alzheimer’s disease will constitute 24.2 percent of Medicare spending by 2040, according to estimates by The Lewin Group (Alzheimer’s Association, 2015).

Recent research, including the Framingham Heart Study, suggests that the age-specific risks of dementia may have declined over the last two to three decades, due to improved control of cardiovascular risk and increasing levels of education (Satizabal et al., 2016). This finding lends credence to the growing idea that we can identify and lower risk factors for dementia, but future research is needed.

For example, we know that increased physical exercise is good for brain health as we age; there are some promising studies that associate exercise with a reduced risk for developing dementia. However, to develop effective strategies to prevent or delay onset of dementia, we need further research to establish evidence-based data about what the optimal types, intensity, and duration of exercise might be, and when during the life span exercise is most effectively employed (Global Council on Brain Health, 2016).

Simultaneously, we must accelerate research for a cure for dementia, because while exercise may lower population risk, it alone is not a proven strategy for dementia prevention in an individual. Unfortunately, whether it is cancer, heart disease, or dementia, even those who have done “all the right things” still can succumb to disease.

Impacts of lack of exercise

While three quarters of people ages 40 and older know that exercise benefits their general health, only 34 percent of people currently meet the public health recommendation of 150 minutes of moderate to vigorous activity per week. We need to find ways to sustain behavior change for individuals to regularly engage in physical exercise and incorporate physical activity into their lifestyles. AARP’s recent survey demonstrated that adults ages 40 and older who exercise were much more likely to rate their brain health higher compared to non-exercisers, and report that their mental abilities have increased over the last five years (e.g., memory, attention span, decision making, etc.) compared to non-exercisers (Rainville and Mehegan, 2016).

We know there are many people of all backgrounds and ages who have expressed a readiness to exercise; we must seize the abundant opportunity for public policies to help nudge the willing into the regular exerciser category. A third of adults ages 40 and older are exercise “contemplators” in that they see the benefits and are considering taking up exercise (34 percent). Two in ten (19 percent) are “preparers” and say they have a firm plan to begin exercising in the near future. For the approximate one-quarter (24 percent) of “non-believers” who see no need for exercise, we have more
Impacts of social isolation
Social isolation can harm health and quality of life. For the older adult, loneliness or lack of social engagement is associated with increased mortality (AARP Foundation, 2012a). As a person ages, major life-changing events can occur, triggering loss of social network or social role, poor health resulting in diminished physical, cognitive, or mental functioning, or a reduction in income and resources. The AARP Foundation has identified the following major risk factors for isolation in older adults: living alone; having mobility or sensory impairment; having low income, with limited resources; caregiving for someone with severe frailty; living in remote or rural areas, or unsafe or inaccessible communities; having psychological or cognitive vulnerabilities; experiencing a small social network and/or inadequate social support; being a non-English speaker; and being a member of a vulnerable group (AARP Foundation, 2012b).

Many of these can be addressed so as to reduce the negative outcomes of isolation through better housing and community design, as well as changing the way people work as they age. For the estimated 17 percent of older Americans who are socially isolated, reducing loneliness and depression, increasing social network size, and improving both quality and quantity of social supports and contacts have the potential to significantly improve the quality of their lives as they age (AARP Foundation, 2012a). The Global Council on Brain Health is examining the evidence base on the relationship of social engagement to maintaining cognitive health as we age, and plans to issue their report and recommendations in 2017.

Who Cares?
One of the greatest challenges we face with an aging society is the very high use and cost of healthcare. Other nations today have the proportion of older people the United States will have in twenty to thirty years, and are able to manage this population without generating the healthcare spending levels that exist in our nation (Selwyn et al., 2015). The demographic change alone is not an insurmountable problem. The corresponding rise in medical use and cost, independent of population aging, will magnify the impact of the demographic change and strain our current system for financing healthcare and LTSS. All of us have a stake in finding less costly ways to provide high-quality care and to promote a healthier, less medically dependent population of older Americans.

Healthcare providers care: they want to improve outcomes for older adults. This can be accomplished when medical professionals incorporate a more holistic approach, which shifts the focus away from providing medical services to addressing social determinants of health. This approach is embodied in a new national center, which is a joint project of the Camden Coalition of Healthcare Providers, The Atlantic Philanthropies, the Robert Wood Johnson Foundation (RWJF), and the AARP Public Policy Institute. The as yet unnamed center aims to improve care and lower costs for high-need, high-cost patients by focusing on their overall health rather than on episodes of illness (RWJF, 2016).

The Center will strive to provide coordinated, patient-centered care, including addressing behavioral and social needs such as housing, transportation, hunger, and providing mental, emotional, and educational support. Efforts to expand coverage under integrated plans and programs can potentially shift a substantial amount of healthcare to less expensive settings, thereby avoiding expensive emergency room admissions, hospitalizations, and institutional placements that result in poorer outcomes, at a significantly higher cost. A healthier aging population served more effectively in less expensive settings would go a long way toward
mitigating the impact of a larger aging population on American healthcare use and expense.

Finally, those of us who are aging and our families, and those who seek a vibrant economy for the future, should care. Not only will we experience better quality of life as we age if we promote healthy aging, but the economy also will benefit because healthy populations are a key driver of socioeconomic growth (World Economic Forum, 2015a). Maximizing Healthy Life Years: Investments that Pay Off states that healthy societies create a competitive advantage, which fuels productivity: “An increase in total life expectancy can also have positive effects on a country’s economic prosperity. Populations that live longer are productive over a longer time period and consume more during that extended life” (World Economic Forum, 2015b).

An active, healthy older population stays employed longer, making contributions to the workforce and generating trillions in federal, state, and local taxes. Conversely, unhealthy populations are expensive for governments, businesses, and families. We must move away from the perception that health represents only a financial drain, to a more enlightened understanding that health for older Americans is an investment that pays off with significant returns.

Conclusion
Lifelong public health promotes active aging that improves the lives of individuals and that can reduce the burden of old age upon the health system. Almost a quarter of the population will be older than age 65 by 2060—far too large a percentage of Americans to sideline. With the expectation that people may live thirty years past traditional retirement age, we have a longevity bonus we can exploit if we help maintain peoples’ vitality. Employers, communities, and governments can create opportunities to facilitate healthy behaviors and promote healthy aging—and the new Administration can be instrumental in bringing about a future of healthy aging for all generations.

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References


Successful Aging in Community:
The Role of Housing, Services, and Community Integration

By Robyn I. Stone

Solving the United States’ impending issue with housing for low- and moderate-income elders should be high on the new Administration’s priority list.

Over the past decade, it has almost become a truism that people prefer to age in their own homes and communities. Most policy and programmatic solutions to the challenges of aging in place have focused on increased access to and improved delivery of home- and community-based services to help older individuals avoid placement in more restrictive care environments. While there have been efforts domestically and internationally to encourage developing age-friendly cities and communities, relatively little attention has been paid in the United States to the lack of adequate housing for our aging population.

Policy makers, housing and services providers, advocates, and researchers are increasingly acknowledging adequate housing as a crucial element in the effort to help older adults age successfully in their communities, to reduce use of expensive healthcare and nursing home care, and to allow for healthier aging and improved quality of life. Unfortunately, public resources for senior housing, particularly affordable, service-rich options, are inadequate and have been cut back at the federal level, just when an increasing segment of the older population lives in substandard housing and in communities where they are isolated.

A multifaceted approach is needed to ensure all older adults can successfully age in their communities of choice.

A multifaceted approach is needed to ensure that all older adults, particularly low-income elders, have the opportunity to successfully age in their communities of choice. The comprehensive proposal outlined below is based in large part on the report Healthy Aging Begins at Home (Bipartisan

Abstract

Little attention has been paid to housing America’s aging low- and modest-income population. The new Administration should develop a policy agenda focused on transforming existing homes and neighborhoods to ensure they allow older adults to remain in their communities as their risk of disability increases over time; integrating healthcare, social services, and wellness initiatives with housing to support population health management and care coordination; and expanding affordable housing options for the older adult population—within the financial resources available to support these goals.

Key words: affordable housing for older adults; linking housing and healthcare; livable communities
Policy Center [BPC], 2016), issued by the BPC’s Senior Health and Housing Taskforce.

A Proposal for Enabling Successful Aging in Community
We recommend that the new Administration develop a policy agenda focused on three areas: transforming existing homes (owned or rented) and neighborhoods to ensure they are livable (physically accessible, affordable, and safe) and allow older adults to remain in their communities as their risk of disability and frailty increases over time; integrating healthcare, social services, and wellness and disease-prevention initiatives with housing to support effective population health management and care coordination (particularly of low- and modest-income older adults); and expanding the supply of affordable housing options for the growing older adult population, within the limited financial resources available to support these goals.

Transforming existing homes and neighborhoods
The proposal begins with the development of a new Modification Assistance Initiative. The Initiative would coordinate federal resources in an interagency program to support physical modifications and the use of technology in the home and neighborhood to ensure that older adults living in substandard or inaccessible housing are able to age successfully in their communities. This program would also work with states and municipalities to establish or expand programs to assist lower-income older adults with home modifications through property tax credits, grants, or forgivable loans.

The U.S. Department of Housing and Urban Development (HUD) should maintain protections and strengthen counseling services for the existing Home Equity Conversion Mortgage insured loan program, and explore new products that assist borrowers in accessing home equity to address housing challenges. The Administration also should work with Congress to reauthorize the Community Innovations for Aging in Place Initiative to identify successful community models for possible replication in low- to moderate-income communities, and to work toward establishing a nationwide suitability rating scale for age-friendly housing and communities.

Integrating housing and services for older adults
The new Administration should take advantage of the current stock of publicly subsidized senior housing and naturally occurring retirement communities to test models that use these settings as platforms for coordinating and delivering healthcare, long-term services and supports, and health education–disease prevention activities (including falls prevention and detection programs) to the millions of low- and modest-income older adult Medicare beneficiaries living in these environments. The Centers for Medicare & Medicaid Services (CMS) should develop targeted demonstrations and evaluations to test the potential of such programs to improve broad health outcomes and reduce healthcare costs.

Expanding the supply of affordable housing for older adults
The new Administration must recognize preventing and ending homelessness among older adults as a human and moral imperative. The Administration should work with Congress to reauthorize the Community Development Block Grant Program (which supports housing projects for low- to moderate-income households) and to develop an inclusive national agenda for ending homelessness among older adults and those with disabilities. Congress should consider supporting the development of new models of supportive housing that are integrated with healthcare and other services, including affordable housing options for low- and moderate-income older adults through theshuffle of the federal housing finance market (which supports affordable rental housing). The Administration should also work with Congress to reauthorize the Section 8 Housing Choice Voucher Program—a critical program for low-income older adults and those with disabilities—and establish a national strategy for housing communities with older residents, as well as affordable and accessible housing for low- and moderate-income older adults.

This proposal also calls for the Administration to ensure that nonprofit hospitals include the older adult population and the status of senior housing in their triennial IRS-required community health needs assessment. To date, most of these assessments, which provide hospitals with information about where they can target their community benefit/philanthropic resources, have not included older adults. A few hospitals and health systems have used these funds to develop affordable senior housing; others have provided on-site pro-bono wellness nurses, clinics, or home-modification services to address the needs of low-income elderly residents for care coordination and better service integration. These efforts, however, have been ad hoc and should be expanded formally.

Expanding the supply of affordable housing for older adults
The new Administration must recognize preventing and ending homelessness among
older adults as a national priority by first ensuring that the U.S. Interagency Council on Homelessness explicitly adopts this goal. The new Administration also needs to work with Congress to fund federal rental-assistance programs at adequate levels and to create and fund a new program specifically for older adult housing that uses project-based rental assistance and low-income tax credits to support new construction and attract wraparound service dollars from Medicare, Medicaid, and other health and social service funders. Also, the U.S Department of the Treasury should use

**Nearly 40 percent of individuals older than age 62 are projected to have financial assets of $25,000 or less.**

the Capital Magnet Fund and the Administration should encourage states to use their National Housing Trust Fund allocations to support the production and preservation of affordable housing for the lowest income elders. Finally, the Office of Management and Budget should convene an interagency taskforce that assesses the impact of federal laws and regulations on the production of new affordable senior housing and identifies legal or regulatory modifications that could reduce costs and increase production.

