KEYSTONE POLICY CENTER

Date: April 23, 2016
Strategic Action Planning Group on Aging
Literature Review – Part 5 of 5: Miscellaneous Reports

Date	Report	By	Topics	Summary/Findings/Key Recommendations

4/2016	The Complexities of Physician Supply and Demand: Projections from 2014 to 2025 – Final Report
	
	51 pages – Read Executive Summary
		Association of American Medical Colleges	Work Force Development
			Work Force Delivering Services to the Aging Population
			
			Health and Wellness Insurance
				The need to assess the capacity of the nation's future health care workforce overall—and physician workforce in particular is more important now than ever for both public and private sectors to act and make the investments needed for a health care system that provides high-quality, cost-efficient health care while also developing the physicians needed to transform the current system and to maximize population health. The pace of change in the world of health care delivery and finance necessitates an almost constant updating and improvement of workforce projections and projections models. That is why in 2015, the Association of American Medical Colleges (AAMC) made a commitment to commission updated national physician workforce projections annually.
				
				Key Findings
				• Physician demand continues to grow faster than supply leading to a projected total physician shortfall of between 61,700 and 94,700 physicians by 2025.
				  ○ Projected shortfalls in primary care range between 14,900 and 35,600 physicians by 2025.
				  ○ Projected shortfalls in non-primary care specialties range between 37,400 and 60,300 by 2025.
				• Under virtually all scenarios, the supply of surgical specialists is projected to decline by 2025; in contrast, the supply of

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				primary care physicians, medical specialists, and other specialists is projected to grow over this period. • For all specialty categories, physician retirement decisions are projected to have the greatest impact on supply, and over one-third of all currently active physicians will be 65 or older within the next decade. Physicians between ages 65 and 75 account for 11% of the active workforce, and those between ages 55 and 64 make up nearly 26% of the active workforce. • Population growth and aging continue to be the primary driver of increasing demand, with the older population expected to experience the greatest growth in demand from 2014 to 2025. During this period the U.S. population is projected to grow by close to 8.6%, from about 319 million to 346 million. The population under age 18 is projected to grow by only 5%, while the population aged 65 and over is projected to grow by 41%. Because seniors have much higher per capita consumption of health care than younger populations, the percentage growth in demand for services used by seniors is projected to be much higher than the percentage growth in demand for pediatric services. • Expansions in medical insurance coverage due to the ACA and the economic recovery have reduced the number of uninsured.
3/2016	2015 Retirement Confidence Survey *39 pages - Skimmed*	Employee Benefit Research Institute	Family Economic Security Retirement Security Retirement Savings Trends	Findings in this year's Retirement Confidence Survey (RCS) include: • The percentage of workers very confident about having enough money for a comfortable retirement, at record lows between 2009 and 2013, increased from 13% in 2013 to 22% in 2015, and, in 2016 has leveled off at 21%.

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				• The percentage of workers somewhat confident increased from 36% in 2015 to 42% in 2016, while the percentage not at all confident decreased from 24% in 2015 to 19% in 2016. • This move out of the not-at-all-confident group is observed primarily among those reporting they or their spouses do not have a retirement plan (defined benefit, defined contribution, or individual retirement account). Whereas in the recent prior years, increases in retirement confidence occurred among those with a plan. • Retiree confidence in having enough money for a comfortable retirement, which historically tends to exceed worker confidence levels, continued to increase in 2016 reaching 39% who are very confident (up from 18% in 2013). The percentage not at all confident was 12% (statistically unchanged from 2013). • Worker confidence in the affordability of various aspects of retirement increased in 2016. In particular, the percentage of workers who are very confident in their ability to pay for basic expenses increased (43% in 2016, up from 25% in 2013 and 37% in 2015). • The percentages of workers who are very confident in their ability to pay for medical expenses (22%, up from 14% in 2013) and LTC expenses (16%, up from 11% in 2013) are slowly inching upward. • 69% of workers report they or their spouses have saved for retirement (statistically equivalent to 2015). Still, a sizable percentage of workers report they have virtually no savings and investments. Among RCS workers providing this type of information, 26 percent say they have less than $1,000, though those who indicate they and their spouse do not have a retirement plan—a defined benefit (DB), defined

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				contribution (DC), or individual retirement account (IRA)—are far more likely than those who have a plan to report this low level of savings (67% vs. 9%) and far less likely to report having saved at least $100,000 (5% vs. 34%). • Retirees are more likely than workers to describe their level of debt as not a problem. 67% of retirees and 44% of workers indicate they do not have a problem with their level of debt.
2/2016	Our Parents, Ourselves: Health Care for an Aging Population *118 pages – Read selected chapters including Preface, Introduction, and A Path Forward and skimmed the rest*	The Dartmouth Atlas Project The Dartmouth Institute for Health Policy & Clinical Practice	Health and Wellness Insurance Medicare Medicaid Prevention Supportive Community Home-Based Services	This edition of the Dartmouth Atlas examines health care for older Americans with an emphasis on the patient's perspective. Using Medicare claims data, this report examines the demographics of older adults, including age, race, enrollment status, and other characteristics, to understand who are the older adults of today in the US. It explores the care experienced by this population, looking at the number and types of care providers they see, along with the frequency with which they have contact with the health care system. It identifies areas in which patient-centered improvements are most needed for older patients and recognizes areas in which those improvements are already under way. Finally, it notes challenges and opportunities presented by special populations, including people with multiple chronic conditions and dementia. While there are many data points in the report, a major is the great diversity of populations and approaches to care across the country. There are places that lead the nation in the percentage of their populations age 75 and older or in the amount of racial diversity within their populations of older adults. These places may serve as an example for other markets in the future. Some markets have a large dual-eligible population with different patterns in terms of how much care is delivered in NHs or other settings. The ability to identify others who may be ahead of the curve on any

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				particular metric can be leveraged by a learning health care system. The report shows that there are areas of improvement through the efforts of clinical providers changing processes of care, such as implementation of better discharge planning and coordination to reduce readmissions, encouraged by changes in payment incentives. Other improvements are due to regulatory changes, such as the removal of high-risk medications from the market when there was a strong case that the harm outweighed the benefits. Still other changes will be through the efforts of older adults and their families as they become more informed and engaged in the decisions made about their health care, such as how the last days and months of their lives will be lived. Finally, there are specific groups of older adults who are vulnerable by virtue of their diseases, either by having multiple conditions or by having dementia. These older adults experience the highest levels of contact with the health care system. Understanding how they are affected by changes in health care delivery or policy, and whether they experience the same improvements as other less vulnerable groups, is a critical challenge. The aging of the population demands that we improve the delivery of care and improve policies to benefit older adults. At a time when large demographic changes are occurring, we are also in the midst of health care system change. **Given the large simultaneous changes, we have an opportunity to incorporate attention to the special needs and concerns that come with an aging population into our redesign of health care delivery and policy.**

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2/2016	Side-by-Side Review of Recent Long-Term Care Financing Policy Recommendations *17 pages – Read entirely*	The Scan Foundation	Health and Wellness Insurance Private Pay/Self-Insured Family Economic Security Retirement Security	This analysis summarizes three sets of policy recommendations to improve America's financing system for LTC. 1. **BiPartisan Policy Center:** Recommendations place a heightened focus on the role of the private market, outline improvements to public programs such as Medicaid, and consider the potential for catastrophic coverage. Recommends: a. Establish a lower-cost, limited-benefit LTCI product b. Allow penalty-free withdrawal from retirement accounts to purchase the lower-cost LTCI products c. Incent employers to offer limited-benefit LTCI through workplace retirement plans d. Allow sale of limited-benefit LTCI through health insurance marketplaces e. Provide incentives for employers to offer policies through workplace retirement plans on an opt-out basis, in order to make retirement LTCI more widely available f. Employees aged 45 and older in DC retirement plans, should be allowed to take distributions from the plan solely for the purchase of retirement LTCI for themselves and/or a spouse g. Create "Retirement LTCI" which would give consumers choice while simplifying decision-making. Product design would: • Cover 2-4 years of need; • Include eligibility for benefits after cash deductibles or an elimination period is met (policyholder selects either a deductible or elimination period for when benefits are triggered);

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				• Include coinsurance; and • Include other features such as inflation protection, non-level premiums, and non-forfeiture benefits h. Allow all health insurance marketplaces the option to facilitate sales of retirement LTCI policies 2. **LeadingAge:** Believes that a system of financing LTSS needs to be insurance-based and guided by the principles of rationality, equity and affordability. Based on research: a. There is new evidence that the current LTSS financing system is untenable b. A universal insurance approach that covers catastrophic costs would have the greatest positive impact on both individuals and public programs, while creating a more rational system c. Supports innovations in the private LTCI market d. Acknowledges that innovative marketing and distribution strategies deserve further development. e. Designs which limit coverage to front-end needs especially have the potential to create greater demand and expand coverage for individuals who are risk for needing LTSS. Changes to various aspects of private LTCI have the potential to substantially reduce private market premiums 3. **Long-Term Care Financing Collaborative:** <u>Recommends:</u> a. A universal catastrophic insurance program aimed at providing financial support to those with high levels of care needs over a long period of time

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				b. A series of private sector initiatives and public policies aimed at revitalizing the LTCI market to help address non-catastrophic LTSS risk c. A modernized Medicaid LTSS safety net for those with limited lifetime incomes who are not able to save for these care needs, as well as for those who deplete their assets paying for medical and LTC costs d. Stronger support for families and communities and better integration of medical treatment and personal assistance e. A series of private sector initiatives and public policies aimed at revitalizing the LTCI market to help address non-catastrophic LTSS risk. Suggests the possibility that employers could add LTCI to their benefits packages as an opt-out benefit. f. Future research on whether tax incentives or other subsidies could encourage participation in LTCI for uncovered risks, in the presence of a universal program covering the catastrophic risk g. Cost-saving tools could include improved policy designs, some of which would require regulatory changes h. Policies could be sold through an electronic marketplace i. Policies could be sold jointly with Medicare Advantage or Medigap j. Regulators could assist in reducing costs of policy approval process k. Policymakers should explore supporting efforts to experiment with hybrid products, and examine protections (such as multi-state reinsurance) for the insurance industry against unpredictable shocks

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				l. Policymakers should continue to work with the insurance industry to strengthen consumer protections and enhance product information.
1/2016	Disability-Free Life Expectancy Over 30 Years: A Growing Female Disadvantage in the US Population (*purchase required – Abstract available)*	American Journal of Public Health	Health and Wellness Prevention	*Objectives.* To examine changes in active life expectancy in the US over 30 years for older men and women (aged ≥ 65 years). *Methods.* Used the 1982 and 2004 National Long Term Care Survey and the 2011 National Health and Aging Trends Study to estimate age-specific mortality and disability rates, the overall chances of survival and of surviving without disability, and years of active life for men and women. *Results.* For older men, longevity has increased, disability has been postponed to older ages, disability prevalence has fallen, and the percentage of remaining life spent active has increased. However, for older women, small longevity increases have been accompanied by even smaller postponements in disability, a reversal of a downward trend in moderate disability, and stagnation of active life as a percentage of life expectancy. As a consequence, older women no longer live more active years then men, despite their longer lives. *Conclusions.* Neither a compression nor expansion of late-life disability is inevitable. Public health measures directed at older women to postpone disability may be needed to offset impending LTC pressures related to population aging.
2016	2016 Alzheimer's Disease Facts and Figures	Alzheimer's Association	Health and Wellness Insurance Medicare Medicaid	Specific information includes: • Revised criteria and guidelines for diagnosing Alzheimer's disease from the National Institute on Aging and the Alzheimer's Association.

