Appendixes

A: Research Method - Data Collection

B: Bibliography

C: Survey Used and Results

D: Community Outreach Analysis

E: Names of Planning Group Members

Appendix A

Research Method

This study was carried out in an exploratory mode. Comparisons were made with the history and outcomes of similar projects in three cities in the North East of the country - Waterbury/Connecticut, Boston/Massachusetts and the Bronx/New York. Additionally, the project group studied the economic realities in Hartford, as they related to starting a new business. In this area alot of emphasis was given to the community needs and eventual benefits that could accrue from a new business venture.

Data Collection

What is the best method to go about this task? This question was asked many times before we actually got started. Eventually, the following steps were decided on:

* The area of North Hartford was first divided into 27 cells, this to minimize the number of individuals any one person was expected to contact.

* The 27 cells were then divided into 4 districts, as shown on the map - **Attachment B.**

* The individuals who oversaw the respective cells/districts then distributed the survey sheet.

* Four community meetings were held, one in each of the four districts, to share information on the idea being researched, and to allay any fears.

* Once the survey results began trickling in, it was decided that more emphasis had to be placed on personal follow-ups that were done.

* To facilitate more and clearer understanding of the elderly-care business in particular and the health-care sector as a whole, numerous articles were photocopied and distributed to the planning group for study. A partial list of the articles read appears in **Appendix B.**

* Meetings were held with middle line administrators in the area hospitals, mainly to determine their views on availability of the types of workers that will be needed, and to determine their willingness or thoughts on working closely with such a company. In both cases the response was positive.

* City personnel were interviewed and their cooperation sought, as it related to this company occupying space in a City facility. The discussions lead to clear statements that the company would be able to secure space in a City building, free of cost for at least five years. This is reflected in the three-year budget outlined in **Chapter 6.**

* A lengthy report entitled : **Report on Aging into the 21st Century ,** was helpful in developing a consensus in the planning group, as to the projected growth in the elderly population - see **Attachment D.**

* After all the number crunching was done in late October 1997, the planning group went back and spoke to a cross section of seniors, about the outcomes that were arrived at, and the likely recommendations that the group was planning. This led to the Community Outreach Analysis - **Appendix E.**

Appendix B:

Bibliography

Age and Aging - July 1997, Pg. 289

Bioreflex Function in Sedentary and Endurance Trained Elderly People (editorial)

American Association of Retired Persons, 1994

Reforming the Health Care System - by, Dorothy A. Jensen, Amanda H. McCloskey and Rolando J. Fuentes

American Behavioral Scientist - Jan 1996 , Pg. 317

Physical Health and Long Term Cure - by, Donald E. Stull, Kyle Kercher and Karl D. Kosloski

American Public Health Policy Series, 1988

Too Poor To Be Sick - by, Patricia A. Butler, JD

Association of Academic Health Care Centers, 1996

The US Health Workforce - by, Marion Osterweis, Christopher J. McLaughlin, Henri R. Manasse, Jr. and Cornelius L. Hopper.

Business Week - Nov.17,1997 , Pg. 48

Let Seniors Pay for Premium Health Care - by, Michael McNamee

Harvard Health Letter - Jan 1996 , Pg. 8 (Brief Article)

Hospitals and Health Network - Oct. 20,1997, Pg. 65

Close, But No Panacea - by, Harris Meyer

Journal of Aging Studies - Fall 1997, Pg. 171

Health Care Reform, Implications for Seniors - by, Neena L. Chappell

National Journal - Aug. 16,1997, Pg. 1636

Brave New World - by Marilyn Werba Serafin

Newsweek - Oct. 13,1997, Pg. 55

Medicare and Boomers - by, Jane Bryant Quinn

New York Times - Nov. 29,1997, Pg. A1

Still Your Grandmother's Bingo, but Supercharged - by, Andrew Pollack

Patient Care - Oct. 15,1996, Pg. 145

Exercise: Rx for a Healthier Old Age - by, Maria A. Fintarone, Karen O'Brien and Brent S.E. Rich

Saturday Evening Post - March/April 1997, Pg. 36

Weight Lifting for Seniors - by, Carol Krucoff

Transaction Publishers, 1996

American Health Care Blues - by, Irwin Miller

US News and World Report - July 14,1997, Pg. 62

News You Can Use: Health and Fitness - by, Laura Tangley

APPENDIX C

SURVEY

These questions are being asked in connection with a study being done, to see if an employee owned company that delivers services to seniors in North Hartford, can be a sound business proposition:-

1. Do you receive the medical care you need? Yes .... No ....

If no, why ? check which ones apply
*** Lack of transportation .....**
*** Forget doctor's appointments .....**
*** Not sure I could get the treatment I need .....**

2. Do you need general assistance in the home from time to time? Yes ..... No ....

3. Would you like to get your regular basic checkups at home ? Yes ..... No ....

4. Can you use help from time to time in getting items from the drug or grocery store and preparing meals? Yes ..... No ....