**The Message to Americans: Yes, You Can Age in Community**

The new Administration would announce this multifaceted plan as a framework for ensuring that all older Americans, whether they are homeowners or renters, and regardless of their economic status and level of disability, have an opportunity to successfully age in their communities. We have an unprecedented opportunity to significantly alter the expensive, overly medicalized way we care for older adults before the Baby Boom Generation overwhelms Medicare and Medicaid. Housing is the centerpiece of this shift from overuse of hospitals and nursing homes to home and community. This comprehensive national senior housing plan is essential if we are to enable people to age successfully and safely in their homes and communities, avoid expensive medical care, and optimize social engagement and productive participation of older adults in our society.

**The rundown on housing**

Housing costs are a major burden for many older adult households, particularly for those living at or below 125 percent of the federal poverty level, where 36 percent of spending goes to housing-related expenditures (Favreault, Smith, and Johnson, 2015). As for physical infrastructure that would enable aging in place, only 57 percent of homes have more than one universal design element (e.g., single-floor living, no-step entries, lever-style door and faucet handles) (Joint Center for Housing Studies of Harvard University, 2014), and a little less than 4 percent of housing units in the United States are suitable for individuals with moderate mobility difficulties (HUD, 2015). This lack of accessibility is particularly troubling given the fact that 38 percent of households ages 65 and older house at least one person with a disability (Lipman, Lubell, and Salomon, 2012).

The need for affordable, accessible housing will become even more challenging over the next twenty years as the baby boomers age. The personal savings of older adults—a critical source of funds to support aging in community—will fall woefully short (BPC, 2016). Nearly 40 percent of individuals older than age 62 are projected to have financial assets of $25,000 or less. Currently, the average amount of per capita home equity among homeowners ages 62 and older is $136,000, but was less than half that amount for black and Hispanic older adult households (Favreault, Smith, and Johnson, 2015). Future cohorts of older adults will have far less home equity available to support their daily living and housing needs.
Older adult renters have no such home equity; an estimated 1.8 million elder households suffer severe rent burden, paying in excess of 50 percent of their incomes just for housing (Jakabovics et al., 2015). And 44,000 older individuals have no home, representing the fastest growing segment of the homeless population (Corporation for Supportive Housing and Hearth, 2011). Over the next fifteen years, the United States can expect to see both a growth in the low-income older adult population and millions of elders transitioning to rental housing, from 5.8 million in 2010 to 12.2 million in 2030 (Favreault, Smith, and Johnson, 2015). In the absence of new supply, rents will likely increase and the housing cost burdens borne by older adults will grow (Joint Center for Housing Studies of Harvard University, 2014).

More than 2 million older adult renters live in some type of publicly subsidized housing, with thousands of low-income older adults on waiting lists. Older adult subsidized housing residents make up a very vulnerable population—70 percent are dually eligible for Medicare and Medicaid and 57 percent have five or more chronic conditions—much higher even than their low-income, “dual eligible” peers living in nonsubsidized housing in the same community (The Lewin Group, 2014). They also have 58 percent higher monthly Medicare expenditures ($1,479) than their non-subsidized peers, and higher rates of hospitalization and emergency department use. These individuals could benefit tremendously from formal links and integration between the housing properties and local health and social services to foster successful aging in community. Recent research indicates that housing–service integration and coordination could help many older adult residents avoid transfers to nursing homes, as well as save Medicare dollars through reduced hospitalizations and emergency department visits (RTI International and LeadingAge, 2014; The Lewin Group, 2014).

The lack of affordable and accessible housing for our burgeoning aging population is a serious problem that will only become more challenging over the next twenty years without serious policy intervention and investment from public and private sectors. Older adults’ ability to successfully age in community, however, goes beyond housing and integration with health and social services. Many elders, particularly those living in rural or suburban areas, lack easy access to transportation, grocery stores, recreational facilities, and healthcare entities. The degree of “age-friendliness” of the local infrastructure has an impact on the health and well-being of older adults and, ultimately, their ability to successfully age in community.

Advocates for publicly subsidized housing for a range of demographic groups are vying for the same shrinking dollars.

The Driving Forces of the Housing Debacle
The aging of the population over the next twenty years, coupled with the recognition that many older individuals will not be able to remain in their own homes or communities (physically and/or financially) without serious intervention, is driving increased attention to our inadequate housing and community infrastructure and serious lack of affordable housing options. Several other demographic and policy trends underscore the need for a comprehensive plan to enable successful aging in community. Affordable housing advocates recently have been shining a light on the current and future population of homeless older adults, as an increasing proportion of older adults are living longer on fixed incomes with little or no housing assets and limited savings.

Current waiting lists for publicly subsidized housing are likely to expand in the face of the elimination of HUD’s Section 202 program, the federal investment that historically supported
service-enriched housing for low-income older adults. The lack of affordable housing stock is creating significant problems for many states, aging services organizations, and managed care plans trying to implement Medicaid-funded home- and community-based service programs such as Money Follows the Person (MFP). MFP’s objective is to relocate older adults and younger people with disabilities from nursing homes to community settings.

Several post–Affordable Care Act healthcare reform efforts are also driving more attention to the link between housing and health. Policy makers are experimenting with alternative financing and delivery strategies to reduce Medicare and Medicaid expenditures through value-based payment schemes that encourage more efficient management of high-risk older individuals, particularly “super utilizers” of hospitals and emergency departments. Also, there is an increased focus on population health management through managed care entities, Accountable Care Organizations, and other alternative delivery systems. Finally, healthcare providers are acknowledging that social determinants of health—including housing—are major contributors to the physical and mental well-being of the individuals they care for, and are exploring ways to address these non-medical factors.

The integration of housing and services, particularly in publicly subsidized senior housing or densely populated naturally occurring retirement communities, provides a unique opportunity to manage high-risk, vulnerable older adults as well as to achieve better population health management of lower-risk elders through links between housing-based service coordinators (often available in senior housing) and health and social service partners.

Community settings provide significant economies of scale to reach many older adults and help with identification and targeting, health education, falls prevention and medication management, care coordination, and good transitional care for high-risk residents. As noted previously, studies have begun to demonstrate the benefits of such integration for elders, health and housing providers, and payers. These early findings provided some of the impetus for HUD’s new investment of $15 million to develop and evaluate a four-year randomized control trial testing a housing-based service coordinator-nurse team model in forty affordable senior housing properties nationwide. The BPC’s report also recommends that CMS fund a demonstration focused on housing–healthcare partnerships serving the low-income older adult population, support evidence-based practices that address falls prevention through clinical interventions and home modifications, and explore the role of technology in achieving better outcomes (BPC, 2016).

There is also a growing “age-friendly communities” movement spearheaded by the World Health Organization, AARP, the federal Administration for Community Living, and several private philanthropic foundations. These efforts shed light on the need to develop local communities that are safe, accessible, and affordable for older adults, and representing a broad range of demographics and geography. Such communities, moreover, are viewed as livable environments for all ages, not just the older adult population.

**Winners, Losers, and the Challenges Ahead**

A number of stakeholders stand to benefit from this comprehensive proposal. Currently homeless older adults and those in unstable, unsafe housing situations (low- and modest-income older adults, with fixed incomes and little or no savings) stand to gain the most from this multifaceted strategy. Family members also benefit tremendously, because older relatives who can no longer remain in their substandard or expensive-to-maintain homes or cannot afford rent will need to move in with kin or rely on family resources to support other housing. Affordable senior housing providers and developers, and the larger community, also will benefit from
investments in current and future housing stock. Service coordinators, other community-based service providers, and those employed in the home-modifications sector will be winners under this proposal.

Assuming that early research findings of savings to the healthcare system from linking affordable senior housing with healthcare and social service partners continue to accrue, health systems and public payers (primarily Medicare) will benefit from reduced expenditures and improvements in the quality of care delivered to and quality of life experienced by older adults. Some savings could be reinvested in the construction of new properties to expand the availability of service-enriched housing. Also, younger families looking for housing in tight housing markets might benefit from houses that become available when older homeowners move to more appropriate housing options. With widespread increases in existing housing preservation and supply expansion, local communities could benefit from jobs in construction and related sectors.

As with any large-scale policy effort, there will be some real or perceived losers. Given the lack of overall federal investment in affordable housing over the past few decades, advocates for publicly subsidized housing for a range of demographic groups (children and families, people with disabilities, the younger homeless population, the chronically mentally ill) all are vying for the same shrinking dollars. There is likely to be concern that the older adult population is “stealing” resources from other more needy groups. In fact, relatively little attention has been paid to the need for older adult housing because there is little recognition of the invisible near poor and poor older populations—cohorts that are likely to grow over the next two decades.

Similarly, any funds allocated to housing-based service coordinators may be viewed by other providers in the aging network as a reduction in their relatively small pot of resources and a redundant use of scarce dollars for community-based services. Research findings from our evaluation of a service-enriched housing model embedded in Vermont’s statewide healthcare reform effort substantiate this concern expressed by area agencies on aging and homecare agencies, organizations that are primarily responsible for delivering care-management services to older adult and younger disabled Medicaid home- and community-based service beneficiaries (RTI International, Stone, and Sanders, 2016). With a growing emphasis on better care coordination and population health management, many health systems are hiring their own care managers–navigators and may not see a business case for relying on housing-based staff.

The challenges to plan implementation
The new Administration will face a number of challenges in the implementation of this comprehensive proposal. There is little appetite at the federal level for new investment in publicly subsidized housing and even less for programs that target the older adult population (including preservation, new construction, and widespread home modification). While CMS is testing new value-based delivery models, most of the funds support large health system efforts; few dollars are supporting true community-based initiatives that recognize senior housing as part of the infrastructure. Healthcare systems will only be interested in partnering with senior organizations that have enough volume of older adult residents to achieve the efficiencies and cost-savings that support their return on investment. Given that older residents may be served by multiple providers and hospitals in a geographic area and are not all enrolled in any one plan, it may be difficult to achieve volume without some new type of bundled payment mechanism and housing networks.

Conclusion
One of the “sleeper” issues related to the aging of the baby boomers is the need for affordable
housing options and the development of more age-friendly housing and communities to enable successful aging in community. Despite the challenges highlighted in this article, the proposal outlined above provides a framework for the new Administration to acknowledge the problem, develop a call to action, explore policy barriers and opportunities for reform, and begin to provide solutions that will benefit a wide range of stakeholders. Federal, state, and local governments, and the private sector, will need to work together to identify the resources required to implement the plan and achieve its bold objectives. Inaction will undoubtedly lead to a crisis for millions of older adults and their families over the next two decades. Comprehensive solutions will take time, but the Administration can start now by creating an awareness of the urgency of the problem and laying out a roadmap for successful aging in community.

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References


The Encore Life: A Generation of Experienced Workers Is Ready to Serve

By Marc Freedman

Social change takes time, but can be accelerated with the steadfast commitment of a cadre of purposeful encore-stage workers.

Judge Edward Ginsburg stepped down from the bench at age 70. He has used the years since to rally legions of attorneys—experienced, seasoned veterans and newly minted lawyers entering a tight job market—in the service of families embroiled in Boston’s labyrinthine Family Court system. Thousands of ordinary people have been helped by these attorneys’ pro bono efforts. And two generations of lawyers—older professionals easing out of full-time practice and younger attorneys just getting established—have built a human matrix of wisdom and experience. Ginsburg’s “encore” career has had an exponential impact, beyond the myriad cases he decided in his primary career: he has created a system to serve the needs of people who otherwise lack representation, and by connecting the generations within his profession, has advanced the cause of justice in Boston (Encore.org, 2016).