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	84 pages - Skimmed		Family Economic Security Retirement Security Impact of Caregiving	• Overall number of Americans with Alzheimer's disease nationally and for each state. • Proportion of women and men with Alzheimer's and other dementias. • Estimates of lifetime risk for developing Alzheimer's disease. • Number of deaths due to Alzheimer's disease nationally and for each state, and death rates by age. • Number of family caregivers, hours of care provided, economic value of unpaid care nationally and for each state, and the impact of caregiving on caregivers. • Use and costs of health care, long-term care and hospice care for people with Alzheimer's disease and other dementias. • The personal financial impact of Alzheimer's on families, including annual costs and the effect on family income. The costs of caring for a relative or friend with Alzheimer's disease or another dementia can have striking effects on a household; jeopardizing the ability to buy food, leading to food insecurity and increasing the risks of poor nutrition and hunger. In addition, the costs can make it more difficult for individuals and families to maintain their own health and financial security. Lack of knowledge about the roles of government assistance programs for older people and those with low income is common, leaving many families vulnerable to unexpected expenses. Better solutions are needed to ensure that relatives and friends of people with dementia are not jeopardizing their own health and financial security to help pay for dementia-related costs.
2016	Health and Retirement Study	Institute for Social Research	Health and Wellness Prevention	The Health and Retirement Study (HRS) was designed to inform the national retirement discussion as the population ages.

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	108 pages – Read First Chapter (Preface), Second Chapter (Introduction) and Final Chapter (The Future) and Skimmed the Remainder	University of Michigan	Family Economic Security Retirement Security Retirement Savings Trends Impact of Caregiving on Family Economic Security Physical Community Housing Work Force Development	Since its launch in 1992, the HRS has painted a portrait of America's older adults, illustrating this growing population's physical and mental health, insurance coverage, financial situations, family support systems, work status, and retirement planning. Through its unique and in-depth interviews with a nationally representative sample of adults over the age of 50, the HRS provides an invaluable, growing body of multidisciplinary data to help address the challenges and opportunities of aging. **Health:** • Health varies by socioeconomic status • Older Americans are in reasonably good health overall, but there are striking differences by age and race and ethnicity • Health has an important influence on older people's ability to work • Lifestyle factors influence older adults' health and physical well-being • Heavy smokers underestimate the mortality effects of smoking • Cognitive health declines with age • Caregiving in the home for older adults with cognitive impairment places a substantial burden on families • The rate of severe depression rises with age • There are considerable differences in use of the health care system, in health expenditures and in the availability of insurance by age and race and ethnicity • Older people use alternative medicine and supplements to a surprising degree • White Americans age 55-64 are less healthy than their British counterparts despite higher overall incomes and higher levels of health care spending

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				Work & Retirement: • Although retirement rates rise steeply at the Social Security eligibility age of 62 and 65, many older people do remain in the workforce either part-time or full-time • Most people are happy and active in retirement • Baby boomers are expecting to work longer, perhaps presaging a reversal in the century-long trend toward earlier retirement • The structure and availability of pensions strongly influences the decision about when to retire • Health problems can have a big influence on the decision to retire early • Married couples tend to make retirement decisions jointly, even when that means one will continue to work **Income & Wealth:** • There are enormous variations in income among Americans over 50 • Variations in wealth among older Americans are even more striking than variations in income • Many Americans save little or nothing for retirement • The relationship between health and wealth can now be studied in a dynamic setting over time and the interactions of the two are important for people approaching retirement • Health also affects the composition of financial portfolios • Financial well-being is strongly related to the health of both partners • Changes in marital status strongly influence women's wealth **Family Characteristics & Intergenerational Transfers:** • Most older Americans live in homes they own

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				• Many older adults live with or close to one of their children • There is an association between family status and well-being • Family help and public programs help keep older people in the community • There are enormous economic costs of providing informal caregiving to people with chronic health conditions • Parents do not support their children equally • The value of informal care provided to people with dementia and chronic illnesses amounts to billions of dollars annually
7/2015	Draft Voluntary Consensus Guidelines for State Adult Protective Services Systems *65 pages – Read Preface, skimmed rest*	Administration for Community Living	Supportive Community Workforce Development Workforce Delivering Services to the Aging Population Workplace Development	The Administration for Community Living (ACL) provided Draft Voluntary Consensus Guidelines for State Adult Protective Services systems to promote an effective adult protective services (APS) response across the country so that all adults, regardless of the state or jurisdiction in which they live, have similar protections and service delivery from APS systems. These draft guidelines were developed by subject matter experts in the field of APS and abuse, neglect, and exploitation of older adults and adults with disabilities. The guidelines are informational in content and are intended to assist states in developing efficient and effective APS systems.
7/2015	Serving Older Adults with Complex Care Needs: A New Benefit Option for Medicare *12 pages – Read entirely*	The Commonwealth Fund	Health and Wellness Medicare Supportive Community Long-Term Support Services Home-Based Services	Analysts of the Medicare program have long noted that it does a poor job serving those with multiple chronic illnesses. Most conspicuous is its lack of coverage for HCBS, which enable seniors with complex conditions to live independently. This brief describes the characteristics and needs of Medicare beneficiaries who require complex care, the goals of a new benefit option that could be made available to this population and a

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			Caregiver Supports	proposed structure that would both improve care and achieve savings:
				• A new entity called the complex care organization (CCO) would form the backbone of the new complex care benefit. Similar to accountable care organizations, CCOs would:
				  ○ Deliver a comprehensive range of health care services including in home care
				  ○ Develop individualized care plans in consultation with each beneficiary
				  ○ Provide care management services
				  ○ Coordinate all care patients receive
				  ○ Ensure that care is both appropriate and high quality
				• Providers would be eligible for a share of the health care cost saving generated from the expected reduction in NH placements
				• CCOS would also be eligible to receive the new chronic care coordination fees that Medicare began offering to primary care providers in January 2015
				• Financial support would be made available to caregivers whether they are family members or friends
				• Additional nonmedical services would be offered to support independent living, including personal care assistance and respite care
				• Benefits would be creatively bundled and tailored to specific needs
				• Cost-sharing would be affordable and based on ability to pay, with larger subsidies provided to beneficiaries with low and moderate incomes

7/2015	Valuing the Invaluable: 2015 Update	AARP Public Policy Institute	Family Economic Security	In 2013, about 40 million family caregivers in the United States provided an estimated 37 billion hours of care to an adult with

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	25 pages – Read entirely		Impact of Caregiving on Family Economic Security Technology and Innovation	limitations in daily activities. The estimated economic value of their unpaid contributions was approximately $470 billion in 2013, up from an estimated $450 billion in 2009. 60% of family caregivers caring for adults in 2014 were employed either full time or part time, placing competing demands on the caregivers' time. There is now greater recognition among policymakers, researchers, and health and social service professionals, that family caregiving is a central part of health care and LTSS in the US today. POLICY RECOMMENDATIONS: **National Strategy** Develop a broad national strategy to better recognize and address the needs of caregiving families. **Financial Relief** Provide financial assistance for family caregivers through a federal or state tax credit (or other mechanisms) to help ease some of the financial costs of caregiving and improve financial security. Consider reforms, such as SS caregiver credits, for time spent out of the workforce for family caregiving reasons. Expand consumer-directed models in publicly-funded HCBS programs that permit payment of family caregivers. **Work/Family** Strengthen "family-friendly" workplace flexibility policies that accommodate employed family caregivers, including flextime and

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				telecommuting, use of existing leave for caregiving duties, referral to supportive services in the community, and caregiver support programs in the workplace. Make improvements to the FMLA, such as expanding coverage to protect more workers, and expanding its scope to cover all primary caregivers, regardless of family relationships. Optimize worker productivity and retention by promoting access to paid family leave. Protect workers with family caregiving responsibilities from discrimination in the workplace. Advance public awareness campaigns at the federal, state, and local levels to educate the public about family caregiver discrimination in the workplace, and about all aspects of family leave policies, including the FMLA and paid family leave in states with such policies. **Caregiver Support Services** Promote assessment of family caregivers' needs (at the federal and state levels) as part of a person- and family-centered care plan, such as through publicly funded HCBS, hospital discharge planning, chronic care coordination, and care transition programs. Ensure that all publicly funded programs and caregiver supportive services at the federal, state, and local levels reflect the multicultural and access needs of the diverse population of family caregivers.