5. Do you get out of the home as often as you would like? Yes ..... No ....

6. Have you been advised by your doctor to do some basic exercises three or four times a week? Yes ..... No ....

If yes, have you been doing it? Yes ..... No ....
If no, check which ones apply
*** Scared of fainting .....**
*** Need help to get started .....**
*** Need someone to assist me along the way .....**

7. Are you covered by Medicare ... Medicaid ... Own Insurance...?

Results Of The Survey

1200 Paper and Telephone Responses

	Yes	%	No	%	Don't Know
1. Do you receive the medical care you need?	70		15		15
2. Does lack of transportation prevent you from seeing the doctor?	5		90		5
3. Do you forget doctor's appointments?	36		52		12
4. Are you certain what medical care is available to you?	40		60		-
5. Do you need general assistance in the home?	90		10		-
6. Would you like to get your regular checkups in the home?	95		5		-
7. Can you use help getting items from the store?	80		5		15
8. Would you like to get out of the home more often?	90		5		5
9. Have you been advised by you doctor to get some exercise?	50		32		18
10. Are you performing the exercises as you have been advised?	15		85		-
11. If you are not getting the exercise as you should, what's preventing you:					
* Afraid of fainting	50				
* Need help to get started	25				
* Need someone to assist you	50				
12. Does Medicare/Medicaid cover you?	76		18		6
13. Are you covered by private insurance?	17		80		3

COMMUNITY OUTREACH ANALYSIS — APPENDIX D

In the very beginning, the planning group felt it was only necessary to speak to a few 'key' seniors in the community, in order to get a sense of what could or could not be accomplished with such a business.

However, thanks to the work of the late Mr. Vern Johnson, who was extremely adept at assembling statistical information, we were able to get consensus for more public involvement. In addition, by this time my project advisor Mr. Lett was also making the point that more community imput was necessary.

Eventually we had our first community meeting at the North Hartford Senior Center, with only eleven persons in attendance. Subsequent meetings of which there were three, had 24, 21 and 19 persons respectively.

The survey was finally ready in June '97 and after two small mailings, 2550 hand delivered and numerous telephone follow-ups through October '97, we were able to amass information from 1200 individuals - 304 paper returns and 896 responses from telephone and face-to-face follow-ups. The group did one hell of a job. The master stroke was dividing North Hartford into 27 cells with four districts, this allowed for breaking the task down into manageable pieces, thus getting more accomplished.

An interesting development of the surveys was, it was learnt that a number of active seniors felt they should be given an opportunity to serve other seniors. Initially it was never in the plans to employ seniors in this endeavor. However, it soon struck us that many of the seniors were themselves trained in the health care field, and coincidentally , they had worked in nursing homes and hospitals in their youth. As a result of this development, one of the recommendations going out of this study, will be for the planners to give serious thought to incorporating members of the senior community into their staff plans.

Generally, the discussions at all levels concerning this idea are quite favorable. I would not be giving the entire picture, if I did not state that some individuals thought the entire idea should have been handled by others, politicians maybe. We were unable to sway those minds by saying we were only looking into the possibility of a business, not actually setting up a business. I guess you cannot win them all.

Early in the process there was complaints that we had not spoken to all corners of the Northend, we went back and made certain we covered all areas. Today I am proud to say : we took the teaching of CED to hearth and went looking for community imput, we found it, recorded it and hope the end result will show it .

APPENDIX E

MEMBERS OF THE PLANNING GROUP

ELEANOR K. BLACK

GERTRUDE BLANKS

WILLIAM BOLDEN

MARY BROWN

WILLIAM BROWN

GLADYS CARTER

*VERN JOHNSON **

MARVIN JONES

F. IRENE PITTMAN

WILLIAM RANDOLPH

D. ANWAR IBRAHIM AL-GHANI

**** Mr. Vern Johnson was extremely helpful on the planning group, though he was unable to see this project to its end, I am certain he is looking down on us. I do hope he approves of the final product we came up with. Vern was called by Almighty Allah In April ,1997.***

Attachments

A: Copy of Project Contract

B: Map of North Hartford

C: Critics: Law Could Be Unhealthful ...

D: Report on Aging into the 21st Century

Background and Boundaries of the community

The area of Hartford, Connecticut commonly referred to as North Hartford, is a community comprising four (4) of Hartford's seventeen (17) neighborhoods - **Blue Hills, Northeast, Upper Albany and Clay Arsenal.** (see appendix on page 6)

While the entire city population of 139,739 (1990 census) is made up of 30.5% White, 35.9% Black, 31.6% Hispanic and 2.0% others, North Hartford's population is broken down as follows:

Neighborhood	%Black	%White	%Hispanic	%Other
Blue Hills	75.16	19.28	3.81	1.75
Northeast	76.8	1.23	20.99	.98
Upper Albany	82.33	1.12	15.54	1.01
Clay Arsenal	45.8	.71	52.4	1.09
Avg. N'Hart.	**70.0**	**5.59**	**23.19**	**1.21**

Within the social and political characteristics of the city, there are many noticeable distinctions:

1.Persons per household: City wide 2.55: average for North Hartford 3.12
Blue Hills 3.10, Northeast 2.87, Upper Albany 3.26, Clay Arsenal 3.23

2. % of female head of households: City wide 31.71: average for North Hartford 42.7
Blue Hills 22.02, Northeast 48.11, Upper Albany 57.86, Clay Arsenal 57.86