Ginsburg is a singular force, but he is not unique: in the United States today, more than 4 million people older than age 60 dedicate their time and talents to “encore” roles, spurred by purpose and the desire to contribute to positive change in their communities and in the world. Five times as many Americans say they hope to move into social-purpose encore roles over time, representing a homegrown army of experienced older adults eager to make a difference (Encore.org, 2014).

Many turn to established, regional structures, like Experience Matters (in Arizona) or ReServe (in New York) to channel their skills into encore assignments. Others participate in national programs, like AARP’s Experience Corps, which addresses childhood literacy. This pool of older adults represents a regularly replenishing natural resource that could improve local communities and the lives of future generations. But the supply of experienced adults exceeds opportunities to put that experience to work.

Mapping the Encore Landscape

We find ourselves at a new stage in our collective history, characterized by increasing longevity. The new Administration can and should advance policies and programs that harness and develop the proven strengths of experienced, “encore” talent in social-impact roles, including funding the 2009 Serve America Act, creating an encore-focused White House Conference on Aging, and expanding access to programs like Americorps and the Peace Corps. As longevity rises and economic and other pressures encourage many people in their 60s, 70s, and beyond to continue to work, encore careers that benefit all generations offer a dynamic, creative alternative to traditional retirement and social isolation.

key words: encore career, encore talent, social impact, longevity, retirement

ABSTRACT The new Administration can and should advance policies and programs that harness and develop the proven strengths of experienced, “encore” talent in social-impact roles, including funding the 2009 Serve America Act, creating an encore-focused White House Conference on Aging, and expanding access to programs like Americorps and the Peace Corps. As longevity rises and economic and other pressures encourage many people in their 60s, 70s, and beyond to continue to work, encore careers that benefit all generations offer a dynamic, creative alternative to traditional retirement and social isolation.
human longevity and vitality. The truth is, people in their 50s, 60s, and beyond want and often need to work for a range of reasons. Some, of course, need to continue to earn an income, to supplement retirement savings, or to sustain their survival. Others wish to delay the receipt of the benefits they have accrued over long working lives.

Many Americans realize their retirement assets are wholly inadequate and focus their attention on working longer. For all but the most secure, continued income dramatically increases lifetime financial security. Financial planners increasingly advise clients that the best way to rescue personal finances is to work a few years longer: working longer has a compound impact on income security in later life, as it delays the drawdown of retirement assets and reduces the number of years those assets have to cover.

Deferring the drawdown of retirement assets by four years increases a person’s eventual monthly income over the life span by 33 percent; an eight-year delay can produce a 75 percent monthly bonus, according to economist Steven Sass, program director at Boston College’s Center for Retirement Research (Munnell and Sass, 2009).

And what’s good for individuals is good for the country: one of the biggest long-term threats to the nation’s economic growth is the projected slowdown in labor force growth, relative to the total population. Conversely, an increase in the labor participation rate by older Americans figures to boost economic productivity and growth, driving increased revenues with no need for higher tax rates, according to the Urban Institute (Butrica, Smith, and Steuerle, 2006).

A New Life Stage: From Potential to Practice

Erik Erikson, the pioneering scholar of human development, argued that older generations’ impulse to invest in younger ones is a hallmark of successful development. Erikson called this impulse “generativity,” encapsulated in his phrase, “I am what survives of me.” Harvard Medical School professor George Vaillant, another expert in midlife development, stated the concept even more fundamentally: “Biology flows downhill.” Indeed, the clichéd framework of intergenerational conflict runs against the grain of human nature. The human drive to connect and share grows more pronounced over time, urging us to pass the torch, from generation to generation, in purposeful, impactful roles.

The challenge is to transform this potential into practice, in ways that bridge age, class, and race. For nearly twenty years, Encore.org has devoted its energies to advancing the roles of experienced adults in society. With founding board member John Gardner, Encore created Experience Corps (now AARP Experience Corps), which today matches thousands of adult tutors with tens of thousands of schoolchildren, and benefits all parties as relationships thrive and literacy rises. We celebrated groundbreaking social innovators older than age 60 with a decade of The Purpose Prize, which has awarded $5 million in total to individuals who created projects and programs that have improved thousands of lives.

Our Encore Fellowships Network (EFN) program matches seasoned professionals with social-sector placements in time-limited, stipended fellowship roles: since 2009, more than 1,200 EFN fellows have made the transition from the for-profit to the nonprofit sector. And our flagship campaign, Generation to Generation, which launched in November 2016, aims to mobilize hundreds of thousands of experienced adults on a
national scale, in encore roles that advance the prospects of children and youth.

Yet even as we strive to open additional opportunities, there are persistent obstacles: ageism, while illegal, continues to undermine the prospects of older adults, despite their wealth of skills and experience. Many corporate institutions are reluctant to adopt the kinds of flexible schedules that encore-stage professionals desire (or may require) to meet non-work family obligations. These forces contribute to a do-it-yourself climate that works for self-starters and encore entrepreneurs; however, millions of others would benefit from systems and pipelines designed specifically to move experienced adults into new roles in the American workforce.

The market value of encore workers’ contributions is substantial: our Encore Fellowships Network alone has directed roughly $100,000,000 in human capital to nonprofits since 2009 when the program was created. Encore talent can fill roles as mentors, second-career teachers, and expert guides in specialized fields such as healthcare navigators, for example, or advocates. Youth-serving roles in particular tap the unique strengths of life experience, especially for the roles that require what only a human being can do (e.g., working as tutors, mentors, coaches, and in capacity-building functions within youth-focused organizations). At this moment, it is vital to evolve from the DIY model to a scalable system of solutions that arise from the private and public sectors, and from government.

What the New Administration Can Do

Social change evolves over time, and only with steadfast commitment. To make encore roles and careers a new social norm that benefits individuals and communities alike, both government and its elected leaders, including America’s new President, can take steps to powerfully influence the conversation.

The first and most obvious point is the example of vitality in later life, as embodied by the new President, who will be among the oldest in the country’s history. Americans have the opportunity to see our newly elected leader as a role model for what it means to be an “older” person in the twenty-first century—an individual who possesses the accrued wisdom that comes with decades of work and life experience.

The Serve America Act and other initiatives

Beyond the inestimable power of the President as an exemplar, government programs (coupled with the funding to sustain them) can do much to shape the encore landscape in this century. In particular, the Edward M. Kennedy Serve America Act, enacted in 2009, has never been sufficiently funded to achieve its goals.

As national-service leaders John Bridgeland and Shirley Sagawa wrote in their recent paper, “An Encore of Service,” fully funding the Serve America Act would open opportunities for experienced adults across a broad spectrum of programs (Sagawa and Bridgeland, 2016). It would substantially expand Americorps, and dedicate 10 percent of Americorps positions for people ages 55 and older. Additionally, the Act describes the changing age and income requirements for the Foster Grandparents program (https://goo.gl/hzY8Ov), a shift that brings in a more ethnically and economically diverse participation, and mandates the creation of a Silver Scholarships program, which will permit workers ages 55 and older to set aside $1,000 for a young person’s education. Most vitally, the Act establishes Serve America Fellowships and Encore Fellowships: each could bring thousands of experienced, savvy workers into new professional roles.

Two additional initiatives could dramatically and visibly expand the use of encore talent, according to Sagawa and Bridgeland. An Encore Service Year exchange, built on the model of the online Service
A Message to the President on Aging Policy

Year Exchange (which connects programs and potential participants, generally at the beginning of their careers), would create a structure for organizations to recruit encore-stage individuals. It would also help experienced adults identify local and regional opportunities to serve. Additionally, White House Fellowships targeted to encore-stage adults would permit people with useful experience to contribute to large-scale solutions on the national stage, and provide visible models for rising generations considering their own eventual encore careers.

Expanded public service opportunities
Expanding existing public service opportunities for experienced adults requires vision as well as funding. The Peace Corps, for example, provides federally funded service options for older Americans, but only about one in ten Corps staffers are ages 50 and older. Promoting encore service in the Peace Corps could increase the participation of talented, experienced workers, who bring decades of expertise to the communities they will serve.

The Administration also could think beyond historic convention and update and expand the portfolio of the White House Conference on Aging. The Conference agenda should include the robust, vital millions of elders who have the capacity to make substantial contributions to the well-being of the country, but too often do not know how to make the contributions they desire.

Since the first White House Conference on Aging in 1961, the President has used this vehicle to prioritize policies that address the needs of the nation’s oldest and most vulnerable elders. The need for such a convening to periodically review policies and develop new ideas in areas such as long-term care, family caregiving, dementia care, and related areas of need will not go away.

But it is time for another kind of White House Conference to focus on encore adulthood, to cultivate policies that spur the engagement of adults with experience and skills, and to spur expansion of federal policies to engage experienced adults as resources for their communities.

Supporting the encore shift: from financing to recruitment
The work of social change is not work only for the President. To help make encore careers the new social norm and personal expectation, members of Congress should be enlisted to recognize the talent and experience of older workers, enumerating this perception within the workforce provisions of major legislation and enabling the creation of new financing vehicles such as “Individual Purpose Accounts” that could help people save and invest money to finance their encore transitions. As well, student loan restrictions could be modified to more fully meet the needs of adult learners and those who are committed to public service.

The federal government has the opportunity to lead by example and become a model employer of encore talent, including taking new approaches to recruitment and flexible work arrangements. Social Security can be a beacon for the generations, signaling the urgency of staying in the workforce instead of retiring to the sidelines, by clarifying and modernizing its income management features to help people use their benefits to support career transitions.

At the local level, mayors and city governments could play a role by recruiting experienced talent into high-impact volunteer roles to help in our overburdened classrooms and social service agencies. They could create “intergenerational impact” zones to showcase the value of bringing older and younger

The truth is, people in their 50s, 60s, and older want and often need to work, for a range of reasons.

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generations together in ways that benefit all.

**A Profound Need, but There Are Ready Solutions**
America and its communities face increasingly complex challenges. Encore service, whether paid or pro bono, performed over the long haul or project-based, can meet gaping human, social, and economic needs. Encore roles can become a new norm for a healthier, longer-lived society, with a steady (and rising) supply of adults with an appetite to serve, and the aptitude to do what only human beings can do.

Pooling our collective human resources, and bringing together older and younger people across the generations can help to solve some of the nation’s most serious problems—and create a social movement and a new life norm for generations to come.

This new era, which sees a new presidential administration, and a time of ever-increasing longevity and vitality, is not only about longer working lives, but also a new social compact. Encore careers stand for the proposition that the opportunity to give back is as important as the opportunity to receive, that the safety net is something we all weave in unity, and that work, refashioned and respected, is a noble activity through which we can make a better world for succeeding generations.

Marc Freedman is founder and CEO of Encore.org in San Francisco.

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**References**


Strengthening Elder Safety and Security

By Laura Mosqueda, Stacey Hirst, and Charles P. Sabatino

What the new Administration can do to improve service coordination, public awareness, research, and training on detecting, preventing, and intervening in elder mistreatment.

In recent years, significant strides have been made to strengthen our response to elder abuse and neglect. Elder mistreatment (including physical and sexual abuse, emotional abuse, financial abuse, and neglect) is becoming understood as a substantial threat to public health that has far-reaching effects on elders, those who love them, and society as a whole.

In spite of the 2010 passage of the Elder Justice Act and the work of several government agencies to improve social service and justice responses, we are still not close to securing funding for existing programs such as the Older Americans Act, and awareness and research on prevention and early intervention against elder abuse are inadequate. The vast majority of elder abuse cases go unreported and unaddressed; elder abuse in its many forms remains a significant factor affecting the physical and mental health and financial well-being of all concerned.

As the baby boom population continues to age, we will pay an accelerating price down the road: Medicare, Medicaid, and social welfare programs will spend more to mop up the results of our inadequate protection of older adults. The impact on women will be especially harmful, as they comprise the majority of the older population and the majority of caregivers.

This article offers several leadership steps the federal government should take to improve cross-state coordination of services, improved public awareness, more and better research, and expanded training on prevention, detection, and intervention.