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				Expand funding for the National Family Caregiver Support Program (NFCSP) to keep pace with demand and better address the unmet needs of caregiving families. Provide adequate state and federal funding for respite programs. Widely disseminate, and implement locally, caregiver support services that are shown to be effective. **Health Professional Practices** Encourage PCPs and other health professionals to routinely identify Medicare beneficiaries who are family caregivers as part of the Health Risk Assessment in Medicare's annual wellness visit. Ensure that electronic health records include the person's family caregiver as a point of contact, whenever the individual's care plan depends on having a family caregiver. Adopt legislation in the states, such as the CARE Act, that requires hospitals to give an individual admitted to a hospital the opportunity to designate a family caregiver and have that family caregiver's name placed in the medical record. Enable registered nurses in states to delegate medical/nursing tasks to qualified direct care workers who provide assistance with a broad range of health maintenance tasks. Develop educational programs, including continuing education, to prepare health care and social service professionals with the technical and communication skills and competencies to integrate family caregivers into the care team, and engage them as partners in care.

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				Advance Planning and Guardianship Establish comprehensive guardianship and power of attorney reforms to help protect vulnerable adults and provide their family caregivers with the tools they need to make important decisions for the care recipient as quickly as possible, regardless of where they live. **Research Recommendations to Inform Policy Development** Promote standard definitions of family caregiving in federally funded and other national and state surveys to better characterize the size, scope, tasks, and outcomes of family caregiving. Improve data collection on employed caregivers with eldercare responsibilities (including surveys conducted by the Department of Labor, Department of HHS and Department of Commerce) to ensure that challenges about work-family conflict and access to workplace leave benefits and protections are addressed. Develop a common definition and unit of measurement for respite care (at the federal and state levels) as a useful indicator of LTSS system performance. Advance measures of "family caregiver experience" and "family caregiver engagement" that meet criteria for endorsement by the National Quality Forum.
6/2015	Caregiving in the US	AARP Public Policy Institute	Family Economic Security Impact of Caregiving on Family Economic Security	Key Findings: **Prevalence of Caregiving** An estimated 43.5 million adults in the US have provided unpaid care to an adult or a child in the prior 12 months.

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	87 pages – Read Introduction and Key Findings Chapters			**Basics of the Caregiving Situation** • The majority of caregivers are female (60%) • 82% are taking care of one person • They are 49 years of age, on average • 85% of caregivers provide care for a relative • 49% are caring for a parent or parent-in-law • One in 10 provides care for a spouse (higher-hour caregivers are almost four times as likely to be caring for a spouse/partner) **Care Recipient Condition** • 59% of care recipients have a long-term physical condition • 35% have a short-term physical condition • 26% have a memory problem **Caregiving Activities and Burden of Care** On average, caregivers spend 24.4 hours a week providing care to their loved one. **Medical/Nursing Tasks** Recent research revealed that, in addition to ADLs and IADLs, family caregivers are increasingly performing tasks that nurses typically perform (injections, tube feedings, catheter and colostomy care). **Presence of Other Help** Only about half of caregivers say another unpaid caregiver helps their recipient (53%). **Choice**

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				When asked if they had a choice in taking on the responsibility to provide care for their loved one, half of caregivers self-reported they had no choice in taking on their caregiving responsibilities. **Stress and Strain of Caregiving** Half of caregivers feel their health is excellent or very good (48%), while 17% say it is fair or poor. By comparison, 10% of the general adult population describe their health as fair or poor. The longer a caregiver has been providing care, the more likely she or he is to report fair or poor health. **Impact of Caregiving on Work** Six in 10 caregivers report being employed at some point in the past year while caregiving. Among them, 56% worked full time, and on average, they worked 34.7 hours a week. **Information Needs and Caregiving Support** 32% of caregivers say a health care provider, such as a doctor, nurse, or social worker, has asked about what was needed to care for their recipient. 16% say a health care provider has asked what they need to take care of themselves. **Long-Range Planning** Half of caregivers expect they will be a caregiver for an adult (either their current loved one or someone else) during the next 5 years.
4/2015	A Business Case for Workers Age 50+: A look at the Value of Experience 2015	AARP Research	Workforce Development Employment and Entrepreneurship Opportunities for Aging Population	**Key findings include:** • The number of Americans age 50+ who are working or looking for work has grown significantly over the past decade, and is expected to continue to increase. 35% of U.S. labor force

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	101 pages – Read Executive Summary and Conclusion		Supportive Community Social Engagement Opportunities Family Economic Security Retirement Security	participants will be age 50+ in 2022. This compares to just 25% in 2002. • The 50+ segment of the workforce continues to be the most engaged age cohort across all generations. 65% of employees age 55+ are considered engaged based on survey data, while younger employee engagement averages 58% to 60%. The level of employee engagement has implications for both retention and business results. It takes only a 5% increase in engagement to achieve 3% incremental revenue growth. • Contrary to common perception, workers age 50+ do not cost significantly more than younger workers. Shifting trends in reward and benefit programs have created a more age-neutral distribution of labor costs, meaning that adding more age 50+ talent to a workforce results in only minimal increases in total labor costs. Furthermore, the incremental costs of 50+ workers may be far outweighed by the value that they add. • Although current and future financial needs are a top reason that employees stay in the workforce past age 50, psychological and social fulfillment also play a role. • Leading employers use a variety of strategies to recruit and retain 50+ workers including flexible workplaces, options for transitioning to retirement, and fostering generational diversity and inclusion.
4/2015	The 2015 Retirement Confidence Survey: Have a Retirement Savings	Employee Benefit	Family Economic Security Retirement Security Retirement Savings Trends	The 2015 annual Retirement Confidence Survey (RCS) highlights:

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	Plan a Key Factor in American's Retirement Confidence *40 pages – Read Introduction*	Research Institute		• Whether or not Americans have a retirement savings plan is a key factor in their outlook about having an affordable retirement. • The percentage of workers confident about having enough money for a comfortable retirement, at record lows between 2009 and 2013, increased in 2014 and again in 2015. • The increased confidence since 2013 is strongly related to retirement plan participation. • Retiree confidence in having a financially secure retirement, which historically tends to exceed worker confidence levels, also increased, with 37% very confident (up from 18% in 2013 and 27% in 2014). • Worker confidence in the affordability of various aspects of retirement has also rebounded. In particular, the percentage of workers who are very confident in their ability to pay for basic expenses has increased (37%, up from 25% in 2013 and 29% in 2014). • Cost of living and day-to-day expenses head the list of reasons why workers do not save (or save more) for retirement, with 50% of workers citing these factors.
3/2015	The Continuing Retirement Savings Crisis *30 pages/Reviewed Executive Summary*	National Institute on Retirement Security	Family Economic Security Retirement Security	The key findings of this report are as follows: 1. **Account ownership rates are closely correlated with income and wealth.** Nearly 40 million working-age households (45%) do not own any retirement account assets, whether in an employer-sponsored 401(k) type plan or an IRA. Half of these households with no retirement savings are headed by someone between age 45 and 65, and may have too few year to catch up. Households that do own retirement accounts

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				have more than 2.4 times the annual income of households that do not own a retirement account. 2. **The average working household has virtually no retirement savings.** When all households are included— not just households with retirement accounts—the median retirement account balance is $2,500 for all working-age households and $14,500 for near-retirement households. 3. **Even after counting households' entire net worth—a generous measure of retirement savings—two thirds (66%) of working families fall short of conservative retirement savings targets** for their age and income based on working until age 67. Due to a LT trend toward income and wealth inequality that only worsened during the recent economic recovery, a large majority of the bottom half of working households cannot meet even a substantially reduced savings target. 4. **Public policy can play a critical role in putting all Americans on a path toward a secure retirement by strengthening Social Security, expanding access to low cost, high quality retirement plans, and helping low income workers and families save**. SS, the primary edifice of retirement income security, could be strengthened to stabilize system financing and enhance benefits for vulnerable populations. Access to workplace retirement plans could be expanded by making it easier for private employers to sponsor defined benefit pensions, while national and state level proposals aim to ensure universal retirement plan coverage. Finally, expanding the Saver's Credit and making it refundable could help boost the retirement savings of lower-income families.
3/2015	Retirement Security 2015: Roadmap for Policy Makers –	National Institute on	Family Economic Security Retirement Security	The key research findings are as follows: 1. **An overwhelming majority of Americans believe there is a retirement crisis**. 86% agree that the nation faces a retirement

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	Americans' View of the Retirement Crisis *36 pages/Reviewed Executive Summary*	Retirement Security	Gender and Cultural Values Related to Retirement Savings Workforce Development Employment and Entrepreneurship Opportunities for Aging Population	crisis, and 57% strongly agree there is a crisis. Surprisingly, the sentiment is highest among those with annual income above $75,000 (92%); but not surprisingly is equally high among the Millennial generation (92%). Public and private sector workers are equally concerned about retirement (87% and 88% respectively) even though public employees are far more likely to have reliable retirement income from a pension. Some 86% agree that America's retirement system in under stress and needs reform, with women and Millennials having the highest levels of agreement, 91% and 93% respectively. 81% say that it is harder for future generations to prepare for retirement. 2. **Three in four Americans remain highly anxious about their retirement outlook, but the concern has dissipated slightly as the economy has recovered**. 74% of Americans say they are concerned, down from 85% as reported in the 2013 study. The high level of concern is consistent across gender, generational and economic lines. 73% agree that the average worker cannot save enough on their own to guarantee a secure retirement. More than half of Americans say they will seek employment after retirement to be financially secure, and 42% are concerned they will have to sell their home after retirement for financial security reasons. 3. **Even though Americans feel slightly less stressed about their retirement prospects, support for steady and reliable retirement income from a pension is high and growing**. 82% say a pension is worth having because it provides steady income that will not run out, while 67% of Americans indicate they would be willing to take less in pay increases in exchange for guaranteed income in retirement. 85% of Americans agree that all workers should have access to a pension plan so they

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				can be independent and self-reliant in retirement, and 86% of Americans say that those with pensions are more likely to have a secure retirement. 4. **Americans continue to feel that leaders in Washington do not understand their struggle to save for retirement, and Americans strongly support efforts by states to set up retirement plans for those workers without access to an employer sponsored plan**. 87% of Americans say Washington policymakers do not understand how hard it is to prepare for retirement, while 84% say Washington needs to do more to help ensure retirement security. As for state efforts to set up retirement plans, 71% agree this is a good idea with three-fourths indicating they would consider participation. Some 86% say that government leaders should make it easier for employers to offer pensions, and this support has remained constant over time. 5. **Americans see retirement benefits as a job feature that is almost as important as salary.** Salary is viewed as important by 75% of Americans, and retirement benefits are close behind at 72%. Health insurance ranks highest, with 84% of Americans saying it is an important job feature. Two-thirds of Americans are willing to forgo salary increases in exchange for guaranteed retirement income. 6. **Americans express strong support for pensions for public employees. Few Americans realize that 75% of public pension costs are paid for with employee contributions and investment returns.** For police officers and firefighters, 88% of Americans say these employees deserve pensions because of job risks. For teachers, 75% of Americans say that pensions are