3. Median income of individuals 65>: City wide 24,200: average North Hartford 16,000.
Blue Hills 22,280., Northeast 12,220., Upper Albany 17,500.,Clay Arsenal 12,000

4. % of individuals 65> living alone: Citywide 15, average for North Hartford 28
Blue Hills 34.3, Northeast 33.7, Upper Albany 23.9 Clay Arsenal 20.1

The City of Hartford as a whole and the North Hartford community in particular, face significant challenges in the areas of social and economic needs. Census data (1990) indicates that Hartford has the lowest median household and family incomes, lowest per capita income and highest percentage of people living below the poverty line, of Connecticut's 169 cities and towns. Within the profile outlined above, it is clear that North Hartford suffers a position even worse than the city as a whole.

Interwoven with the statistical information above, is the social and economic position of the community's over 65 population. Following is copied from the 1990 census report:
....92.1% of Hartford's population of persons over the age of 65, live in households and only 7.9% live in institutions or other group quarters. Frail elderly make up 4.5% of the population, 11.7% are Hispanic and 27.8% are Black. Comparing the latest figures with those of 1980, it is evident that the minority elderly population in Hartford is increasing and that elderly are living in poverty. A large percentage of Hartford's elderly (65 and above) live alone, a situation that is quite evident whenever social workers visit those living alone: requests for workers to stay for hours, statements of not having had a visitor for weeks ,are heard too often.
Compared to the total population in Hartford, North Hartford's senior population is as follows:

Neighborhood	%Black	%White	%Hispanic	%Other
North Hartford	70.0	5.59	23.19	1.21
N'Hford Senior	**77.0**	**6.8**	**9.8**	**6.4**
City Senior	**27.8**	**50.8**	**11.7**	**9.7**

Problem Statement

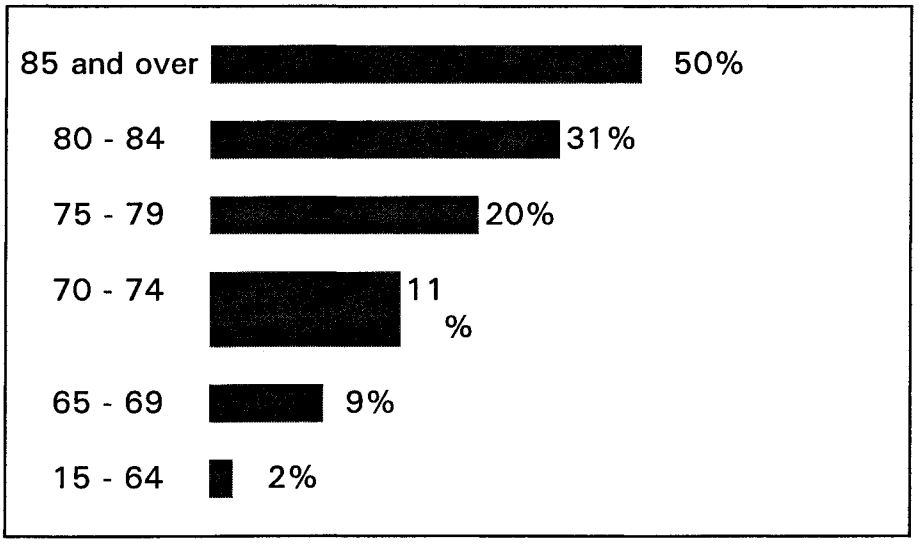
This contract addresses one of the needs of the minority senior population of this community.

.... if no solution is found, then the 7,600 seniors' population of this community who are increasingly living in isolation and below the poverty level, will continue to go without basic home care, direction to needed health care and lack of human communication, thus continuing to suffer the twin ills of poverty and isolation.

The elderly population in this community parallels the senior population of the nation, in general. Areas of similarity are:

1. The "oldest-old", those aged 85 and over, are the most rapidly growing elderly group.
2. The elderly are becoming more racially and ethnically diverse.
3. Elderly women outnumber elderly men.
4. As a result of **(3)** above, most elderly men are currently married, while most elderly women are widowed.
5. An increasing number live alone.
6. More and more elderly are living in dependency.

THE NEED FOR PERSONAL ASSISTANCE WITH EVERYDAY ACTIVITIES INCREASES WITH AGE. PERCENTAGE OF PERSONS NEEDING ASSISTANCE WITH EVERYDAY ACTIVITIES, BY AGE: 1990-91 (U.S. CIVILIAN NONINSTITUTIONAL POPULATION)



Project Goal

....to complete a Feasibility Study leading to the formation of an Employee Owned Company. The objectives of this company will be to:

1. **Deliver basic home care to 'shut-in' seniors.**
2. **Direct seniors to needed health services not offered by the company.**
3. **Provide regular physical communications for those seniors living alone or with a companion, who are afraid and or unable to leave their homes.**

Maximum Objectives

1. To gather imput from a wide cross section of the community, on the perceived value of such an enterprise.
2. Explore the financial resources available for launching such an enterprise.
3. Develop a business plan for the venture.
4. Establish a core group to bring the study to operation.