A Message to Americans: Elder Abuse Is a Mortal Menace

From an academic perspective, elder abuse is a complex social issue. But, from a lived experience, elder abuse is a mortal menace that cannot be ignored, especially when considering the following facts:

• Elder abuse leads to a 300 percent increase in premature death, excess morbidity, and untold suffering for victims (Dong et al., 2009).
• Elder abuse victims are admitted to nursing homes at four times and to hospitals at three times the rate of non-victims (National Adult Protective Services Association, 2016).
• In 2013, more than 9,700 complaints of abuse,
gross neglect, and exploitation of nursing home residents were made to state Long-Term Care Ombudsman programs (Administration on Aging, 2013).

- Financial exploitation impoverishes victims, leading to increased reliance on family and safety net programs (Gunther, 2011).
- Victims whose lives are tipped over by financial exploitation and abuse often spiral downward, and they are unable to regain independence (Lachs et al., 1998).
- Elder abuse makes victims more dependent upon caregivers, with a corresponding toll on caregivers’ physical and mental health, employment, and financial security (Connolly, 2012).
- Verbal abuse leads to serious declines in mental health comparable to those caused by physical abuse (Mouton et al., 2010).

Elder abuse is a killer that the nation can conquer if it has the will and ability to make informed policy based on valid and reliable information. A comprehensive federal strategy would ensure stakeholders, which include victims, family members, agencies that serve older adults, government, and the public at large, work collectively to create systemic changes addressing this complex threat. Communication and actions should encourage cooperative interventions that reduce or prevent elder abuse by enabling older adults to stay connected within their communities, linking up older adults to dense networks of professionals, and supporting all those who interact with and care for older adults. To promote public interest in elder abuse prevention, we must reframe elder abuse from being thought of as simply an individual issue (happening to “them”) to a collective issue (happening to “us”) that can be addressed with workable solutions.

Proposal: A Comprehensive Federal Strategy to Address Elder Abuse, Neglect, and Exploitation

A comprehensive federal strategy to address elder abuse, neglect, and exploitation requires action from the executive and legislative branches. The executive branch must encourage and direct initiatives to address elder abuse, while the legislative branch must ensure adequate funding for already enacted legislation, and when needed, recommend new legislative action.

Executive actions

The President wields considerable influence not only in directing agency policy priorities and activities, but also in bringing attention to selected issues, convening and encouraging leaders in the private and public sectors to take action, and, when necessary, using the bully pulpit to push for constructive action and policy.

Because the federal government is most directly responsible for regulating business and commerce across state lines, financial exploitation of older adults is the aspect of elder abuse federal authorities could most directly target. But all domains of elder abuse and neglect need targeting by the federal purse, which now only sparsely funds a broad array of prevention services, direct services, education, and research.

The recommendations below begin with personal presidential influence strategies that can be initiated easily, and the list ends with more formal executive branch initiatives that would mandate specific outcomes.

Talk. We recommend that the new President talk about the hidden epidemic of elder abuse and exploitation in highly visible speeches and events, including the State of the Union address. The lack of visibility of elder abuse as a serious national problem has been a long-standing bar-

Medicare, Medicaid, and social welfare programs will spend more to mop up the results of our inadequate protection.
rier to action. The President’s voice can help pull the reality of elder abuse out of the shadows and into the public eye.

Create. Create an Office of Elder Justice within the White House to serve as the champion, leader, and organizer of the executive actions described in this article.

Convene. Convene banking and financial services leaders by invitation to the White House to develop and commit to a consensus plan of action to prevent and respond to elder financial exploitation of clients and customers. The outcome would be a voluntary agreement (e.g., similar to the idea of creating a School Health Advisory Council in the “Let’s Move” campaign) at a White House event with financial industry leaders present. Such an agreement might, for example, commit the industry to establishing policies and procedures for identifying and responding to suspected exploitation, training of personnel, including employing gerontology experts within the corporate structure, creating collaborations with local Adult Protective Services (APS) and law enforcement, or collaborating in a public education campaign.

Award. In connection with the above initiative, the White House should establish an Elder Justice Protection Award specifically for financial institutions and services that demonstrate an exceptionally high level of effort and success in abuse prevention and response programming. The honor and visibility of such an award can serve as a strong incentive for members of the financial services community to enhance their efforts.

Encourage. Encourage the Treasury Department, through its Financial Crimes Enforcement Network (FinCEN) to enhance reporting of data and outcomes from Suspicious Activity Reports (SAR), including giving feedback on outcomes to financial institutions that file SARs. SARs are documents that financial institutions must file with the FinCEN following a suspected incident of money laundering, fraud, tax evasion, or other criminal activity.

FinCEN has issued an advisory to banks that describes elder financial exploitation and its indicators and asks banks to specify “elder financial exploitation” when applicable in their SARs. While FinCEN publishes annual SARs statistics, FinCEN does not routinely report back to the reporting financial institution on their findings or actions. This leaves institutions in the dark about the effect of their protective action. Likewise, feedback on SARs to local law enforcement or APS in a timely manner could close an information and enforcement gap that would help gauge the effectiveness of action or highlight the need for more or different resources.

Direct. Direct the Elder Justice Coordinating Council (EJCC) to create and coordinate a national action plan to combat elder financial exploitation. The Elder Justice Act established the EJCC within the Office of the Secretary of the Department of Health and Human Services (HHS) and included a group of federal agency heads charged with setting priorities, coordinating federal efforts, and recommending actions to ensure elder justice nationwide. The Administration should direct the EJCC to build upon foundational work already done—specifically the nine broad recommendations already developed by the EJCC, (Elder Justice Coordinating Council, 2013) and upon the Elder Justice Roadmap (Connolly, Brandl, and Breckman, 2014), a stakeholder report funded by the Department of Justice and HHS.

As part of this effort, the Administration should ensure funding and leadership to activate the Advisory Board on Elder Abuse, Neglect, and Exploitation. This body, authorized by the Elder Justice Act but never launched, is to consist of twenty-seven members from the general public with expertise in elder abuse, neglect, and exploitation. The EJCC should use the Advisory Board in developing the national action plan. Several federal agencies, such as the Department of Justice, the Consumer Financial Protection Bureau, and the Federal Trade Commission have made significant strides in addressing elder finan-
cial exploitation, but with a national strategy articulated, all financial, health, and social services executive branch agencies will have a benchmark against which to evaluate their efforts and plan future steps.

**Prod.** Prod the federal agencies responsible for funding research relevant to the health and welfare of older persons to prioritize research on elder abuse, neglect, and exploitation and report annually on research funded. The knowledge base relating to elder mistreatment lags decades behind that of child abuse and domestic violence; the lack of data is a tired excuse used to justify lack of action. The result is that those on the front lines often are without the tools or resources to detect elder abuse or to effectively respond to it. It also means that we know little about which preventive measures are effective. Elder mistreatment research should be made a national priority.

A 2011 report by the Government Accountability Office (2011) noted the inadequate federal research dollars targeting elder abuse, compared to amounts spent on analogous areas of child abuse and domestic violence issues. In addition to assigning research dollars directly to the topic of elder mistreatment, there are opportunities to piggyback elder mistreatment research onto existing priorities, such as the Healthy Brain Initiative.

**Legislative actions**

The White House provides a national budget each year for consideration by Congress, which has the ultimate responsibility for appropriating funds for all government responsibilities. While the White House can recommend new legislative initiatives, the biggest need is to ensure adequate funding for four centerpiece laws already enacted: the Elder Justice Act, the Older Americans Act, Social Services Block Grants, and the Victims of Crime Act—although more than a dozen other laws have components that allow for a focus on elder justice. Unlike the executive actions recommended above, these laws address the breadth of elder abuse, neglect, and exploitation, and not just financial exploitation; and they enable to varying degrees direct services, education, policy development, and research. They authorize a rudimentary national infrastructure, but they are hobbled by the lack of funding.

Job number one of the new Administration is to remedy this sparse funding. While additional legislative initiatives, described below, would expand the range of supports available, adequate funding under existing legislation is the most important first step. The President should lead a call to strengthen and target appropriations under these four Acts.

**The Elder Justice Act** (EJA). This Act was the first comprehensive legislation to address elder abuse. Enacted into law in 2010, the EJA is a four-pronged initiative to enhance national coordination of elder justice activities and research; establish forensic centers to develop expertise and jurisprudence in elder abuse, neglect, and exploitation; strengthen adult protective services; and enhance the capacity of long-term-care settings to prevent and respond to abuse, neglect, and exploitation.

The Act authorized a total of $777 million over four years from 2011 to 2014 for services, grants, and programs to combat elder abuse. Yet since its enactment, appropriations have ranged from nothing to a zenith of $4 million in FY15 and $8 million for FY16. President Obama’s budget for FY17 called for a $2 million increase for the Elder Justice initiatives to develop a national APS data system and to continue APS research. These funding levels provide only the most modest of starts to serious implementation.

In addition, the Administration should make reauthorization of the Act one of its highest priorities in aging, because its original authorization expired at the end of 2014.

**The Older Americans Act** (OAA). The OAA includes multiple titles and provisions that have significant relevance to elder abuse. But funding for the OAA has not kept pace with inflation or population growth for years, and current levels
are insufficient to meet burgeoning needs. Overall spending for OAA programs has barely changed since 2004, and is now rapidly shrinking relative to steadily rising need. Since 2010, and especially following sequester cuts in FY13, OAA appropriations have lagged farther and farther behind the increasing costs of living, while the older adult population continues to grow.

**Job number one of the new Administration is to remedy sparse funding for elder abuse, neglect, and exploitation.**

The OAA provides the architecture for services relevant to elder abuse that could be far more effective with adequate funding. This includes the following services:

- A position in the Administration on Community Living (ACL) responsible for developing objectives, priorities, and long-term plans for elder justice activities; a National Ombudsman Resource Center in the ACL that supports front-line efforts to address abuse in long-term-care settings; and a National Center on Elder Abuse to gather research evidence and provide information on elder abuse, to provide technical assistance and training, and to conduct research and demonstration projects.

- An array of supportive services funded under Title III that includes legal assistance and counseling, LTC ombudsman, prevention of elder abuse, and victim assistance and crime prevention programs.

- An array of programs and demonstrations funded through Title IV and Title VII grants directed at or relevant to abuse and exploitation, including outreach and education programs, research, national and state legal assistance support, LTC ombudsman programs, caregiver workforce training, and the promotion and expansion of state comprehensive elder justice systems.

These services could provide an impressive return on investment if properly funded. OAA programs represent less than 0.2 percent of federal discretionary spending, but leverage volunteers and as much as $3 in state, local, and private dollars for every $1 of federal funding. These services and supports can save taxpayer dollars by enabling older adults to remain independent and healthy in their own homes, and delaying or even preventing more costly, and often unwanted, hospital and institutional care commonly paid for through Medicare and Medicaid.

**Social Services Block Grants.**

Social Services Block Grants to states fund an enormous array of services prioritized by each state, and have been the only source of federal funding for APS, and an important source of funding for other crucial services for victims of elder abuse. This program has been flat-funded in recent years as the prevalence of elder abuse has risen, starving APS programs nationwide of the resources they need.

**Victims of Crimes Act (VOCA).**

The VOCA Fund, also called the Crime Victims Fund, was created by the bipartisan Victims of Crime Act of 1984 as a mechanism to fund compensation and services for the nation’s victims of crime via fines and penalties on federal criminal offenders. Releasing higher levels of VOCA funding allows jurisdictions to plan holistically to reach and serve all victims of crime, including victims of elder abuse and exploitation, and to engage new community partners, such as Adult Protective Services, in this effort.

In FY15, Congress set VOCA disbursement at a level approximately equal to the amount deposited into the fund from criminal fines and penalties collected in the previous year. That release of $2.36 billion gave relief to long-standing funding pressure that had severely constrained the ability of providers to meet the needs of all the nation’s crime victims. States began taking thoughtful approaches to use this funding effectively, engaging in needs assessments and strategic planning with stakeholders, setting training frameworks to ensure that services are
of high quality, and working to improve data collection and outcome measurement.