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				deserved to compensate for low pay. The vast majority of Americans, 71%, support public pensions because employees fund a significant portion of these benefits. But, only one-fourth of Americans understood that public employers pay for 25% or less of public pension costs. More than 8 out of 10 Americans say that all workers, not just public employees, should have a pension. 87% of Americans say pensions are a good way to recruit and retain qualified teachers, police officers and firefighters. 7. **Protecting Social Security benefits is increasingly important.** 73% of Americans say it's a mistake to cut government spending in such a way as to reduce Social Security benefits for current retirees, which is up from 67% in 2013. When it comes to benefits for future generations, 69% oppose cutting government spending that reduces Social Security benefits. Americans appear unaware of the benefits of delaying Social Security payments. They are divided when it comes to increasing the amount of SS benefits by delaying benefit withdrawals at an older age: 42% agree with a delay while 52% disagree.
2015	Gauging Aging: Mapping the Gaps Between Expert and Public Understanding of Aging in America *35 pages - Skimmed*	FrameWorks Institute	Work Force Development Family Economic Security Retirement Security Health and Wellness Supportive Community Social Engagement Opportunities	Experts emphasize that increased longevity has opened up opportunities for many more years of civic, social and economic contribution by older Americans, but that *our society must make adjustments to our public institutions, policies and infrastructure in order to best leverage these changes. Specifically:* • Workplace policies should be restructured to allow people to work longer and with a greater degree of flexibility. These accommodations should extend not only to older adults, but to those in elder caregiving positions as well.

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			Caregiver Supports	• Public spending must be made more efficient to accommodate the aging demographic shift and provide for the health care and retirement income security needs of older adults. • Patterns of ageist discrimination need to be addressed so that older Americans can fully contribute to our civic and economic life. • SS must be strengthened to ensure retirement income security. • The nation needs to expand a well-prepared healthcare and geriatric workforce, and address the growing need for LTC. • Better institutional and social supports must be provided for the more than 40 million people in the US who provide unpaid care to family members and loved ones. • Greater investments must be made in research to better understand both the aging process and the implications of an aging population for our society. These gaps represent a set of challenges to efforts to elevate support for policies and practices that can better respond to the overall aging trend, and productively leverage the contributions of older Americans while also helping meet their needs. Future reframing work will need to focus on addressing the following: 1. **Negative understanding of aging**. The negative modeling of the aging process as an obstacle to be overcome or an enemy to be vanquished prevents people from accessing and applying much of the expert story. These deep negative understandings block productive thinking about the policies and actions required to improve the well-being of older adults and increase their opportunities to contribute to society. 2. **Individualism.** The default to individualistic thinking about the aging process, and the multiple ways in which attribution of

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				responsibility is automatically assigned to individuals, is a direct impediment to thinking about the importance of structural, systems and policy-level solutions on many aspects of the expert agenda. 3. **Lack of understanding of demographic changes**. The poor understanding of the larger demographic trend of aging in our population, and its broad and shared implications for our nation, prevents members of the public from seeing the urgency and opportunities that experts attribute to this issue. 4. **Absent Ageism**. A lack of attention to ageism keeps this issue off the public's radar, and impedes attempts to address patterns of discrimination across the full spectrum of our society. 5. **Fatalism**. Fatalism about our collective ability to engage in, and find solutions to, the challenges of an aging population depresses people's sense of efficacy which, in turn, decreases support for policies and solutions.
12/2014	The Future of the Nursing Workforce: National-and State-Level Projections 2012-2025 *18 pages – Read first five pages*	US Department of Health and Human Services Health Resources and Service Administration Bureau of Health Workforce National Center for Health Workforce Analysis	Workforce Development Work Force Delivering Services to the Aging Population	**Key Findings** *Nationally, the change in RN supply between 2012 and 2025 is projected to outpace demand*. • Approximately 2.9 million RNs were active in the workforce in 2012 • Assuming RNs continue to train at the current levels and accounting for new entrants and attrition, the RN supply is expected to grow by 33% nationally • The nationwide demand for RNs is projected to grow by only 21% • The number of new graduates that entered the workforce has substantially increased from approximately 68,000 individuals in 2001 to more than 150,000 in 2012 and in 2013

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				• Emerging care delivery models with a focus on managing health status and preventing acute health issues, will likely contribute to new growth in demand for nurses *Substantial variation at the state level is observed for RN supply and demand.* • Projections at the national level mask a distributional imbalance of RNs at the state level • 16 states are projected to experience a smaller growth in RN supply relative to their state-specific demand, resulting in a shortage of RNs by 2025 • States projected to experience the greatest shortfalls in the number of RNs by 2025 are Arizona (with 28,100 fewer RNs than needed) followed by Colorado and North Carolina (each with 12,900 fewer RNs than needed) • Growth in supply is expected to exceed demand growth in the remaining 34 states, including all of the Midwestern states. *The LPN supply is also projected to outpace demand at the national level.* • Approximately 730,000 LPNs were active in the workforce in 2012 • Assuming LPNs continue to train at the current levels and accounting for new entrants and attrition, the LPN supply is expected to grow by 36% percent nationally • The demand for LPNs is projected to grow by only 28% by 2025 • Similar to the RNs, emerging care delivery models will likely contribute to new growth and demand for LPNs • Projections at the national level mask a distributional imbalance of LPNs at the state level

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				• 22 states are projected to experience a smaller growth in the supply of LPNs relative to their state-specific demand for LPN services resulting in a shortage of LPNs by 2025 *The Evolving Role of the Nursing Workforce* • The rapidly changing health care delivery system is redefining how care is delivered and the role of the nursing workforce • Supply and demand will continue to be affected by numerous factors including population growth and the aging of the nation's population, overall economic conditions, aging of the nursing workforce, and changes in health care reimbursement • Research to model the demand implications of trends in care delivery is ongoing and health workforce projection models will be updated as needed
12/2014	NRRI Update Shows that Half Still Falling Short *9 pages - Skimmed*	Center for Retirement Research at Boston College	Family Economic Security Retirement Security Retirement Savings Trends	Today's working households will be retiring in a substantially different environment than their parents did. The length of retirement is increasing as the average retirement age hovers around 63 and life expectancy continues to rise. At the same time, replacement rates are falling because of the extension of Social Security's Full Retirement Age and modest 401(k)/IRA balances. • According to the 2013 Survey of Consumer Finances, median 401(k)/IRA balances for households approaching retirement were only about $110,000 • The National Retirement Risk Index (NRRI) shows that, as of 2013, more than half of today's households will not have enough retirement income to maintain their pre-retirement standard of living, even if they work to age 65 – which is above the current average retirement age – and annuitize all their financial assets, including the receipts from a reverse mortgage on their homes

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				• The NRRI clearly indicates that many Americans need to save more and/or work longer
7/2014	A State Policy Framework for Integrating Health and Social Services *10 pages – Read entirely*	The Commonwealth Fund	Health and Wellness Insurance Medicaid Supportive Community Long Term Support Services Related Support Services Home-Based Services Community Support	Medicaid agencies are beginning to explore health delivery models that connect patients directly to community-based public health and social services. In doing so, they are looking to take advantage of both new and existing funding strategies and Medicaid policy options to promote more effective service linkages. To help guide these efforts, this issue brief details three components necessary for an integrated system of health and social services: 1. A coordinating mechanism responsible for managing collaboration across services 2. Quality measurement and data-sharing tools to track outcomes and exchange information 3. Payment and financing methods that support and reward effective service integration A five-step framework is described to help states develop an implementation plan that addresses the infrastructure requirements, incentives, and decision-making authority needed to support health and social services integration. 1. Establish goals 2. Identify gaps and opportunities 3. Prioritize opportunities for integration 4. Establish an implementation roadmap 5. Create a measurement strategy

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2014	Housing America's Older Adults – Meeting the Needs of an Aging Population *44 pages – Read Executive Summary*	Joint Center for Housing Studies of Harvard University	Physical Community Transportation and Mobility Public Transportation Housing	Affordable, accessible, and well-located housing is central to quality of life for people of all ages, but especially for older adults (defined here as 50 and over). POLICIES TO SUPPORT AGING IN COMMUNITY: 1. Expand the array of housing options 2. Promote alternatives to automobile travel 3. Coordinate housing and supportive services 4. Improve residential care options 5. Engage older adults in the community There is still time for the nation to prepare for the evolving needs of older adults by expanding the supply of housing that is affordable, safe, and accessible; providing opportunities for older adults to connect socially yet live independently; and integrating housing and LTC services to support those aging in private homes. These changes will improve not only quality of life for older adults, but also the livability of communities for people of all ages.
2014	How American Society will Address Long-Term Care Risk, Financing and Retirement *35 pages - Skimmed*	Society of Actuaries	Health and Wellness Insurance Medicare Medicaid Private Pay/Self-Insured Supportive Community Long-Term Support Services Family Economic Security Retirement Security	Conclusions: **Medicaid** Medicaid will evolve to cover a wide range of LTSS, and states will find a way to finance the changes. **Medicare** Medicare will continue to cover certain benefits that are LTC in nature, potentially creating a policy shift that admits Medicare coverage is not just post-acute care. Such recognition dramatically increases the possibility of reform of Medicare to cover LTC in a more comprehensive way, likely be in the form of managed LTC.