Minimum Objectives

1. Determine whether or not such a project is feasible in the community.
2. Establish an interest group, to oversee continued exploration of this community problem.

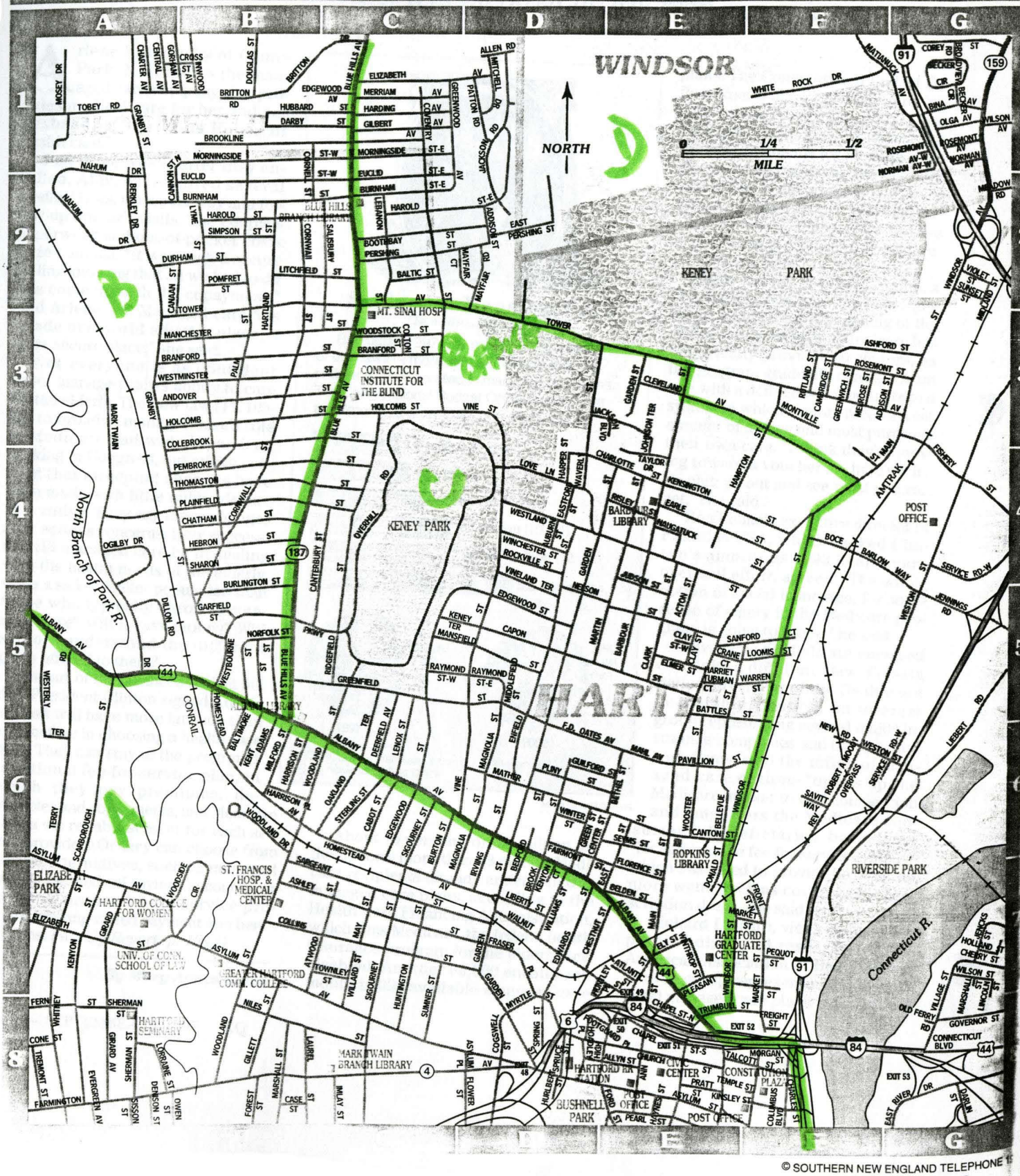
Project Purpose

....to demonstrate the capacity of the North Hartford community, for developing mechanisms designed to meet the economic and social needs of the community - specifically in this instance, by establishing an Employee Owned Company, to deliver health related services to seniors in the North Hartford community - specifically:

1. HOME CARE 2. Direction to needed health care
3. Companionship

Attachment B

MAP 4 HARTFORD AREA STREETS (NORTH) MAP 4



ATTACHMENT C

Critics: Law Could Be Unhealthful For Elderly — and for Medicare

Concerns raised over ability of managed care to deal with needs of seniors and whether federal program will reap any savings

Arlene Krasowsky of Ozone Park, N.Y., thinks the managed care company that provides medical care for her and her husband is "the Rolls Royce of health care."

Just three weeks after they enrolled, Alex, 82, required several medical tests, a hospital stay and follow-up doctor's visits. The couple's paperwork and out-of-pocket costs were minimal. "It was such a secure feeling knowing that all we had to do was come up with the copayment," said Arlene, 54. Managed care has "made our world a better place, a more secure place," she said.