Going forward, Congress should continue to adhere to the policy of setting VOCA funding levels in line with collections in subsequent fiscal years and assure that services for older adults are specifically included in the use of these funds. This will ensure improvement of our national crime victim response system, particularly improving the lives of victims of elder abuse.

**Other legislative initiatives.** Multiple proposals have been offered in past Congresses to address elder abuse, and they deserve White House support, but ultimately these are a second tier of priority after the above initiatives gain traction. The most important examples have been reauthorizations of existing laws, most importantly the OAA, which was reauthorized in April 2016. Reauthorization of the Elder Justice Act (H.R. 988 in the 114th Congress) remains an unfinished task needing strong advocacy.

Other important bills in the 114th Congress included the following:

- The Elder Abuse Victims Act of 2015, S. 1663, H.R. 4963 (goo.gl/ZAwV62);
- The Elder Protection and Abuse Prevention Act, S. 2747, H.R. 5018 (goo.gl/gBfl4b);
- The Elder Abuse Prevention and Prosecution Act, S. 3270 (goo.gl/4aDLeZ); and
- The Senior$afe Act of 2015, S. 2216, H.R. 4538 (goo.gl/WeMLyL).

**The Scope of the Problem**

Elder abuse is a hidden and growing epidemic that victimizes some 5 million older people a year. For every one case of elder abuse reported, twenty-four remain hidden (Connolly, Brandl, and Breckman, 2014). Types of abuse that occur at the hands of others include physical abuse, sexual assault, neglect, financial exploitation, and emotional abuse. Polyvictimization (i.e., enduring two or more types of abuse simultaneously) is common. Self-neglect is the most common type of abuse reported to APS and deserves special consideration, as it has some unique aspects when it comes to prevention and detection.

The groups at greatest risk for mistreatment—people ages 85 and older and people with dementia—are expected to grow substantially as 77 million baby boomers enter retirement and age over the next twenty years. A majority of caregivers (60 percent) (National Alliance for Caregiving and AARP, 2015) and elder abuse victims (69 percent) (Lifespan of Greater Rochester et al., 2011) are female, placing women at the center of the issue. Minority groups, including African Americans and Latinos, may also be at a higher risk, and little is understood about the cultural differences in how the concept of elder abuse is understood and interpreted among different cultures. Availability and access to supports and services within the community are key in the prevention and care of elders who have been abused. Manpower shortages related to those who care for older adults in all sectors (health, social services, caregiving) are likely to further exacerbate the problem.

**Doing nothing about elder abuse is the easiest, most dangerous, and costliest course to take.**

The human and economic toll of elder mistreatment is great. Victims experience an increased risk of poverty, isolation, and disability. Additionally, elder abuse causes illness and injury, tripling the rate of premature death. And victims are four times more likely to be admitted to nursing homes, and three times more likely to be admitted to hospitals, than those who are not abused (National Adult Protective Services Association, 2016). The impact on mental health is apparent and obvious, although not yet quantified. Abuse and neglect lead to increased costs for Medicare, Medicaid, other public programs, businesses, caregivers, families, and older people themselves. Unnecessary hospitalizations and
adverse events equate to $2.9 billion per year in Medicare hospital costs (MetLife Mature Market Institute et al., 2011). Thus, government (i.e., “we the people”) bears the cost of elder abuse through its direct and indirect effects on the health and well-being of older adults and the community at large.

The Consequences of Inaction
Doing nothing is the easiest, most dangerous, and most costly course to take. The economic, individual, and societal consequences will continue to overburden the system if no action is taken. It is a hugely expensive problem, costing everyone in our society tens of billions of dollars annually. As baby boomers continue to age, these costs will rise exponentially. Taxpayers will foot the lion’s share of the bill, primarily through Medicare and Medicaid. Furthermore, victims of elder abuse experience greater suffering and death, are more likely to be admitted to nursing homes, are more dependent upon informal (i.e., unpaid caregivers) caregivers, and are more impoverished. Elder abuse not only impacts victims, but also takes a huge health and financial toll on caregivers and has massive uncalculated downstream costs that require policies to help alleviate potential consequences.

The Politics of a Solution
A solution to elder abuse would benefit individuals, society, government, and other organizations and industries that serve elders. Older adults at risk of mistreatment and the loved ones who care for them would benefit from reduced suffering and death and reduced financial risk and losses. Individuals would be less likely to rely on public programs due to impoverishment, which in turn would offer cost-savings for society and the government. A modest investment could yield billions of dollars in cost-savings.

Though many agree that it is a problem, competing priorities and limited resources continue to divert efforts to prevent elder abuse. Despite the existing legislation discussed above, elder mistreatment lags far behind other family violence issues, such as child abuse and domestic violence. Elder abuse prevention has bipartisan support and offers low-hanging fruit opportunities for progress at modest cost that could reduce victimization and improve the lives of millions of people of all ages.

Conclusion
Research, services, policy, and infrastructure to address elder abuse are inadequate, and the problem lacks effective champions. The arena of elder mistreatment, which may be even more complex than other forms of family violence, requires an organized multi-disciplinary, multi-agency, multi-system response that does not yet exist. A coordinated strategic response should incorporate government, private actors, and public–private partnerships.

To make elder justice a priority, we must engage stakeholders across the board through a coordinated effort led by an Office on Elder Justice in the White House. We are greatly in need of leadership and guidance from the executive branch of government. This office would have the authority to prod, stimulate, and nurture programs and policies to address elder mistreatment. Without a champion in this role, efforts will continue to lack the priority and resources needed to be effective. As priorities shift with the next election cycle, elder justice must remain a top priority to avoid even greater suffering, death, and financial loss.

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Ten thousand baby boomers are turning age 70 every day in the United States. And, as a result of advances in healthcare and technology, baby boomers are living longer than ever before. Since the time when our Social Security system was enacted, these advances have helped to extend Americans’ life expectancy by nearly twenty years. This extension in the longevity of our nation’s population is a positive development, but our society has not accounted for the fundamental implications and effects of this change upon Americans’ work and family lives—especially with respect to caregiving.

The implications for caregiving are profound. In years past, families relied primarily upon daughters—adult women in the family who did not hold careers outside the home—as the default caregiving infrastructure. But with more than 60 percent of all working-age adult women now employed outside the home, that model is no longer viable. And, whereas most long-term care (LTC) was provided through institutions like nursing homes, today, 90 percent of Americans prefer to age at home and in their communities. While a homecare workforce exists to help support American families, these workers’ wages are so low that they struggle to sustain and care for their own families.

An obvious solution exists: by updating our caregiving systems and policies, the incoming Administration has the opportunity to support the ability of the growing, unprecedented numbers of older adults and people with disabilities to live well in America. At the same time, there is the obligation to support working families as they seek to care for their loved ones and contribute as members of the American workforce. A focus on these changes in systems and policies can help our nation realize the promise of thriving longevity.

First-Line Caregivers: Family and Friends
In many instances, caregivers for an older adult are people the elder knows intimately; i.e., a family member, friend, or neighbor. According to the National Alliance for Caregiving (NAC), it

>ABSTRACT  Caregiving for older adults is an increasingly important issue in the United States. However, there are inherent infrastructural problems with both paid and family caregiving. This article provides the new President and Administration with a guide to eldercare, discusses the current status of caregiving, and offers recommendations for policy and cultural shifts to accommodate current cultural and societal changes in ways that are sustainable and healthy for the care receiver, and the paid or family caregiver.  

| key words: | family caregiver, professional caregiver, eldercare, Caring Across Generations, National Domestic Workers Alliance, immigrant workforce, care workforce |
is estimated that nearly 66 million family caregivers, or so-called informal caregivers, provide support and assistance with tasks, such as bathing, finances, shopping, and laundry, to a sick or disabled person. And, in 2008, approximately 28 million U.S. households had one or more family members who had provided care to an older relative. Approximately 43.5 million adults in the United States served as unpaid caregivers to people ages 50 and older (NAC and AARP Public Policy Institute, 2009). Other estimates put this number closer to more than 50 million unpaid caregivers (National Family Caregivers Association, 2000). By all accounts, these numbers are expected to increase dramatically over the coming decades. Additionally, in 2013, approximately 40 million family caregivers provided 37 billion hours of care at an estimated worth of $470 billion to disabled and/or mentally impaired older family members (Reinhard et al., 2015).

We must support working families as they seek to care for their loved ones and contribute as members of the workforce.

Caregivers assist with tasks and activities of daily living (ADL) that are personal (PADL) (e.g., bathing, feeding, toileting, and transfers), instrumental (IADL) (e.g., shopping, finances, and household chores), and socioemotional (e.g., going out, being with family). Increasingly, caregivers also provide more complex medical care, including medication management, wound care, and maintaining IVs. Yet very few caregivers receive any training or support for such increasingly complex care (Reinhard, Levine, and Samis, 2012).

At whatever level, this care provision can be short term, (e.g., following an expected event such as surgery or a brief acute care incident such as a fall or other accident) or long term (such as when a family member has a chronic condition like Alzheimer’s disease or terminal cancer). If the person needing care gradually loses the ability to take care of his or her own needs, the family caregiver is under pressure to take on more care responsibilities. In the case of chronic conditions, the impaired family member can require significantly more support, often putting their caregiver at risk for multiple negative physical and mental health consequences.

The Complexities of Caregiving

Over time, as the stress of providing care increases, family caregivers report a variety of negative physical, emotional, and mental health symptoms. Providing care for a relative with a chronic illness is a complicated scenario that can be both rewarding and incredibly difficult. Compared to their non-caregiving peers, many family caregivers report a variety of conditions, including depressive symptoms, increased stress and burden, anxiety, guilt, and emotional strain. Family caregivers report diminished physical health as well, such as increased risk of heart disease and other serious chronic conditions. Another issue is social isolation and lack of social support, a common complaint of family caregivers who report higher levels of stress than non-caregivers. Most unsettling, beyond their increased morbidity, are the high rates of mortality seen among family caregivers. Still, providing care to a chronically ill family member also yields tremendous rewards. Family caregivers report feeling competent and positive because they believe they are providing good care. They also tend to form a closer relationship with their relative, and African American caregivers report experiencing lower levels of burden and distress (Apesoa-Varano et al., 2016).

It is not surprising that families hold strong opinions about how care should be provided and who should provide the care. For people with memory loss, their preferred care provider or caregiver is normally a close and trusted family member—typically their spouse or part-
ner or adult child—rather than a paid provider or other family member or friend (Whitlatch, 2010). Although there is no comparable data for cognitively intact adults, there is no reason to believe that their preference would differ. People with memory loss prefer their family caregiver to help with all tasks (i.e., IADLs, PADLs, and socioemotional tasks) and their caregivers are fully aware of this strong preference. Moreover, people with memory loss tend to be consistent over a two-year period in their preferences for and values about care (Reamy et al., 2012).

Unfortunately, caregivers who are tasked with providing all aspects of care can become stretched so thin that they end up suffering from life-threatening health conditions. To preempt and offset this problem, appropriate services and support for the family caregiver (e.g., respite, education about their relative’s illness, counseling, care planning) can help prevent the buildup of this care-related stress, and help families provide care in a more balanced manner (Orsulic-Jeras et al., in press). A balanced plan of care that mobilizes a broad network of support, including family, friends, and service providers (and not just the family caregiver), has the potential to offset current and future caregiving stress. Preventing the consequences of long-term caregiving stress is especially important, given the evidence that family care is the preferred source of care (Whitlatch, 2014), and supporting its use could greatly help produce fiscal savings (Reinhard et al., 2015), more effective services, and healthier family caregivers (and older adults) overall.

The Current Landscape of Eldercare in America

An estimated 66 percent of community-dwelling older adults who need assistance receive all of their care from family caregivers (Doty, 2010). Another 26 percent of older adults receive support from family caregivers and professional caregivers, with just 9 percent relying only upon professional care. Services for family caregivers often are linked to the services available to their impaired family member. For example, a few public programs offer home healthcare for impaired older adults. This can serve as respite (i.e., time away from providing care) for family caregivers—but only if the older adult qualifies for the service.