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			Retirement Savings Trends Impact of Caregiving on Family Economic Security Physical Community Housing Work Force Development Employment and Entrepreneurship Opportunities for Aging Population Public Finance	**Health Insurance** The importance of passage and implementation of the ACA to retirement and LTC decision-making has been underappreciated. Shoring up health insurance coverage for the population shy of 65 means better physical and financial health. What the ACA potentially means is that the Medicare eligibility age of 65 could be changed/aligned with SS' normal retirement age of 66 because individuals now have access to affordable health insurance with no fear bad health deprives them of access due to underwriting or pre-existing conditions. **Long-Term Care and Life Insurance, and Annuities** Changes in the life and annuity market to cover LTC may accelerate in the future. If so, the important point is that this helps with the annuitization of retirement, a goal of many aging experts. In addition, there is room for legislative action for private insurance products with little budget implication if the existing retirement products (IRAs and the like) are restructured so there is explicit recognition of LTC. **Social Security** SS checks will come in lower than what people expect; as a consequence they will delay retirement so as to "restore" the difference. **Pensions** There will be minor changes to pension issues, mostly around auto-enrollment and making sure companies are not held to severe fiduciary standards (meaning held liable if pension investments don't turn out well). But employers will mostly continue to avoid the problem by offloading retirement risk to

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				employees by continuing the trend away from defined benefits to defined contributions. These trends weaken the safety and comfort of more and more Americans **Housing and Reverse Mortgages** The home isn't going to be what it used to be, but there is still some money there and better ways to get at it. **Family, Caregiving and Workforce** The family will continue to be the first line of care, but other unskilled caregiver systems will evolve to add to the mix. Society, especially including employers, will be forced to adapt. **Possibilities for More Expansive Reform** There will be a wide array of policy proposals or product ideas to address the growing number of individuals moving into older ages and retirement. But absent some completely unexpected policy proposal or product that fixes all these problems and makes them go away, these changes will be marginal and incremental.
2014	Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Disabilities and Family Caregivers 120 pages – Read Executive Summary and Major Findings Chapters	AARP The Commonwealth Fund The Scan Foundation	Health and Wellness Insurance Medicaid Supportive Community Long Term Support Services	MAJOR FINDINGS: • The cost of LTSS continues to outpace affordability for middle-income families, and private LTCI is not filling the gap. • Public policy makes a difference. Measures that are directly affected by public policy have a clearer road map toward improved performance. These include: ○ The reach of the state's Medicaid program for people with disabilities who have low incomes. ○ The reach of the state's Medicaid LTSS for people with disabilities who have low incomes. ○ The functions of the state's ADRCs to help people find and access services.

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				○ The proportion of Medicaid and state LTSS funds that support HCBS. ○ The proportion of new Medicaid LTSS beneficiaries who use HCBS. The proportion of participants in publicly funded LTSS programs who direct their own services. ○ Limiting the inappropriate use of antipsychotic medications in nursing homes. ○ Legal and system supports for family caregivers. ○ Nurse delegation practices for consumers to get help with health maintenance tasks like medications. ○ Policies to improve transitions, including providing instruction to family caregivers. • States with more effective transitions have lower use of NHs and generally score better on both choice and quality. ○ These states tend to minimize disruptive transitions among care settings and focus more on helping nursing home residents return to their homes and communities. • Some states have made progress on important indicators, but there are persistent wide differences in state performance. ○ The states that ranked highest across all five dimensions were Minnesota, Washington, Oregon, Colorado, Alaska, Hawaii, Vermont, Wisconsin, California, Maine, the District of Columbia, and Connecticut • The gradual pace of improvement must accelerate to be ready for the aging of baby boomers. ○ The pace of change has been slow at a time when we need to prepare for baby boomers entering their 80s in the next 12 years. This is particularly important

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				because the availability of family caregivers is already declining.
10/2013	The Longevity Economy Generating Economic Growth and New Opportunities for Business *20 pages – Read Introduction and Last Chapter, Skimmed rest*	Oxford Economics for AARP	Workforce Development Services to Aging Population Employment/ Entrepreneurship for Aging Population Technology and Innovation Health and Wellness	The Longevity Economy is the term that represents the sum of all economic activity serving the needs of Americans over 50 and including both the products and services they purchase directly and the further economic activity this spending generates. The Longevity Economy is transforming the larger US economy. The distinctive consumer preferences, work-life choices, personal needs, and family responsibilities of Americans over age 50 are pushing the broader economy in new directions. Companies that are able to capitalize on this trend will enjoy a market of over 106 million that is expected to grow by over 30% in the next 20 years. However, the demands of this market segment can be more complex than those of younger consumers. Meeting the Longevity Economy on its own terms will require important shifts in understanding and approach, including: • **Recognizing new spending habits**. The Longevity Economy's distinct wants, needs, likes, and dislikes continue to shift, and are not always predictable. • **Understanding the digital side of the Longevity Economy.** Companies must not dismiss technology as irrelevant to the Longevity Economy, and instead determine which technologies these customers prefer and which best support their needs. • **Keeping ahead of health care trends**. The Longevity Economy's health care spending patterns are evolving, dictated in part by their preference to age in place. • **Adjusting to longer working lives.** As more over-50 workers opt to stay in the labor force, employers that want to retain

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				their skills need to accommodate their physical requirements and their preference for greater flexibility. • **Adjusting to a multigenerational labor force.** Likewise, employers will have to create an inclusive culture that accommodates the needs of both younger and older workers.
9/2013	A Comprehensive Approach to Long-Term Services and Supports *45 pages - Skimmed*	Long-Term Care Commission	Health and Wellness Insurance Medicare Medicaid Private Pay/Self-Insured Work Force Development Work Force Delivering Services to the Aging Population Supportive Community Long Term Support Services Related Support Services Home-Based Services Caregiver Supports	Congress established the Long-term Care Commission in recognition of the current and increasing nationwide need for long-term services and supports (LTSS). **Recommendations follow:** 1. To spread the risk for the costs of LTSS as broadly as possible, provide benefits to people of all ages who need them, and allow individuals and families to meet their responsibilities, a public social insurance program that is easily understood and navigated must be established. That program could provide comprehensive benefits or a more limited package. But a social insurance program must be at the core of an effective LTSS financing system. A social insurance core would not eliminate the roles of private insurance or of family financing or caregiving. Rather, it would make these roles more manageable. 2. To ensure high-quality services for individuals and their families in all service settings, the law must assure that direct-care workers are paid a living wage, are well trained, and have opportunities for career advancement. 3. To integrate family caregivers into a comprehensive LTSS system, public programs providing services to LTSS beneficiaries must appropriately engage family caregivers and address their needs.

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				4. To meet the needs of those who qualify for Medicare, the current Medicare program must be adapted to reduce counterproductive, outdated and unreasonable barriers to outpatient therapies, home health and SNF care. 5. To strengthen Medicaid, existing financial incentives to states for quality HCBS must be extended and streamlined to make it easier to rebalance Medicaid LTSS. In addition, Medicaid's benefits must be improved for people who rely on Medicaid's services. 6. To provide news ways to access LTSS for persons with disabilities, tax-preferred savings accounts must be provided for people and their families who are not currently receiving LTSS through the Medicaid program, the Medicaid buy-in program for workers with modest earnings must be expanded, and a new program for workers with significant disabilities who have higher earnings must be piloted.
8/2013	The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers *12 pages – Read entirely*	AARP Public Policy Institute	Supportive Community Long Term Support Services Related Support Services Home-Based Services Community Support Caregiver Supports Health and Wellness Insurance Medicare Medicaid	• The supply of family caregivers is unlikely to keep pace with demand to assist the growing number of frail older people in the future. • In just 13 years, as the baby boomers age into their 80s, the decline in the caregiver support ratio will become dramatic; from 7 potential caregivers per frail older person today, the caregiver ratio is projected to shrink to just 4 in 2030 • The care gap is expected to widen even more as the ratio continues declining to 2.9 by 2050, when we have three times as many people aged 80 and older as there are today

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			Private Pay/Self-Insured	• These national trends will be reflected in major declines in the caregiver support ratio in all 50 states and the District of Columbia • Rising demand and shrinking families to provide support suggest that the US needs a comprehensive person and family-centered LTSS policy that would better serve the needs of older persons with disabilities, support family and friends in their caregiving roles, and promote greater efficiencies in public spending

3/2013	The Aging Workforce: Challenges for the Health Care Industry Workforce
	
	9 pages – Read entirely
		National Technical Assistance and Research Center to Promote Leadership for Increasing the Employment and Economic Independence of Adults with Disabilities	Work Force Development
			Work Force Delivering Services to the Aging Population
			Employment and Entrepreneurship
			Opportunities for Aging Population
			Workplace Development
			Technology and Innovation
				The aging of the U.S. population has tremendous implications for the health care industry, both as employers of an older workforce and as providers of services to a growing number of older patients.
				
				Research and data show:
				• By 2020, nearly half of all registered nurses will reach traditional retirement age
				  ○ Currently, the average age of a nurse in the United States is 50
				• Nearly one-quarter of physicians in a 2007 nationwide survey were 60 years or older
				• In 2001, more than 80% of all dentists in the US were older than 45
				  ○ The number of dentists expected to enter the field by 2020 will not be sufficient to replace the number of dentists likely to retire
				
				Promising strategies that could be implemented by employers and policymakers to address the changing needs and challenges presented by mature health care workers:

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				<u>For Employers</u> *Workforce assessment* is a critical first step for employers to map the demographics of their current workforce, identify current and projected skills gaps, plan for leadership succession, and facilitate the transfer of knowledge from their mature workers to entry-level hires. *A disability management strategy* should also be considered by health care employers. Such a strategy would draw on a variety of techniques to reduce declines in work performance tied to age-related physical, cognitive, or sensory disabilities. *Changes to the traditional physical organization of the health care workplace* allow health care workers to stay employed longer. Encouraging health care employers to make design and ergonomic improvements to the physical environment and to take advantage of new and innovative technologies in the workplace can ease the physical burden on many health care workers. *Peer mentoring and job shadowing* are other techniques that could increase the skill levels of new entry workers into health care and keep mature workers productive longer. *Productivity enhancement tools, also known as "assistive technologies,*" are used by employers for their workers with disabilities and older workers. Such tools are often referred to as "reasonable accommodations" in the Americans with Disabilities Act (ADA). *Employers ought to better educate their hiring managers and supervisors on the real meaning behind reasonable accommodation, as it is delineated in the ADA*, and the