Not everyone is as confident about managed care's ability to care for the elderly. The new law (PL 105-33) to broaden managed care's role in Medicare had wide bipartisan backing in Congress, but critics contend that sweeping changes have been made with little public debate or scrutiny. They say these changes raise serious concerns: How successful will managed care be in dealing with the health needs of the elderly, often a sicker, frailer population than those who typically enroll in managed care? Will it save money? Will seniors understand the different plans offered to them?

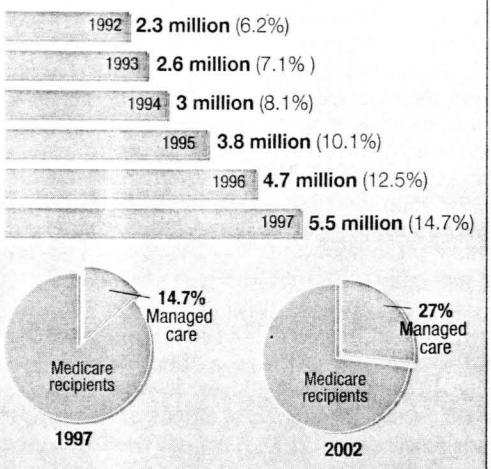
As part of the balanced-budget bill that President Clinton signed Aug. 5, seniors will have more latitude than ever before in choosing a health care plan. They can stay in the program's traditional fee-for-service plan, in which they pay premiums, deductibles and copayments, and Medicare pays a set reimbursement for each service provided. Or they can choose from several alternatives, such as managed care plans, medical savings accounts, or so-called private fee-for-service programs offering varied payment and benefit plans. *(Weekly Report, p. 1843)*

By Mary Agnes Carey

Seniors in Managed Care

(In millions of people)

By August 1997, 5.5 million, or 14.7 percent, of the nation's more than 38 million Medicare recipients were enrolled in managed care plans. The Congressional Budget Office predicts that enrollment will grow to 27 percent by 2002.



SOURCE: American Association of Health Plans; Congressional Budget Office

MARILYN GATES-DAVIS

About 15 percent, or 5.5 million ,of the nation's more than 38 million Medicare recipients already are enrolled in managed care plans, according to the Health Care Financing Administration, which runs Medicare, the federal health insurance program for the elderly and disabled. Another 80,000 enroll each month in 398 available managed care plans. The Congressional Budget Office expects that 27 percent of recipients will be enrolled by 2002. More managed care options, combined with climbing premiums for Medigap (supplemental insurance for services not covered by Medicare) and incentives to lure managed care providers to rural areas will all help accelerate the role of managed care in Medicare. *(Options, p. 2147)*

Cathy Hurwit of Citizen Action, a consumer group, said the new legislation may mark the beginning of the end of the security that Medicare has historically provided to seniors, as the program gradually changes from one with a defined set of benefits to a system in which seniors receive a set amount of money and must purchase their own care. "I think they're moving toward a voucher . . . here's a little chit; go out and see what you can get," she said.

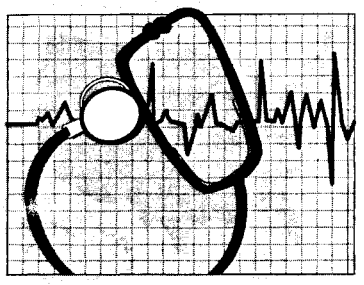
Ron Pollack, executive director of Families USA, which backed Clinton's ambitious 1993 health care overhaul effort, agreed. "The whole notion of social insurance, for some sense of equity in the Medicare program, is going to erode," he said.

Advocates of Medicare managed care take a different view. Pamela Bailey, president of the Healthcare Leadership Council, an interest group representing several major insurance companies and other health care firms, said the influx of managed care options "opens up the Medicare market to real competition and empowers the Medicare consumer." Beneficiaries have been "locked into the fee-for-service system," which has failed to provide benefits seniors want, such as coverage for prescription drugs, she said.

Richard I. Smith, vice president for public policy and research for the American Association of Health Plans, a trade group representing more than 1,000 managed care plans, said the new

30

Medicare Options Available



As part of the balanced-budget bill that President Clinton signed Aug. 5 (PL 105-33), seniors enrolled in Medicare can choose to stay in traditional fee-for-service plans or select one of several new or expanded options under the "Medicare+Choice" plan.

In traditional fee-for-service, Medicare covers hospitalization and doctors' expenses, with beneficiaries paying a monthly premium and meeting deductibles and copayments. The managed care options would cover the same services, with many plans covering additional items, such as prescription drugs. Beneficiaries in managed care would continue to pay Part B premiums (which cover doctors' visits), but their out-of-pocket costs would be reduced. Critics say the disadvantages of managed care, in which gatekeepers monitor a patient's access to treatments and specialists, are that patients must pay more to see a doctor who is not in the plan, and the plan may not cover a procedure that the patient thinks is necessary. The new options include:

- **Health maintenance organization (HMO):** An HMO provides health care in a geographic area with set benefits at a set fee. A primary care doctor often serves as a "gatekeeper," controlling access to specialists and medical procedures. Enrollees typically pay a monthly premium and a small copayment for each doctor visit. The benefits package varies by plan; many cover prescription drugs, which makes HMOs attractive to seniors. Currently, 5.5 million of the nation's more than 38 million Medicare participants are enrolled in HMOs.
- **Preferred provider organization (PPO):** A PPO is similar to an HMO in that both plans collect monthly premiums and small copayments from beneficiaries, who are generally restricted to visiting doctors on a list of "preferred providers." In a PPO, which is currently available in the private sector but new to Medicare, enrollees can visit doctors who are not on the list, but they face higher copayments when they do.
- **Provider sponsored organization (PSO):** Under this plan, a group of doctors and/or hospitals offer a benefits package for a monthly premium and small copayments. It is similar to an HMO, but does not have a separate administrative entity. Doctors and hospitals run the plan themselves.
- **Medical savings accounts (MSA):** This program will permit 390,000 seniors to set up tax-exempt accounts to be used for qualified medical expenses. Seniors who choose them also will have to purchase high-deductible (up to $6,000) insurance policies to cover catastrophic illnesses. Beneficiaries whose accounts have reached 60 percent of the annual deductible level can withdraw additional money for any purpose, although it will be treated as taxable income. That provision may appeal to healthier seniors who can afford to meet a high deductible. But consumer advocates worry that lower-income beneficiaries may be lured by the financial incentives, then find themselves unable to pay the high deductible.
- **Private fee-for-service:** These are private indemnity plans that cover the same services as Medicare fee-for-service. Advocates say this option allows seniors to see any doctor they wish (including those who do not participate in Medicare), although they may have to pay more to do so. Such plans are not required to follow Medicare's fee schedule, so premiums are not capped. Doctors and other providers could charge patients up to 115 percent of what the insurance plan pays.
- **Private contracting:** This plan allows physicians who are not in the Medicare program to enter into private contracts with beneficiaries for a particular service covered by Medicare. The doctors could charge the beneficiary more than what is allowed under Medicare's fee schedule. Neither the doctor nor the patient would submit a claim to Medicare. The patient continues paying Medicare premiums and using Medicare coverage for basic services. Advocates say this choice broadens a senior's options for treatment, but critics contend it will benefit only wealthy seniors who can afford to pay extra for their care.

— Mary Agnes Carey

law will build on current success: enrollment in Medicare managed care has more than doubled since 1992. "The revolution has already begun and it's serving seniors quite well," he said, adding that as time goes on, people who have been in managed care while working may want to stay in it when they become eligible for Medicare.

Getting Out the Word

The new or expanded options are expected to be in place by Jan. 1, 1999.

The Department of Health and Human Services (HHS) and its Health Care Financing Administration (HCFA) are developing ways to explain the new options to the elderly. The agency is drafting regulations that will govern the new plans and has issued marketing guidelines to clarify policies on advertising and promotions.

The government plans to put information about Medicare managed care options on the Internet so consumers can examine current documents, such as a particular plan's benefits, copayments and approved providers. It is unclear whether that information also will be mailed to seniors' homes.

The financing administration is surveying current enrollees in Medicare managed care, and plans to make the results public, along with a review of performance data that the managed care plans began reporting Jan. 1.

Some economists and consumer groups, however, are skeptical about whether the government can adequately explain the benefits and consequences of managed care.

Uwe Reinhardt, a health economist at Princeton University, said seniors must receive details not only on prices but also on how the plans compare in areas such as patient satisfaction. He is not sure the new law guarantees that. "I don't think the information infrastruc-

ture is [illegible] to make this meaningful for [illegible]," he said.

Diane Archer, executive director of the Medicare Rights Center, a consumer organization based in New York, agrees. Legislators have approved expanded choice in Medicare without having enough information to evaluate how well those choices will perform for seniors, she said: "Congress has put the cart well before the horse."

Bruce Vladeck, outgoing administrator at the Health Care Financing Administration, said he is "reasonably confident" that the agency will have enough money to implement such educational efforts in fiscal 1998, and negotiations are ongoing to assure the agency can meet the demands the balanced-budget act places on it.

Such guidance is key to helping seniors avoid confusion about plans and their acronyms, such as preferred provider organizations (PPOs) and provider sponsored organizations (PSOs). "There now is going to be a bewildering set of choices people can make," said Pollack of Families USA. "What kind of decision is the typical senior going to make when they hear this alphabet soup?"

Robert Stinson, 54, of Massapequa, N.Y., is not sure he made the right decision when he chose managed care for his Medicare coverage. Stinson is battling his insurer over the bill for treatment he received at an emergency room while on vacation in Florida. The emergency room physician said the procedure was needed to stabilize Stinson for his trip back home, but the health plan's doctor disagreed.

Stinson, who is disabled, said he believes the treatment saved his life. But his insurer refuses to pay the $7,900 hospital bill. Stinson said that on an annual income of $24,000, he cannot afford to pay, and he is appealing the insurer's decision. "I'll fight it to the grave," he said.

Currently, seniors who try managed care and do not like it can opt out within a month. That will tighten, however, to discourage seniors from hopping between managed care and fee-for-service plans. By 2002, seniors will only be allowed to leave a managed care plan during their first six months of enrollment. By 2003, it will be three months. The only exception will be for first-time enrollees, who will be allowed to leave any month the first year. The first year also will be the only time that seniors who drop out will be guaranteed renewal of their Medigap policies.