There also are a number of alternative services designed to reduce the stress of providing care (e.g., support groups, counseling, case management) that are not tied to the older adult’s eligibility. For these services to be effective, they must be sensitive to the unique situations of caregivers with diverse cultural and socioeconomic backgrounds. Overall, it is critical that services for family caregivers are able to meet the unique, changing, and potentially long-term needs of caregivers of all backgrounds.

The growing homecare workforce

Most families cannot handle caregiving all on their own. One option for meeting caregiving needs is to strengthen the formal support system (i.e., homecare workers who are not family members) that is already in place. A well-trained homecare workforce is a critical and fundamental part of the formal support system that we must strengthen in order to meet the needs of our nation’s expanding older population.

Current and projected growth in the need for paid supports and services in the home is expected to drive an increase in the homecare workforce. Homecare is already the fastest growing occupation in our economy, and is projected to grow at five times the rate of any other occupation in the future. Homecare occupations are projected to add more jobs to the economy than any other occupation between 2014 and 2024 (U.S. Department of Labor, Bureau of Labor Statistics, 2015).

Professional caregivers face many of the same stresses and obstacles as family caregivers, along with special challenges that come with caring for non-family members. First, care
workers are managing care in partnership with the patient’s family members, who may live thousands of miles away. Building a relationship that facilitates effective care coordination across long distances can be extremely challenging.

Second, there is the work itself, which can be punishing and isolating. A unique set of skills and qualities is required when the work is centered around upholding the dignity, health, and well-being of others. Workers toil for long hours, (sometimes around the clock) on tasks ranging from bathing and toileting, to physical therapy and cooking. And, there is a significant—yet often underappreciated—aspect of the work that is anchored in human connection and relationships. Often what is most critical to an older adult’s well-being is human interaction. Despite its significance, this work often is referred to as “unskilled,” “companionship,” or “help,” and is largely associated with so-called women’s work. Such labels undervalue the skills required and duties performed.

Third, race is a factor that shapes the conditions of care work. The care workforce always has been disproportionately composed of both women of color and immigrant women. And, there is a long history of racialized exclusions of this workforce with respect to basic rights and benefits that other workers take for granted—wage and hour protections, and the right to organize and form unions. All of these dynamics have created a context in which the workforce that America leans on to care for its families stands on extremely shaky ground logistically and financially.

Fourth, much of the workforce is poor and often burdened with family responsibilities of its own. Ellen (not her real name) takes home between $8 and $9 per hour. This wage must stretch to cover the cost of feeding, housing, educating, and caring for her children. For people like Ellen, often running through their minds are the following questions: Who will care for me when the time comes? How will I afford my own care?

The workforce we count on to support the growing numbers of family caregivers in America cannot care for themselves—or their own families—on the wages they earn. The average annual income for homecare workers is $13,000 per year (PHI, 2015). Their wages are so low that 30 percent of the homecare workforce must rely on public assistance to survive. This contributes to the high rates of turnover in the care workforce. And, it often leads to the best-qualified caregivers leaving this profession to seek economic stability for their families.

To create a strong paid workforce that can support family caregivers and individuals in need of services, we must improve the quality of homecare jobs. In order to do so, we must invest in our caregiving infrastructure—including financing long-term care so that families and employers can pay higher wages and offer benefits, while investing in training, professional development, and career pathways for the workforce.

Policy Steps Toward a Strong Care Infrastructure

Changes in American demographics and the needs of working families represent a unique opportunity for federal action. Supporting family caregivers, attracting, training, and retaining an adequate-size professional workforce, and improving the quality of long-term services and supports (LTSS) will require a greater pool of financial resources than will be available in the coming years to individuals who need care and to their families. Ultimately, American families need a national program that can provide access to supports and services to help family caregivers, supplement family support with paid care, and provide paid care when a family caregiver is not available.

Approaches to financing LTC

Unfortunately, we lack credible and sustainable proposals today for a federal program to finance LTSS. In the short term, the federal government
should support states to develop model LTC programs that would ultimately inform the development of a national program with broad access. This support could include planning grants for up to five states that meet a set of criteria, including agreeing to design comprehensive LTC programs to serve all residents with LTC needs; commitments from key stakeholders interested in participating; and collecting data that would inform the development of a federal program.

Federal grants also could provide general research support to states that are beginning to develop LTC plans so they could better understand and address the issues and needs. States currently lack the data needed to support extensive necessary modeling to develop LTC financing structures. Modelers, lacking data on the needs of low-income populations, often draw conclusions that lump the dynamics in higher-income populations together with lower-income populations, when in reality, the choices and supports are quite different. And, in fact, the lowest income populations are able to access some support for caregiving, whereas middle-income families are not.

Most families cannot handle caregiving all on their own.

Forging an effective plan
For the longer term, the President should propose a comprehensive federal plan to prepare for America’s changing caregiving needs. The new Administration can help create the type of care infrastructure families need by developing and implementing policy that achieves the following goals:

• Provide quality caregiver training and respite care for family caregivers;
• Support quality jobs that pay a living wage, and allow for professionalization and training of the homecare workforce by supporting inclusion in federal workforce training initiatives, partnerships with community colleges and other training institutions, and research that demonstrates a connection between quality jobs and quality care;
• Foster state-level innovation toward publicly financed solutions to families’ LTC needs;
• Support research and development of a federal, publicly financed LTC program with more care choices and better access to quality services for families (by making care more affordable);
• Forge a path to legal status for the immigrant caregiving workforce; and
• Use the White House platform to raise awareness around caregiving and change the value our society and culture put on care.

Conclusion: Progress Is Possible
Fortunately, in recent years, some progress has been made, thanks to the direct advocacy of care workers, and their organizations, along with
unions and elected leaders at the state and federal levels. Seven states have passed legislation to increase protections for the domestic and home-care workforce. Thanks to President Obama and Secretary of Labor Tom Perez, in October 2015, nearly 2 million homecare workers gained minimum wage and overtime protections after more than eight decades of exclusion, through a regulatory change referred to as the Department of Labor’s Home Care Rule (U.S. Department of Labor, Wage and Hour Division, n.d.).

In addition, there are some good local models for training and strengthening the homecare workforce. For example, the Washington State Home Care Training Fund (http://healthcareerfund.org) trains 40,000 homecare workers per year, elevating the quality of care and the number of qualified workers prepared to meet the growing need for homecare in that state. However, these models are more the exception than the rule, and the opportunities to forge change are much greater. By making a new investment in the care workforce, the new Administration can make a significant difference in the choices available to families, the quality of life for America's growing cohort of older adults, and the workforce that supports them.

A key challenge will be addressing the affordability of care for families and individuals who need it. Our existing solutions are insufficient and outdated. There is a common misconception that Medicare covers long-term care—which it largely does not. The private long-term-care insurance model has faced many challenges. It is both expensive and increasingly difficult to find. Even private insurers are beginning to call for a public solution. Cost is still the central challenge facing family caregivers who need to either pay for a facility or hire a homecare worker. It is clear that families cannot address this challenge alone; a public solution is needed.

The workforce of caregivers we count on cannot care for their own families on the wages they earn.

Creating a care economy that allows every working family to thrive is one of the single most important tasks of our time. Valuing care and supporting our caregivers, both professional and family caregivers, will allow America to strengthen its workforce, improve quality of life for older adults and people with disabilities, and transform poverty-wage care jobs into professionalized work with real pathways to opportunity. We are at a critical crossroads in the development of solutions, and encourage this Administration to lead us into the future.

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Bringing the Pieces Together: Person-Centeredness Is Key to Transforming Policy and Services

By Gretchen E. Alkema

A description of the American landscape of care, and how a person-centered approach can make life better for our nation’s older adults.

Policy makers, providers, and consumer advocates have struggled for years with two seemingly disparate yet interrelated phenomena that affect access, quality, and health services cost in the United States. The first phenomenon is that the United States spends much more on healthcare and much less on non-medical supportive services than any other industrialized nation, with overall abysmal results ensuing for quality of health and life measures (Squires and Anderson, 2015).

This discrepancy affects all people who encounter the healthcare system, including older adults who currently are healthy and want to stay that way. Yet its negative impact is most pronounced among the small percentage of older adults living with multiple chronic health conditions and functional limitations—individuals who have nearly doubled the Medicare spending of their healthier counterparts and experience few improvements on quality (Komisar and Feder, 2011; Rodriguez et al., 2014).

The second phenomenon is that services for older adults, particularly for people with significant health and daily living needs, are fragmented, uncoordinated, unresponsive, and difficult to access for these individuals and their family caregivers (Commission on Long-Term Care, 2013; Stone, 2000). Most older adults, regardless of their level of need, can and do live at home in their community—and have a better chance of staying at home if they have support from family and friends, and access to safe and affordable housing, reliable transportation, responsive medical care, and other needed services. However each service line—healthcare in its various forms, behavioral health, rehabilitation, long-term services and supports (LTSS), community-living supports, caregiver services, and housing, to name several—operates as its own unit with separate policy...

**Abstract**

Older adults with chronic conditions and daily living challenges often need support for medical and non-medical care. But healthcare in the United States has largely ignored non-medical supports, while creating confusing and complicated-to-navigate service silos. One solution: reorient the management philosophy and operations of delivery systems to a person-centered-care framework; and foster connections across services platforms toward care integration that rewards value and person-focused outcomes. This article discusses elements contributing to the state of high-cost–low-value institutional structures, efforts to better integrate services through a person-centered care framework, and future policy directions. **key words:** chronic conditions, daily living challenges, non-medical supports, person-centered care
structures, funding, and measurement criteria that define success or failure.

At the system level, these intersecting phenomena result in isolated programs, operated by an overwhelmed workforce through unbalanced and rigid financing, all trying to meet a burgeoning need. At the person level, the results are similarly untenable: individuals (particularly older adults) in need and their family caregivers feel engulfed by an information overload in a nonsensical service maze, while simultaneously feeling abandoned by providers that adhere only to their own program rules and boundaries.

A solution to this conundrum is twofold: reorient the management philosophy and operations of delivery systems to a person-centered care framework; and foster connections across services platforms toward care integration that rewards value and person-focused outcomes. This article discusses elements contributing to the state of high-cost–low-value institutional structures, current efforts to better integrate services through a person-centered care framework, and policy directions for the future.

How Did We Get High-Cost–Low-Value Institutional Structures?

While most system thinkers assert the truism in the famous quote that states “every system is perfectly designed to get the results it gets” (Batalden and Conway, 2015), most might also agree that poorly performing systems, from the end-user perspective, were not designed with such failure in mind. Rather, systems evolve in response to internal and external forces (e.g., demographic, economic, policy, and political) over time, and are driven by expectations of their worth and value, or lack thereof (Pressman and Wildavsky, 1984).

This holds true for systems serving older adults. Few people developing the first laws, regulations, and financing for nursing facilities could have anticipated how population aging, advances in healthcare and rehabilitative sciences, state politics, federal funding, and the Affordable Care Act would transform the industry from almshouses to what is primarily a post-acute-care service line. Even fewer could have imagined the interplay between hospitals and nursing facilities that often occurs when a seriously ill person has psychosocial and environmental challenges neither entity can solve, resulting in a hospital-to-facility-to-hospital discharge loop that ends only when outside forces, such as family members or death, intervene.

The Person-in-Environment model

A “person-in-environment” model articulates the layers at play and how these have interacted over time and space to mold the service delivery system available to older adults today (see Figure 1, below).