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				effectiveness of assistive technologies. The greater extent to which assistive technology is seen as helping workers be more productive longer, the greater likelihood employers will provide them. *Employers should be encouraged to take advantage of existing federal and state programs that provide support for job accommodations*, such as the resources of the ODEP-funded Job Accommodation Network or state vocational rehabilitation agencies. **For Policymakers** Policymakers have an important role to play in raising the visibility of workers with disabilities employed in a variety of health care settings. In order for employers to think differently about older workers and workers with disabilities in health care, they must be able to see these workers in action, whether it is a physician in a wheelchair or an aging nurse with hearing or vision issues. Stories of successfully employed health care workers with disabilities should be published in all forms of media. *Health care organizations should educate their policymakers and managers* about the use and availability of accommodations and assistive equipment, including simple or low-cost items. *Policymakers should work with state and local labor market and workforce development experts to identify and publicize clearer career pathways that allow older health care workers to transition into less physically demanding health care occupations as they mature.* Occupational fields such as health care informatics, health information technology, medical coding, and health care administration present opportunities that do not require the same type of physicality as bedside or direct patient care. Policymakers

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				also have a role in encouraging training of current and future health care workers. Other workforce development initiatives, often with philanthropic support, are aimed at encouraging older job seekers to consider training at community colleges for "encore" careers in health care and other public service fields. *Better research and data are needed regarding the costs and benefits of employer initiatives to hire, train, and retain older health care workers.* Employers, researchers, and workforce policymakers agree that more, and better, data need to be collected, and existing data need to be better mined to understand the impact of the aging workforce on employers' bottom lines.
3/2013	An Examination of Resident Abuse in Assisted Living Facilities *45 pages – Read Abstract, Executive Summary and Analysis and Discussion*	US Department of Justice	Health and Wellness	An estimated 39,100 Assisted Living (AL) settings exist in the US, with about 971,900 beds, providing services to 733,300 persons every day. Elders living in AL settings may be particularly vulnerable to abuse because many suffer from cognitive impairment, behavioral abnormalities, or physical limitations – factors that have been reported as risk factors associated with abuse. In this research, perceptions of abuse in AL coming from a large sample of Direct Care Workers (DCWs) and administrators are examined. Overall, the study found resident abuse by staff to be relatively uncommon. However, in some areas (such as humiliating remarks) substantial improvements in the rates could be made. Resident-resident abuse was more common than staff abuse. In both cases (staff abuse and resident-to-resident abuse) verbal abuse and psychological abuse were reported most often.
2/2013	The Aging Population: A Crisis in Plain Sight	The Commonwealth Fund	Health and Wellness Insurance Medicaid	Providing LTC services and supports to the elderly and people with disabilities is the biggest problem in health care policy today. No

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	10 pages – Read entirely	Washington Health Policy Week in Review		national strategy exists in the US since the CLASS Act was repealed. A few national policy ideas are floating around:
				• Provide tax incentives for private LTCI and increase protections for consumers
				• Create a mandatory system of social insurance to underwrite the kinds of services that will be demanded (similar to Japan and Germany)
				• Creation of a commission (with a congressional mandate) to make recommendations to lawmakers
				• Public-private partnerships might be formed for the sale of highly regulated private LTCI policies (LTCI exchanges or use existing health insurance exchanges)
				  ○ Participation could be voluntary or mandatory
				  ○ Incentives built in to encourage sign up sooner rather than later

2013	The Impact of an Aging US Population on State Tax Revenues *34 pages - Skimmed*	Federal Reserve Bank of Kansas City	Public Finance Issues Related to the Aging Population Longer Term Projections	Aging of the population has important implications for state tax revenue because as the baby boom generation retires, the nation's labor force participation rate is expected to decline and, with it, income and spending. Most people earn less and spend less during retirement, suggesting that an aging population could reduce government revenue, particularly from sales taxes and individual income taxes. These sources of revenue make up more than 80% of total state tax collections. • The effect will differ across states because they vary in the degree to which they rely on income taxes and sales taxes • This article examines the effects of aging populations on tax revenue across all 50 states. Isolating the effect of demographic change on tax revenue—by holding constant all

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				other factors (such as likely income growth and other variables)—the results suggest that the aging of the population alone from 2011 to 2030 will reduce both income tax and sales tax revenue per capita in nearly every state • Strong overall growth in state income tax collections is projected in states like AZ and CO that expect fast population growth • Total revenue from all taxpayers will grow in most states due to population growth, while taxes paid per person will decline • Across all states, average taxable expenditures per capita are expected to fall 0.5% compared with what they would have been absent demographic changes Policymakers can expect that an aging population will put downward pressure on consumption and sales taxes, on a per capita basis, as was the case with individual income taxes. At the same time, even as sales taxes per capita decline, total population growth will drive total sales tax collections higher. In addition, the variation in sales tax revenue found across states illustrates that tax collections are influenced not only by sales tax rates but also by decisions about which goods and services are taxed and by the ways that spending on these items varies across age cohorts.
2013	The State of Aging & Health in America 2013 *60 pages – Read Executive Summary*	National Center for Chronic Disease Prevention and Health Promotion,	Health and Wellness Prevention	The report provides a snapshot of the nation's progress in promoting prevention, improving the health and well-being of older adults, and reducing behaviors that contribute to premature death and disability. In addition, the report highlights mobility (referring to movement in all of its forms) and how optimal mobility is fundamental to healthy aging.

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		Division of Population Health		• The growth in the number and proportion of older adults is unprecedented in the history of the US. Longer life spans and aging baby boomers will combine to double the population of Americans aged 65 years or older during the next 25 years to about 72 million. By 2030, older adults will account for roughly 20% of the U.S. population. • During the past century, a major shift occurred in the leading causes of death for all age groups, including older adults, from infectious diseases and acute illnesses to chronic diseases and degenerative illnesses. More than a quarter of all Americans and two out of every three older Americans have multiple chronic conditions, and treatment for this population accounts for 66% of the country's health care budget. • The report presents several calls to action intended to encourage individuals, professionals, and communities to take specific steps to improve the health and well-being of older adults. They include: ○ Developing a new Healthy Brain Initiative Road Map ○ Addressing lesbian, gay, bisexual, and transgender (LGBT) aging and health issues ○ Using data on physically unhealthy days to guide interventions ○ Addressing mental distress among older adults ○ Monitoring vaccination rates for shingles
2012	Healthy Aging 2.0: The Potential of New Media and Technology *4 pages – Read entirely*	Centers for Disease Control and Prevention	Health and Wellness Supportive Community Home-Based Services Work Force Development Technology and Innovation	Approximately 125 million Americans are living with one or more chronic diseases, and this number is expected to grow to 157 million by 2020. Approximately 84% of adults who are aged 65 or older have one or more chronic conditions.

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				The power of telemedicine technologies to harness the capability of existing health care systems can help sustain the overall public health infrastructure. New media and technology allow older adult e-patients, especially those with chronic conditions, more opportunity to access health information, receive online support, and engage health care professionals for disease management support in their homes. The evolution of e-patients and mobile devices and the use of social networking and telemedicine interventions have led to opportunities to achieve better chronic disease outcomes. These interactive, technologically mediated interventions can empower, engage, and educate older adults.
2012	Long-Term Care Insurance: 2012 Update *4 pages – Read entirely*	AARP Public Policy Institute	Health and Wellness Insurance Family Economic Security Retirement Security	**Paying for Long-Term Care** Without private insurance or public program coverage, the high cost of LTC is unaffordable for most Americans. **Who Buys Long-Term Care Insurance?** Relatively few older people have private insurance that covers the cost of LTC. **Cost of Long-Term Care Insurance** The high cost of LTCI is the reason that most people give for not purchasing coverage. **Premium Rate Stability** An important issue for consumers is whether premiums will increase beyond what they can afford. **Lapse Rates**

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				There has been a downward trend in LTCI voluntary lapse rates for more than a decade. **Inflation Protection** Inflation protection is an important policy feature because the cost of LTC has increased significantly over time. An individual who purchases LTCI in his or her 60s may not need benefits for 20 or more years. Without inflation protection, the value of the insurance benefits is likely to erode. **Tax Treatment** Nearly all policies sold today meet federal standards, specified by the Health Insurance Portability and Accountability Act of 1996, for favorable tax treatment. Individuals with qualified LTCI policies can deduct their premiums, up to a maximum limit that increases with age.
12/2011	Aging in Place: A State Survey of Livability Policies and Practices *84 pages – Read Executive Summary*	National Conference of State Legislatures and the AARP Public Policy Institute	Physical Community Transportation and Mobility Walkable Communities Bike/Pedestrian Infrastructure Volunteer Transportation Public Transportation Housing Universal Design Supportive Community Home-Based Services	The great majority of older adults have a strong desire to live in their own homes and communities. However, unsupportive community design, unaffordable and inaccessible housing, and a lack of access to needed services can thwart this desire. This report examines state policies that can help older adults age in place. **Land Use** *Integrating Land Use and Transportation Policy* • Coordination between transportation and land use planners allows communities to thoroughly plan for housing, commercial and retail uses, and public services in the context of multiple forms of transportation. • *Transit-Oriented Development (TOD)*

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				As transit systems—from light rail to bus rapid transit—continue to be built around the country, serious attention has focused on development of housing, offices and retail near transit stops, commonly known as transit-oriented development (TOD). *Joint Use* • Using community facilities for various missions and services can save taxpayer dollars, provide better access to services, and promote community cohesiveness. **Transportation** *Complete Streets* • Many communities were not designed to make it easy for residents to walk, bicycle or use public transportation. The streets may be too wide for safe crossing, or a lack of sidewalks may inhibit a walk to the store or transit stop. The idea of "complete streets" includes planning, designing, constructing, maintaining and operating transportation projects and systems, keeping in mind the needs of all users—motorists, bicyclists, pedestrians and transit passengers—regardless of age and ability. *Pedestrian Safety* • Although adults age 65 and older comprised less than 13% of the population in 2008, they were involved in 15% of vehicle fatalities and 19% of pedestrian fatalities. An older vehicle occupant is 18% more likely to die in a crash than someone under age 65. A more staggering statistic reveals that an older pedestrian is 61% more likely to die when hit by a motor vehicle than a younger one. The unique vulnerability of pedestrians and bicyclists on the road has inspired some state legislatures to pass laws designating pedestrians and bicyclists as "vulnerable users."