Reinhardt said legislators should extend the lock-in period to five years to make both seniors and health plans live with the benefits — and consequences — of their choices.

A Reduction in Spending?

The Congressional Budget Office says the new managed care options and related provisions will reduce Medicare spending by $22.5 billion over five years. Backers of the new options explain that under managed care, the government pays managed care providers a set amount per beneficiary, regardless of how much their medical care costs the insurance company. "I think the program offers a lot of certainty to the government," said Smith of the health plans association. Traditional Medicare pays on a per-service basis, so costs can easily escalate as more care is needed.

"There now is going to be a bewildering set of choices people can make. What kind of decision is the typical senior going to make when they hear this alphabet soup?"

— Executive Director Ron Pollack, Families USA

But Hurwit of Citizen Action believes increasing managed care's role in Medicare will ultimately cost more, especially if aggressive marketing campaigns lure more beneficiaries than projected to managed care plans. At a base rate of $367 per month per beneficiary in 1998 — the minimum payment to managed care providers — the government will spend at least $4,404 a year per senior, whether they get sick or not. Under fee-for-service, government costs are lower for seniors with few medical expenses. "Instead of paying bills when they're due, Medicare is going to be buying insurance," Hurwit said.

Vladeck said managed care plans will not save money over the long term until reimbursement rates are reduced. Starting in 2000, Medicare payments to managed care providers are to reflect demographics and health history. In theory, payments would be lower for healthier seniors and higher for others. But Vladeck warned that those efforts will not succeed unless base payments also are kept in check. "You can risk adjust all you want but if the base level from which you're adjusting is inflated, you'll still be overpaying," he said.

How Will The Sickest Fare?

Bruce M. Fried, director of HCFA's Center for Health Plans and Providers, said managed care "holds great promise" for improving the medical treatment of seniors and others who suffer from chronic illnesses. Such benefits include a "better continuity of care," he said, "with increased coordination and case management; expanded services and benefits with protection from high copayments and deductibles; and more prevention and primary care."

But a key fear of opponents to expanded managed care is that the industry will not provide enough care for seriously ill seniors. They argue that a set payment ($367 a month) may be an incentive to provide less care rather than more. "One of the risks," said Patricia Smith, senior coordinator for the American Association of Retired Persons' federal affairs health team, is that health plans will be motivated "to underservice to live within the payment."

A recent article in the New England Journal of Medicine supports such concerns. The report found that Medicare beneficiaries enrolling in HMOs tend to be healthier before enrollment, requiring fewer hospitalizations than seniors who stay in fee-for-service. But when those same beneficiaries leave managed care and return to fee-for-service, they "appear to be less healthy and report using more out-of-plan services before disenrollment than those who switch from one HMO to another."

Smith of the managed care group said the article was flawed because it looked only at seniors who had left managed care, rather than looking as well at those who stayed. But that data was not available, said Robert O. Morgan, an author of the study. The health financing administration publishes data on beneficiaries' experience in fee-for-service, but does not publish similar data on beneficiaries in managed care — although it plans to soon.

Some advocates for seniors, such as Smith of the AARP, worry that the elderly may have a tough time battling back if an HMO or other managed care provider denies care or sets up roadblocks. "As you become more frail and sicker, it is simply harder to be aggressive," she said.

What's Next?

Archer of the Medicare Rights Center fears Congress has cleared the way for what will basically become "a game

of bait and switch" with seniors and the disabled. As managed care broadens into Medicare, the program's costs will rise because of the set reimbursement per beneficiary. And as those costs rise, Congress will reduce reimbursement levels to save money. In response, managed care companies will scale back benefits, eliminating prescription drug coverage and other benefits that managed care plans have traditionally offered. "It's only a matter of time" for such a scenario to unfold, Archer said.

Rep. Pete Stark, D-Calif., plans to introduce legislation to shore up consumer protections as managed care plays a greater role in Medicare. An aide said Stark sees a conflict between HCFA's role promoting managed care at the same time it tries to regulate the industry by, for example, monitoring finances and marketing practices.

Advocates for the elderly hope their concerns over managed care's new role will be resolved by the 17-member bipartisan commission that the law created to address Medicare's long-term structural and financial problems. The panel is to review three proposed Medicare changes that lawmakers left for another day: Increasing the eligibility age, requiring a copayment for some home health services and asking wealthier Medicare recipients to pay more for their benefits.

The panel may also examine the next step for saving money under managed care, such as creating a competitive bidding system among plans. The group may examine unintended consequences of the Medicare provisions, such as whether they fail to provide adequate medical care for the chronically ill.

Democratic Rep. Sherrod Brown of Ohio is not optimistic that the panel will be a catalyst for change. He fears it will reach no more than an "inoffensive consensus," and will not want to make decisions that offend doctors, insurance companies or other players in the industry.

John Rother, director of legislation and public policy for the AARP, warned against high expectations. Anticipating the commission will emerge with an answer to all of Medicare's woes is "setting it up for failure," he said.