When defining the person in layer one, older adults now are more heterogeneous than ever. Even with life expectancy variations by race, ethnicity, and-or economic condition, older adults have unprecedented longevity, while
concurrently being affected by differing health and function status. For example, 52 percent of adults who live to age 65 will at some time have a high level of need for daily assistance. However, many in this group will have high needs for less than a year, and only one in seven will have high needs for five or more years. Most actuaries, doctors, and families are unable to predict if and when an older person will need substantial support, for how long, and for which needs. Changed family structures and geographic dispersion mean fewer people are in the immediate area to offer hands-on support to an older loved one with needs. Caregivers not living in the area seek solutions via the Digital Revolution and often find Web-based information that is diffuse, condition-specific, or lacking in useful information and poorly managed.

At the third layer, the newest communities were created amid an American individualist spirit that arose when the automobile was king and the post–World War II housing boom championed suburban, multi-story, single-family homes. Most American communities today would fail a basic “age-friendliness” test in terms of mobility, distribution, and accessibility of core resources (e.g., housing, transportation, food, and health-care services), and a willingness to embrace the coming aging demographic with innovative daily living and social engagement solutions.

Finally, state and federal policy (the final two layers) created the legal and regulatory structures and their associated funding that allowed our current delivery systems to emerge. Unfortunately, states and the federal government have tackled various social policy challenges facing older adults through isolated actions, without staying true to an overarching vision for success. For instance, nearly every cabinet-level federal department has at least one agency that authorizes services and funding for age-based or age-related services. But these allocations are independent of any unified policy statement from the executive or legislative branch on what aging should look like in America and how to improve the lives of older adults in need.

Balancing the tensions: standardization vs. personalization

In this interactive person-in-environment model, each layer stands on its own and is held together through two dynamic tensions: standardization and personalization. Starting from the most dominant layer, federal and state policy action seeks to ensure standardization of laws, rules, and regulations for the planning, delivery, execution, monitoring, and enforcement of services, with or without public funding. This is an essential role of government, with the ultimate goal of achieving public safety, access to needed services, and equal protection under the law. Operating from this tension works well for providers, payers, and regulators regardless of the kind of service (healthcare, home-delivered meals, transportation, etc.). Each service functions as its own unit, adhering to the structure and process that dictate its operation and measuring value based upon how well it executes these elements to provide safe, accessible, and equitable support. However, the only way to evaluate a successful outcome and the value of the service is to know how it meets the needs of the intended end user.

All of these distinct interventions come together within an individual’s unique experience. The counter-tension of personalization originates from a person’s goals, needs, preferences, and resources and stretches out toward the rest of the person’s larger environmental context. Personalization means that what a person thinks, feels, and believes is at the core of her or his humanity and is present in every engagement she or he has with others. This includes all providers within the broader service
delivery system—whether these services work with and acknowledge each other or not. Operating via personalization cannot be accomplished without talking with the person directly (or with her or his family when the person is unable to communicate); only by doing so can one understand what is most important to an individual in their present circumstances, and subsequently ensure autonomy and appropriate service choice.

Although recent federal and state policies call for a greater appreciation of and engagement in personalization, service systems are more familiar, comfortable with, and rewarded for leaning toward standardization.

Why does this happen? There are several possible reasons. First, personalization may be perceived as time-consuming and too expensive. There is a lack of well-tested and easily implementable tools and process flows for gaining a clear understanding of older people’s values, preferences, and goals in a time-sensitive manner. Also, as payment shifts from volume to value, delivery systems are beginning to change their structure and business operations. However, newer payment methodologies are still anchored in evaluating medical transactions (e.g., did you get a flu shot?), and have not fully shifted to measures that reward person-centered structures, processes, or outcomes (e.g., how is a person’s full range of needs and goals used to drive care planning?) (The SCAN Foundation, 2016).

Underlying these three reasons is something potentially deeper and more insidious—that personalization is devalued unintentionally when providers operate from a well-meaning, “I know what is good for you” core belief. This perspective works well in urgent, safety-conscious scenarios, such as a natural disaster or a person having a heart attack. Sometimes providers believe they must follow evidence-based guidelines irrespective of how these resonate with a person’s goals because such guidelines relate to a payment-focused quality measure. Yet few situations for older people, including those having substantial needs, meet the emergency threshold, and strict adherence to evidence-based guidelines should not override care planning based on a person’s expressed needs and wishes.

*The right providers would engage with individuals at the right time, the right place, and for the best cost.*

The covert pervasiveness of this myth—the necessity of paternalism—has maintained the status quo of services operating independently, with each providing its own brand of support without ensuring autonomy, dignity, and appropriate care coordination for its customer base. It is how a caregiver for an older person with severe cognitive impairment is harangued about getting a loved one’s blood drawn to check HA1c levels (a diabetes screening), when it is clearly against that person’s wishes. It is how older people can end up having five care managers from different settings, such as adult protective services, healthcare, housing, and so on. The result: each service unit looks at its own part of the human puzzle in its own way, has little to no financial incentive to operate differently, and ultimately believes that “I’m doing the right thing for my client/patient/resident.”

A Course Correction: Person-Centered Care Across Service Platforms

Anyone involved in a major personal change process will acknowledge that deeply ingrained behavior patterns seem hard, if not impossible, to break. This is true for system change as well. The first action is to envision a new way of being that is consistent with the change. Several entities have set a new vision that holds in union the dual tensions of personalization and standardization.

In 2001, the Institute of Medicine (IOM) defined multiple aims for improving the health-care system for the twenty-first century. Among these were to create a more person-centered
system that respects and addresses the individual’s preferences and needs and for individual values to guide the clinical care provided (IOM, 2001). Similarly, the 2011 National Quality Strategy (NQS) acknowledged that a person-centered approach would see “a person as a multifaceted individual rather than the carrier of a particular symptom or illness [and] requires a partnership between the provider and the patient with shared power and responsibility in decision making and care management” (U.S. Department of Health and Human Services, 2011).

Building on the IOM and NQS work, along with efforts from many others (The SCAN Foundation, 2013), the American Geriatrics Society (AGS) released a national consensus definition for person-centered care. According to its expert panel, “person-centered care means individuals’ values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals.” This approach can also include input from family and other caregivers, if the person wishes. AGS clearly articulated eight characteristics necessary in a successful person-centered care program, ranging from creating a goal-oriented plan of care to performance measurement grounded in feedback from the person and their family (AGS, 2016).

**An Ideal System: Delivering and Paying for Person-Centered Outcomes**

The next action is to map out how the vision could be implemented. What would an ideal system of person-centered care actually look like in practice?

Individuals of any age who are living with chronic health conditions and functional limitations would have access to a readily available network of affordable options that provides high-quality care and supports, allowing these individuals to live well and safely in their homes and communities. The needs, values, and preferences of these individuals and their family caregivers would be regularly identified, honored, and addressed by the providers, organizations, and delivery systems that serve them. Healthcare providers would be knowledgeable about services that have traditionally been thought of as beyond their scope, such as LTSS and behavioral health, with providers being responsible for connecting people with available support options to help them live functional lives.

Older adults and their family caregivers feel engulfed by an information overload, in a nonsensical service maze.

Community-based providers in the LTSS and behavioral health realms would help individuals navigate various options for care and provide tangible services when needed. These community-based providers, operating as the day-to-day eyes and ears, watching for subtle or major functional changes, would link accurate and timely information back to healthcare providers to enable individuals to use all services in the most appropriate and cost-effective manner. All providers would focus on making and maintaining key integrated connections between the main service platforms—primary, acute, behavioral, and rehabilitative care with LTSS and other community-living supports—and place the individual in the center of the care experience.

Payment methods using public funds would ensure the availability of routine and specialty services across the spectrum from providers that meet quality standards for safety and accountability. Financial enhancements and-or withhold would be based on quality measures evaluating structure, process, and outcomes from a person-centered perspective and would include asking the person and his or her family about how the constellation of services meets their needs (The SCAN Foundation, 2016).

Care-coordination processes and plans would also help people and families with financial means
to use their resources in tandem with available public resources through the most efficient and effective ways possible. Overall, the right providers would engage with individuals at the right time, the right place, and for the best cost, involving family as appropriate and creating a rational plan of care that puts the person’s preferences, values, and desires first (AGS, 2016; The SCAN Foundation, 2012; Westphal et al., 2016).

Next Steps in Championing Person-Centered Care

The time has come for all parts of the service delivery system to see and engage with those living with chronic health conditions and daily living challenges as people with variable needs that shift over time, not solely as healthcare patients. Without this perspective, it is impossible to know and plan for all the possible permutations of care delivery for a person without asking about their goals, needs, preferences, and resources. Service systems using a person-centered approach find that they can be responsive to individuals and family caregivers while balancing safety (clinically defined by evidence or ethically defined by providers) with autonomy (Wilber et al., 2015).

While organizations adopting a person-centered approach have potential to benefit all types of customers, the best-case scenario for implementing person-centered care effectively is when organizations serve those with the most substantial health and daily living needs. By appropriate targeting strategies, coupled with matching services through a robust intervention package, many systems have demonstrated a clear business case for person-centered care—one in which saved resources can be reinvested into community-living supports that really matter to people (Tabbush et al., 2016).

The complexity of care delivery systems means that each component will have to adapt and customize core operations based on many factors, including populations served and local context (Minvielle et al., 2014). A common denominator across all system components should be a laser focus attention on function, whether at the individual level or across a defined population. The idea of “functioning well” is a value judgment—one often informed by the knowledgeable opinions of providers and caregivers, but ultimately defined by the individual in light of his or her life circumstances.

Finally, the brass ring in achieving person-centered care is when policy makers and system implementers redefine their daily work so that its central tenet is championing someone’s highest level of functioning at any age, health status, and ability relative to that individual’s personally defined baseline. While efforts are afoot to transform the national narrative on aging into one that breaks from stereotypes, the ultimate measure of success is to create systems of care that enable every older person to live out his or her life with dignity, choice, and self-determination, in the place they call home.

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References


All generations dream of a future with greater prosperity and more financial security. However, the Millennials and succeeding generations are coming of age in a much different world from that of prior generations, and the challenges they face are many. Leaving these challenges unaddressed will affect these cohorts’ ability to age successfully and healthfully, and will jeopardize their economic and overall security in old age. Investments to improve life experiences at younger ages increase the likelihood for greater health and financial resilience, as well as for personal fulfillment at later stages of life—benefiting individuals and society as a whole.

How can we prepare for a brighter future? At this critical juncture, appropriate federal policy initiatives launched in the first 100 days of the new Administration would signal a commitment to the future of the Millennial generation and those that follow.

To meet every goal we have as a nation—whether the goal is broadly shared economic prosperity, international competitiveness, a strong national defense, a clean energy future, or longer and healthier lives—we must adapt to a new era comprising a different demographic profile. Doing so requires significant and far-reaching efforts, and the time to start is now.

A few important themes point us toward appropriate federal policy initiatives that will secure the future of the Millennials and younger generations.

**The Shift Toward a Majority-Minority Nation**

For the first time in U.S. history, our country is simultaneously growing older and becoming America Must Invest In Its Next Generations

By Jean Accius and Jarmin Christine Yeh

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**The Shift Toward a Majority-Minority Nation**

For the first time in U.S. history, our country is simultaneously growing older and becoming
more diverse. This has important implications because the destinies of racially and ethnically diverse younger and older generations are intertwined. In highlighting diversity and differences, the intention is not to separate, but to connect through generational unity.

By 2030, roughly 75 million baby boomers (born between 1946 and 1964) will be older than age 65, making them eligible for increased social services. This demographic change has important implications for Medicare, Medicaid, and the Older Americans Act. According to the Congressional Budget Office (CBO), the aging population will increase demand for long-term services and supports (LTSS) (CBO, 2013). As some scholars have argued, it is nearly impossible to finance and meet the needs of a population that will nearly double in size with the budget we have today (Wiener, 2013). As significant as that impact will be on federal and state budgets and individual resources, the Millennials, almost twenty years behind the baby boomers, will be a far larger cohort and potentially less well-prepared.