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				Rural Access • Small towns often have a main street and an interconnected network of calm streets near the downtown core that can foster walking, public transportation and bicycling trips. In more remote settings, livability might mean additional mobility through use of transit or paratransit services. *Human Service Transportation Coordination* • Coordination of transportation services is a process in which two or more organizations interact to jointly accomplish their transportation objectives. When properly implemented, coordination can increase the efficiency of resource use, improve service delivery, and enhance customer knowledge of and access to transportation services. *Volunteer Driver Laws* • Volunteer drivers are vital to the success of many specialized transportation programs; however, significant legal ambiguities surround their use. The core concerns involve liability and insurance coverage. Ambiguities surrounding civil liability can make it difficult for agencies and organizations that use or retain volunteer drivers. **Housing** *Affordability* • Given that many older adults do not drive and must make ends meet on fixed incomes, they especially benefit from the availability of affordable and accessible housing options near to transportation and other services. *Building Standards that Promote Accessibility* • Nearly 90% of people over age 65 indicate they want to stay in their home as long as possible, and four of five in that age bracket believe their current home is where they will always

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				live. However, according to the Administration on Aging, from 2007 to 2008, only 3.7% of older people moved, as opposed to 13.1% of those under age 65. Accessible building standards allow older Americans to remain in their homes longer, instead of either spending money on retrofits or relocating to other housing. Although the Americans with Disabilities Act (ADA) requires any building built after 1992 to be "readily accessible to and usable by" those with disabilities, it does not apply to private housing, unless that housing was funded through state and local government housing programs. Further, the Fair Housing Act applies only to multifamily housing. *Models to Provide Services at Home* • A Naturally Occurring Retirement Community (NORC) is a housing complex or neighborhood that was not planned specifically for older people, but has organically evolved to house a large population of older Americans.
6/2011	Rebalancing Long-Term Services and Supports: Progress to Date and a Research Agenda for the Future 32 pages - Skimmed	The Hilltop Institute, UMBC AARP Public Policy Institute	Health and Wellness Insurance Medicaid Supportive Community Long Term Support Services Related Support Services Home-Based Services	This report discusses progress in rebalancing Medicaid LTSS spending, how the ACA can support states' continued efforts to rebalance LTSS, and opportunities for future research to support continued system transformation. A Research Agenda for the Coming Decade was laid out in the final chapter, including: **Assess the experience with the new authorities in the ACA**. The ACA mandates evaluations of CFC and health homes. MFP is being evaluated as required by the DRA. Other programs in the ACA should be evaluated as well (e.g., SBIP, the 1915(i) state plan option, and demonstrations sponsored by CMMI).

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				Evaluate innovative models for LTSS delivery. New evidence-based models for integrating BH services into the LTSS system need to be developed and evaluated so that individuals with serious mental health conditions and problems with SA can manage their conditions and successfully reside in the community. Similarly, new health home models should be developed and evaluated for individuals with co-morbidities and chronic conditions that engage primary care providers, link medical care and LTSS, and address the divide that exists between Medicare and Medicaid financing. **Test new models for integrating care for dual eligibles**. There is a need for research to better understand the pathways to dual eligibility, the challenges dual eligibles encounter in accessing and coordinating services and supports across the medical and LTSS systems, and the incentives driving Medicare and Medicaid provider behavior **Develop and evaluate LTSS delivery models that recognize the diverse needs of diverse populations**. The populations needing LTSS vary, ranging from frail, older adults to younger adults with brain injuries or other physical disabilities to individuals with co-morbid conditions such as serious MI coupled with heart disease, diabetes, and/or chronic obstructive pulmonary disease (COPD). **Conduct research on more effectively assessing consumer needs for LTSS.** A number of provisions in the ACA require states to have core standard assessment tools in place. More research is needed on such tools, including how to measure functional and health status, identify unmet needs, and develop consumer-centered care plans that address unmet needs and take into account natural supports.

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				Examine how rebalancing is transforming care settings and service utilization. As states consider policies to incent provider behavior, research on the impact of state policies aimed at restricting NF growth, expanding community-based services, and increasing the direct care workforce will be informative. **Develop metrics to measure progress in rebalancing**. A common methodology to measure rebalancing progress within and across states is needed.
11/2010	Home and Community Preferences of the 45+ Population *25 pages – Read Executive Summary*	AARP Research & Strategic Analysis	Physical Community Housing Supportive Community Community Support	Key Findings: • Nearly three-quarters of respondents strongly agreed with the statement, "What I'd really like to do is stay in my current residence for as long as possible," while slightly more than one-tenth somewhat agreed with the statement • Two-thirds of respondents strongly agreed with the statement, "What I'd really like to do is remain in my local community for as long as possible," while roughly one-fifth somewhat agreed with the statement • Two-thirds of respondents agreed that they want to stay in their home because, "I like what my community has to offer me," while one quarter say, "I cannot afford to move"
4/2010	Technologies for Remote Patient Monitoring for Older Adults *30 pages – Read Executive Summary,*	Center for Technology and Aging The Public Health Institute	Health and Wellness Supportive Community Home-Based Services Work Force Development Technology and Innovation	A majority of older adults are challenged by chronic and acute illnesses and/or injuries. Eight out of ten older Americans are living with the health challenges of one or more chronic diseases. In addition, falls are the most common cause of nonfatal injuries and of hospital admissions for trauma among older adults. Remote patient monitoring (RPM) technologies have been shown to be effective in helping to manage chronic disease, post acute care,

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	Discussion and Conclusion			and monitoring the safety of the older adult population. RPM technologies can help older adults slow the progression of chronic disease and ensure continued recovery after being discharged from an acute care setting. RPM technologies also can alert caregivers and prompt intervention when a vulnerable older adult is injured or in harm's way. The US health care system could reduce its costs by nearly $200 billion during the next 25 years if remote monitoring tools were used routinely in cases of congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), and chronic wounds or skin ulcers. RPM technologies can facilitate six components of chronic disease management: (1) early intervention—to detect deterioration and intervene before unscheduled and preventable services are needed (2) integration of care—exchange of data and communication across multiple co-morbidities, multiple providers, and complex disease states (3) coaching—motivational interviewing and other techniques to encourage patient behavioral change and self-care (4) increased trust—patients' satisfaction and feelings of "connectedness" with providers (5) workforce changes—shifts to lower-cost and more plentiful health care workers, including medical assistants, community health workers, and social workers (6) increased productivity—decreased home visit travel time and automated documentation This paper discusses the benefits of broader diffusion of proven RPM technologies for older adults with chronic health conditions, their family caregivers, the LTC workforce, and society at large.

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1/2010	Catalyzing Technology to Support Family Caregiving *26 pages – Read Executive Summary*	National Alliance for Caregiving	Supportive Community Caregiver Supports Technology and Innovation Family Economic Security Impact of Caregiving	To catalyze technology innovation to support family caregiving, the roundtable developed several recommendations: • Create better "concept maps" and find more appropriate language to describe the varied and complex caregiving landscape • Continue to collect extensive data about the prevalence, burden, and impact of caregiving and the role of technology • Spur a broad national conversation on caregiving • Develop compelling business cases for employers and healthcare providers to support caregiving • Provide caregiving coaching as an integral component of all solutions • Inspire social conversations about caregiving to encourage more learning and support within families and communities Technology-based solutions have the potential to lighten the burden that falls on family caregivers, particularly by helping them to coordinate the demanding tasks and the complex networks of relationships involved with caring for others. Technology could also help improve the health of both caregivers and care recipients. All those with an interest in supporting family caregiving—caregiver advocacy and support organizations, employers, entrepreneurs, foundations, healthcare institutions, and the media —should understand this report's recommendations and follow them as they apply to their efforts.
3/2009	National Elder Mistreatment Study	US Department of Justice	Health and Wellness Work Force Development Workplace Development	The overall aim of this project was to use Random Digit Dialing telephone survey methodology to conduct a national epidemiological study to determine prevalence and risk factors for elder mistreatment, defined generally as physical, sexual, emotional, neglectful, or financial mistreatment of a person age 60

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	183 pages – Read Abstract and Executive Summary		Family Economic Security Supportive Community Social Engagement Opportunities Physical Community	years or above. The study obtained the following past-year prevalences: • Emotional mistreatment: 4.6% • Physical mistreatment: 1.6% • Sexual mistreatment: 0.6% • Potential neglect: 5.1% • Current financial exploitation by family: 5.2% • Lifetime financial exploitation by non-family was: 6.5% IMPLICATIONS FOR POLICY AND PRACTICE <u>Specific Suggested Areas of Intervention or Prevention:</u> • Emotional mistreatment is a relatively common event, with one in 20 older adults experiencing this form of abuse in the past year. It is rarely reported, and even less frequently acted upon in criminal justice settings. Most emotional abusive events are 'legal' and, though cruel, lack any criminal justice system remedy. This virtually assures its sustained frequency. • Emotional mistreatment of older adults in the workplace may be more common than predicted, as employed older adults reported more of this form of abusiveness. This, together with the first point seems to indicate a general societal acceptance of this behavior. • Relative to the general population, it appears that perpetrators of emotional physical and sexual mistreatment have high unemployment, increased substance abuse, and increased likelihood of mental health problems. Particularly striking was the older adult report that perpetrators of mistreatment were socially isolated. These perpetrator deficits may present targets for intervention which have the direct corollary benefit of reducing elder mistreatment.

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				• Prevalence of financial exploitation is extremely high, with one in 20 older adults indicating some form of perceived financial mistreatment by family members occurring at least one time in the recent past. Specific resources and civil remedies should be directed toward this type of mistreatment (e.g., dedicated prosecutors of financial mistreatment in geographic regions with high numbers of older adults). • Financial exploitation by family members and by strangers was increased among the more physically disabled adults, indicating perhaps a greater need for monitoring for this subgroup of elders. • Use of social services does not seem to be associated with lower levels of familial financial mistreatment and potential neglect, and has little effect on the more 'typical' forms of emotional, physical, and sexual mistreatment, indicating a 'missed opportunity' for intervention and a need for training in awareness and intervention among social service staff. • Low income, poor health, and low social support all independently predict neglect and point to a deficit in community connection and resources in this population. Enhanced monitoring to assure that older adults, particularly non-white older adults, are not falling victim to neglect is necessary, as is increased attempts to 'reconnect' isolated older adults to their community. • Social support has emerged as a central risk or protective factor for virtually all forms of elder mistreatment. Moreover, prior research indicated that social support is linked to improved health and mental health. Programs that enhance and build relationships between older adults and members of their community, that is, programs that act against the age related forces of isolation (reduced mobility, poorer health,

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				increased morbidity of friends and family) have the potential to yield extremely high benefits.
2009	Meeting Transportation Needs in an Aging-Friendly Community *11 pages - Skimmed*	Journal of the American Society on Aging	Physical Community Transportation and Mobility Walkable Communities Bike/Pedestrian Infrastructure Public Transportation	All indications are that neither traditional public transit services nor special demand services will come anywhere near meeting the mobility needs of the country's aging population. Perhaps surprising to some, the auto-based system and walking emerge as the most realistic travel options currently available for many older adults. Possible ways to increase both the safety and mobility of older people in each: **Public Transit**: increasing safety and security in all parts of the system, providing better information both before and during travel, expanding the hours of service and providing additional routes, making service more reliable, and enhancing driver training. **Special and demand-responsive services**: no matter how much public transit services are modified and improved, some older people will not be able to use them. To respond, society could expand requirements so that older people unable to drive qualify for service. **Improving the highway system:** the most promising mobility option is to modify all the components of the auto-based infrastructure so that older people can drive safely longer. **Pedestrian improvements**: raised pavement markings, median islands, improved user-activated signal crossing devices, enhanced signals, improved pedestrian crossings, adopting traffic-calming

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				devices such as narrowing streets, lowering speed limits, and using traffic circles to slow traffic. Recommendations To address these needs, must do the following: • Adopt policies that provide substantially more funding for transit operators to develop meaningful transit services and increase ADA-type paratransit services for older people without serious disabilities • Provide better support and financial resources for the wide variety of community transportation providers • Develop programs and policies to keep older people driving safely as long as possible • Enhance and maintain the pedestrian network • Ensure that traffic regulations are enforced All of these actions must be combined with the major focus on retrofitting the neighborhoods in which the majority of older people are aging in place.
9/2006	Out of Isolation: A Vision for Long-Term Care in America *10 pages – Read entirely*	National Commission for Quality Long-Term Care	Health and Wellness Insurance Work Force Development Work Force Delivering Services to Aging Population Workplace Development Technology and Innovation	The Commission's roadmap for comprehensive reform of the nation's LTC system encompasses six broad areas of systems change: • *Transform culture* – improve individuals' QOL and QOC through initiatives including resident-centered care and sensitive provision of palliative and hospice care • *Empower individuals and families* – create a greater array of high-quality, accessible and affordable LTC services, especially HCBS. Provide family caregivers with information, support and

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			Supportive Community Long Term Support Services Related Support Services Home-Based Services Community Support Family Economic Security	training to enable them to continue their central role in the lives of those with disabilities. • *Workforce* – support those who provide care by improving their work conditions, pay and benefits and by ensuring greater opportunities for training and advancement • *Technology* – use technology more effectively to enhance consumer independence and promote consistently better quality of care • *Regulation* – uniformly implemented regulations with strong enforcement and continuous quality improvement and innovation • *Finance* – public and private financing should work together to enhance individual choice about care options and settings, improve quality, reward innovation and demonstrate fiscal responsibility
1/2006	Health Coverage for Aging Baby Boomers: Findings from the Commonwealth Fund Survey of Older Adults *40 pages – Read Executive Summary*	The Commonwealth Fund	Health and Wellness Insurance Medicare Family Economic Security Retirement Security Retirement Savings Trends	This report presents a new analysis of The Commonwealth Fund Survey of Older Adults that explores the extent and quality of health insurance coverage for baby boomers who are in the workforce, with a special emphasis on those with low and moderate incomes. Among the key findings are: • **Older adults have high rates of chronic health conditions**. The incidence of chronic conditions increases dramatically with age, placing older adults at greater risk of incurring high medical costs than younger adults. 62% of 50-64- year-olds in working households reported they had at least one of six chronic conditions. High blood pressure, arthritis, and high cholesterol were the most common problems, with about 30% of respondents citing any one.

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				• **Many working older adults have unstable health insurance coverage.** One-fifth of older adults in working families were either uninsured at the time of the survey or had histories of unstable coverage since age 50. Older adults in working households with low and moderate incomes report particularly high rates of unstable coverage. • **Older adults with low income, with individual coverage, or with no insurance spend substantial shares of their income on coverage and health care**. ○ *Premiums.* 55% of older adults with coverage on the individual market spend $300 or more per month, or $3,600 or more annually, on premiums. In contrast, only 16% of older adults with employer coverage spend in excess of $3,600 per year on premiums. Nearly two of five insured working older adults with household incomes under $40,000 spend 5 percent or more of their income on premiums and nearly one-quarter (23%) spend 10 percent or more. ○ *Deductibles*. Despite their higher premiums, 48% of older adults with individual coverage have per-person annual deductibles of $1,000 or higher. In comparison, about 8% of older adults with employer coverage face deductibles of $1,000 or more per year. ○ *Out-of-pocket costs*. 38% of uninsured older adults and 37% of older adults with coverage through the individual market spent $1,000 or more per year on out-of-pocket health care costs, including prescription drugs. In contrast, 21% of older adults with employer coverage spent $1,000 or more. • **Older adults who are uninsured, have individual coverage, and have low or moderate incomes have reduced access to**

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				care. 23% of older adults in working households reported at least one cost-related access problem. 54% of uninsured older adults and 30% of older adults with individual coverage reported at least one access problem. Older adults of low or moderate income were also more likely to report cost-related access problems. • **Older adults report high rates of medical bill problems.** 35% of older adults in working households either had a medical bill problem in the last 12 months or were paying off accrued medical debt. The problem was most severe among uninsured older adults. • **Older adults are concerned they will not be able to afford health care.** 66% of older adults in working households said they were very or somewhat worried they might not be able to afford needed medical care in the future. • **Older adults would be interested in new Medicare savings accounts and participating in Medicare early**. 71% of older adults in working families said they would be interested in having 1% of their earnings deducted from their paychecks and placed into an account, which could later be used to pay for LTC or other health services that Medicare does not cover. In addition, 72% of older adults in working households said they would be very or somewhat interested in enrolling in Medicare before age 65.
8/2002	The 2030 Problem: Caring for Aging Baby Boomers *21 pages – Read entirely*	Health Services Research	Public Finance Longer Term Projections Family Economic Security Retirement Security Retirement Savings Trends	The "2030 problem" involves the challenge of assuring that sufficient resources and an effective service system are available in thirty years, when the elderly population is twice what it is today. **Principal Findings** The economic burden of aging in 2030 should be no greater than the economic burden associated with raising large numbers of

Date	Report	By	Topics	Summary/Findings/Key Recommendations
			Impact of Caregiving on Family Economic Security Health and Wellness Insurance Medicare Medicaid Private Pay/Self-Insured Prevention Supportive Community Long-Term Support Services Home-Based Services Social Engagement Opportunities Caregiver Supports Physical Community Transportation and Mobility Housing Work Force Development Work Force Delivering Services to the Aging Population Employment and Entrepreneurship Opportunities for Aging Population	baby boom children in the 1960s. The real challenges of caring for the elderly in 2030 will involve: (1) making sure society develops payment and insurance systems for LTC that work better than existing ones, (2) taking advantage of advances in medicine and BH to keep the elderly as healthy and active as possible, (3) changing the way society organizes community services so that care is more accessible, and (4) altering the cultural view of aging to make sure all ages are integrated into the fabric of community life. Despite the preceding positive analysis of the macroeconomics of aging, there remain some substantial challenges to getting ready to meet the long-term care needs of Baby Boomers. In fact, four types of challenges need to be addressed: 1. Creating a finance system for LTC that works 2. Building a viable and affordable community-based delivery system 3. Investing in healthy aging in order to achieve lower disability rates 4. Recharging the concept of family and the value of seniors in American culture

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			Volunteer Opportunities for Aging Population	
7/2002	State Long-Term Care: Recent Developments and Policy Directions *113 pages – Read Introduction and Conclusion*	Office of the Assistant Secretary for Planning and Evaluation Department of Health and Human Services	Health and Wellness Insurance Medicaid Supportive Community Long Term Support Services Related Support Services Home-Based Services Physical Community Transportation and Mobility Housing	LTC policies and programs are determined in the US by 50 separate state governments, each with different demographics, economies and political philosophies. For many years, the main direction of LTC state policy was to support institutionalization of frail elders and people with disabilities. As individuals with disabilities and their families began to advocate and push for greater choice and for increased opportunities to remain in their homes and communities, states began to broaden their focus on HCBS. These programs and services run the gamut from in-home care to adult day services to supportive housing and transportation. Today, most states are seeking to curb increasing costs for NHs that are largely paid through the Medicaid program. States also are expanding the range of HCBS that they offer to provide greater options for the elderly, people with physical disabilities, people with mental retardation or DDs, and other diverse populations with disabilities. The trend toward greater state spending on HCBS encountered a major obstacle in 2001, however, as state revenues began to shrink at the same time as Medicaid spending was rising. Several themes emerge from this review of state long-term care actions in 2001. In future months, states are likely to: • Continue to assess quality of care in NHs and assisted living facilities and endeavor to improve quality through more stringent regulation and inspection and through incentives to the facilities to hire more staff and upgrade their training. • Attempt to enable more people who can live in community settings to move out of NHs and ICF/MR facilities. This effort also may force many states to consider housing and

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				transportation issues in conjunction with more traditional LTC services. • Consider ways to increase the numbers of direct care workers in LTC and provide incentives to NHs, home care agencies, and other LTC providers for recruiting and retaining these workers. • Increase the number of publicly funded programs that allow and encourage consumer direction of services. • Improve information dissemination to consumers about LTC options and alternatives. Uncertainty about the economy may limit state LTC initiatives that require greater spending in the near future. However, states are showing that they can still design innovative programs and services that expand options for the frail elderly and people with disabilities to live independent lives.