The Millennials (born between 1982 and 2004) are not only the largest living cohort, comprising 83.1 million people, they are also more racially and ethnically diverse than preceding generations (U.S. Census Bureau, 2015). This illuminates the United States’ racial generation gap—the difference in percentage of youth compared to older adults from racial or ethnic minority groups (Pastor, Ito, and Carter, 2015). For example, among Millennials, 44.2 percent belong to racial or ethnic minority groups compared to 21.7 percent of baby boomers (U.S. Census Bureau, 2015).

The racial generation gap has an inverse trend between younger and older age groups, with long-term implications for our nation’s future. Along every rung of the generational ladder, the older the age group, the larger the share of the population composed of non-Hispanic whites, and the reverse is true for younger ages. At the oldest end of the ladder, 82 percent of Americans ages 85 and older are white, yet more than 50 percent of Americans ages 5 and younger are from racial or ethnic minority groups—the first age group to reach majority-minority status (Brownstein, 2015). Data project that by 2050, the U.S. population will reach majority-minority status (Pastor, Ito, and Carter, 2015; U.S. Census Bureau, 2015).

We need not look far to get an idea of the socioeconomic, cultural, and political implications of a majority-minority society. This demographic trend has already created challenges in public spending, regional cohesion, economic sustainability, and social movements in states like California, Hawaii, New Mexico, and Texas, which have already reached majority-minority status.

The racial generation gap also is altering America’s urban landscape. While many baby boomers will likely “age in place” in the suburbs, or retire and migrate to high-amenity areas such as the Mountain West and South, urban areas are seeing a sharp rise in racial and ethnic minorities. Much of the projected older adult gains will be in non-metropolitan areas or outer suburbs of fast-growing metropolitan areas. Central cities and inner suburbs of metropolitan areas will feature a younger, working-age, multi-racial, and multi-ethnic population, as well as house a disproportionate number of the nation’s disadvantaged older adults, people living in poverty, and people with disabilities (Frey, 2000; Pastor, Ito, and Carter, 2015; U.S. Census Bureau, 2015).

While demography is not necessarily destiny, the implications of these demographic changes are important to consider when investing in the next generation. There is an intimate connection between our oldest Americans, many of whom need the care and support provided by younger workers, and our youngest Americans, whose prospects in a changing economy depend upon which social policies are enacted now. The effectiveness of social policies will depend upon having a deep understanding of the implications of these demographic changes if national goals, which must include eradicating poverty and
racism, will be achieved before the Millennials reach older adulthood.

For instance, younger generations are vulnerable to inequitable investments in social infrastructures and support systems; this will challenge their ability to achieve the American Dream. Implications include where they might live and whether or not housing will be affordable; whether or not they will have access to quality education and training without being crippled by student loan debts and thus be competitive in a global marketplace; whether or not they will have employment opportunities that provide livable wages and retirement security; whether or not home-, health-, and community-based supports and services will be well-integrated so these generations can care for the younger and older members of their families without sacrificing their own careers and retirement.

To mitigate the racial generation gap and transition into an equitable majority-minority nation requires substantial social policy shifts now, plus ongoing efforts to find transformative ways to engage and connect across race and generations.

Greater Investment in and a Renewed Commitment to Our Social Contract

For some, America can be a land of opportunity. For many, however, significant challenges faced early in life compound over time, unless interventions change that trajectory. There is a linkage between starting life as a disadvantaged, poor, unhealthy young person and becoming a disadvantaged, poor, unhealthy older person (Ferraro and Shippee, 2009). Investments to improve the life experiences of young people increase the likelihood of greater health and financial resilience for them in old age.

Meanwhile, with modern advancements, human longevity has increased. Today, we have a society made up of a number of cohorts: the Silent Generation, born between 1925 and 1942, the Baby Boom Generation, Generation X, the Millennials, and Generation Z (those people born between 2004 and the present). These groups think differently and have different needs and aspirations. Each generation has gone or will go through life with a different set of circumstances influencing their relative social and economic condition as they reach old age. The experience for today’s younger generations (particularly Millennials and younger) has been shaped by the consequences of decades of inequitable investments in social infrastructures and support systems, which, if left unchecked, will hamper their ability to prepare adequately for retirement.

There are already nearly 10 million Millennial caregivers, and that number is expected to increase.

Such collective problems, which will only worsen with time if not faced, will require collective solutions. The interests of racially and ethnically diverse younger and older generations can spur innovation in the form of creating opportunities in the design and delivery of products and services, as well as in determining policy priorities and strategies that reflect the different life experiences and mutual benefits of these growing groups. We must seek opportunities to reallocate resources, and invest in initiatives that elevate the role of support systems and sow generational unity. The underlying ethos must encourage community members to make short-term individual sacrifices for the long-term communal good. The country must renew its social contract to care for one another if it expects to influence the well-being of the Millennials before their retirement or old age. The following are suggested areas in which to focus federal policy, though this is far from a comprehensive list.

Eliminate education inequality and invest in education

A well-educated citizenry and world-class workforce are essential to nearly all of our national goals. Investing in education honors our obliga-
tion to serve this generation and the next. Focusing on innovation and economic growth is necessary to help the United States remain globally competitive and ensure its citizens age with greater independence and dignity.

Whether individuals within up-and-coming generations go on to be politicians, physicians, entrepreneurs, or artists, the challenges they face will demand critical-thinking skills and creative problem-solving. Those abilities can be developed by investing in comprehensive curricula, such as STEAM education (Science, Technology, Engineering, Arts, and Mathematics), and nurturing new talent from early childhood education to college and beyond.

**Eliminate inequality**

Success also requires addressing the root causes of education inequality. More than sixty years after *Brown v. Board of Education*, the case that ended legal segregation in public schools, the U.S. education system is still very much separate and unequal (Cook, 2015). Moreover, low-income children became a majority in U.S. public schools beginning in 2013 (Southern Education Foundation, 2015).

Many factors contribute to education disparities, which are stratified by race and class and correlate with other inequalities, such as disparities in health, residential location, access to technology, achievement expectations, dealings with the justice system, parental free time, quality and distribution of teachers, per-pupil spending, and other factors and circumstances (Cook, 2015; Singer, 2015; Spatig-Amerikaner, 2012). Left unaddressed, education disparities and achievement gaps could diminish a qualified workforce (Cook, 2015).

Investing in early childhood education and high-quality care environments through strong federal policy would show a commitment to this and future generations of Americans. Education disparities already affect young children, and this unequal starting line has lifelong impacts. Early childhood education and care are often expensive for families, though necessary for parents who must work. Even younger Millennials are approaching childbearing age and may be forming households soon. Making high-quality childcare more accessible to families will ensure that more children are better prepared when they enter formal schooling.

**Improve the financial outlook for Millennials and generations beyond**

According to Pew Research Center (2014), “Millennials experience higher levels of student loan debt, poverty, unemployment, and lower levels of wealth and personal income than any other generation at the same stage of life.” Millennials are more likely to have a college degree compared to previous generations; however, for many, their education was financed through student loans. Millennials owe, on average, $35,000 in student loan debt. According to a recent survey of Millennials from Citizens Bank (Businesswire.com, 2016), 59 percent reported they were unsure how long it would take to pay off their student loan debt, and an equal percentage said they now regret the amount they borrowed to finance their college education. More than a third said if they could do it all over again, they would not have gone to college.

Compounding their financial woes, many Millennials entered the workforce during the most pronounced downturn since the Great Recession. As of mid-2014, they represented 40 percent of all unemployed workers (Fottrell, 2014). Many others are underemployed, making significantly less in wages while doing jobs that may not require a college degree. Because of limited opportunities for economic mobility, many Millennials are experiencing higher rates of poverty relative to other generations at similar points in their lives. This is due to a prolonged period of flat wage growth, in which increases in productivity do not return gains to workers. Without corrections that distribute more of the gains from growth to the middle- and lower-
income groups, all of our retirement systems built on lifetime earnings will be in jeopardy.

The numbers are hardly more encouraging with respect to another traditional indicator of economic security—home ownership. Home equity has been the generator for middle-class wealth for today’s retirees. However, more than 60 percent of Millennials do not own a home; the highest level on record (White House Council of Economic Advisors, 2014). The world is changing and homeownership may become less important or difficult to attain. Given this reality, what avenues for wealth creation will be available to younger generations?

Complicating matters further, cities often present greater career opportunities, but are increasingly unaffordable (Thompson, 2014). Consequently, social mobility and the American Dream remain out of reach for many Millennials. Instead, many Millennials return home to live with parents, who often support their children financially, risking their own retirement security.

Creating meaningful pathways to employment and work development opportunities can help address the harsh economic realities facing many Millennials. Addressing student loan debt and the alarming default rate are critical to expanding economic security. Families need to know the costs and understand the long-term burden of having to repay large amounts of student loan debt. They also need information regarding the value of education, hiring rates for various programs, and current and projected future earnings for those professions. Repayment options and enrollment in income-driven repayment plans that cap monthly payments to a percentage of earnings can help individuals meet their financial responsibilities while balancing other obligations. A stronger effort to increase awareness of such options can help.

Access to employer-based retirement plans needs to be more prevalent. Work and Save plans blend personal, public, and private responsibility. Under these plans, employees can set aside savings through a simple payroll deduction. These accounts are voluntary and also portable, so as Millennials switch employers, their accounts can follow them. These plans can go a long way to help Millennials save while working.

According to a national poll conducted by the Young Invincibles, Millennials strongly support a state-facilitated retirement plan that is voluntary for workers who do not have other alternatives to save for retirement. Meanwhile, there is evidence that they will save for retirement if given the chance. The poll also found that more than two-thirds of Millennial workers with access to an employer-sponsored retirement plan were consistently making contributions to it. Yet, 43 percent did not have access to an employer-sponsored plan (Young Invincibles, 2016). Supporting efforts to give millions the opportunity to take charge of their financial futures through a Work and Save Plan is an important step toward enabling financial independence for a generation lacking retirement planning options.

Acknowledge caregivers as a crucial part of the solution

Already Millennials are playing a key role in an area commonly overlooked within our healthcare and LTSS delivery systems. Family caregivers are the backbone of the LTSS system and are critical partners in healthcare. There are already nearly 10 million Millennial caregivers, and that number is expected to increase as the population ages.

The typical Millennial caregiver is a 27-year-old adult caring for a 60-year-old female relative, most often a parent or grandparent. In some cases, these caregivers also are caring for spouses, siblings, aunts, uncles, close family
friends, families of choice, and their own children. These family caregivers work thirty-five hours a week and most live with, or are residing within twenty minutes of those they care for (AARP Public Policy Institute and National Alliance for Caregiving, 2015). The pressures of caregiving take a toll on emotional, physical, and financial health. Millennial caregivers are often juggling school, work, and caregiving without paid help.

Yet Millennials are not the typical group that policy makers and service providers consider when they think about caregivers. Millennials will need more support to avoid sacrificing their careers and their own economic security in the process of caregiving. Public and private sectors can play a significant role in providing such support. Paid family leave, flexible hours, and respite care can provide much needed relief to the millions of Millennials who are working, providing care, and going to school.

Greater investments in technological solutions to address the challenges of caregiving can also help improve the quality of life of older adults, as well as assist caregivers. Working with Congress to create and implement a national strategy that recognizes and supports family caregivers with meaningful private and public solutions would signal a strong commitment to Millennials and future generations of caregivers. This includes looking for ways to develop a larger and more professional paid LTSS workforce.

**America Can Lead the Way Forward**
America is not alone in facing issues related to longevity and an aging society. America is, however, well-positioned to be innovative about social policies that will ensure the Millennial generation and the next generation will be able to grow old healthfully and successfully, with equity and dignity. Increased life span means more Americans will deal with issues of aging at the individual level; and, as a nation, we will need to address an array of seemingly unrelated, but nonetheless pertinent demographic concerns. Acknowledging America’s diversity will allow us to craft strong federal policies that will impact the life opportunities for millions of young Americans aspiring to success. To invest in these kinds of solutions is to invest in America’s future, ensuring our role as a global leader.

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The Aging and Disability Business Institute focuses on preparing, educating, and supporting CBOs and healthcare payers to collaborate and provide quality care and services.

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