Arlene Krasowsky does not see the need for the government to meddle in managed care. She said her husband's care makes a good case for how well seniors can fare with their new choices. "We don't have to worry and we can afford it," she said. "We're not all Donald Trumps, you know." ■

LAW/JUDICIARY

Crimes Committed With Guns May Carry Higher Penalties

The House Judiciary Committee returned Sept. 9 to the long-simmering debate over mandatory minimum sentences as the panel approved a bill that would increase sentences for crimes committed with firearms.

The measure (HR 424) was approved, 17-8. Its main purpose is to clarify for the courts what Congress meant in a 1988 law (PL 100-649) when it created penalties for using a gun in committing a crime. The Supreme Court ruled in 1995, in *Bailey v. United States*, that the criminal had to discharge or brandish the weapon for federally enhanced or minimum penalties to kick in. *(1988 Almanac, p. 82)*

Some see that interpretation as too narrow. The new bill, sponsored by Sue Myrick, R-N.C., would say the criminal merely has to possess the weapon.

At the same time, the bill would expand existing mandatory minimum sentences for gun crimes. Possession of a gun during commission of a violent or drug-trafficking crime would add 10 years to the offender's sentence for the underlying crime. Brandishing the weapon during a crime would yield an additional 15 years. Firing it would add 20 years.

Crime Subcommittee Chairman Bill McCollum, R-Fla., said the bill aims to send the message that Congress is serious about gun crimes. "If you use a gun in the commission of a crime, you will get the book thrown at you," he said.

Democrats charged that Congress should not be in the business of micromanaging criminal justice procedures.

Rep. Bill Delahunt, D-Mass., said the types of mandated sentences in HR 424 would encroach on the mission of the U.S. Sentencing Commission, which was created to take politics out of sentencing. "We are legislatively beating ourselves on the chest," Delahunt said. "It just doesn't make sense." ■

By Dan Carney

LAW/JUDICIARY

Sex Offender Bill Sparks Debate

A House Judiciary Committee markup of a bill to help states coordinate registries of sex offenders turned into a debate over state sodomy laws, and whether homosexuals would be stigmatized by the new registries.

The relatively non-controversial bill (HR 1683), sponsored by Rep. Bill McCollum, R-Fla., was approved by voice vote Sept. 9. It would require sex offenders to register anew each time they move.

But Rep. Charles E. Schumer, D-N.Y., and other Democrats found a potential problem with the registries that they brought up in committee and will likely take to the floor. Schumer said five states that have anti-sodomy laws — Arizona, Mississippi, Kansas, Louisiana and South Carolina — have indicated that they would put consenting adults convicted of sodomy on state sex offender registries.

Schumer offered an amendment that would cut federal Byrne Grants for crime fighting by 10 percent to any state that puts such consenting adults in the registries. His amendment was defeated 12-19 in a party-line vote.

Legislation allowing states to set up registries of sex offenders was first enacted as part of the 1994 omnibus crime law (PL 103-322). The registries would let communities know if a convicted sex felon has moved into the neighborhood. *(1994 Almanac, p. 273)*

Schumer argued that any state that publishes names of people who engage in consensual sex acts was perverting the legislation's purpose.

McCollum countered that nothing in the original legislation authorizes the names of non-violent sex offenders to be placed in the registries. He also said the federal government should not pass judgment on state laws.

Schumer had initially thought Republicans might accept the amendment. After the vote, he said he planned to take the issue to the House [illegible] ■

By Dan Carney

ATTACHMENT D

Administration on Aging

AGING INTO THE 21ST CENTURY

May 31, 1996

National Aging Information Center
7830 Old Georgetown Road, Suite 100
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Hypertext conversion by Saadia Greenberg, January, 1997

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Demographic Changes

Growth of the elderly population

On the basis of the middle series of the Bureau of the Census population projections released in 1996, we can anticipate a moderate increase in the elderly population until about 2010, a rapid increase for the next 20 years to 2030, and then a return to a moderate increase between 2030 and 2050 (Table 1). Similar projections prepared by the Social Security Administration (SSA) support these figures (SSA, 1995). In the early period, the elderly population is expected to increase by 17 percent, from 33.5 million in 1995 to 39.4 million in 2010. In the next period, 2010 to 2030, the population aged 65 and over is expected to grow by 75 percent to over 69 million. During the 2030 to 2050 period, the growth rate is projected to increase 14 percent, and the number of elderly is expected to increase to about 79 million. Because the growth of the elderly population in the early period is not much different from that of the population under age 65, the proportion of elderly in the population will not change significantly between now and 2010, remaining at approximately 13 percent. However, from 2010 to 2030, the growth rate of the elderly exceeds that of the population under age 65, so that the proportion of the elderly in the overall total increases sharply to 20 percent. Thereafter, at least until 2050, the age segments of the population grow rather evenly and the percentage of the elderly in the overall population remains unchanged.

Table 1 - Projections of the Population, by Age and Sex: 1995 to 2050

(Numbers in thousands. Minus sign denotes a decrease. Middle series of U.S. Bureau of the Census.)

	BOTH SEXES			SEX		
AGE GROUP AND YEAR	Number	Percent of all ages	Percent increase from 1995	Male	Female	Sex Ratio[1]
ALL AGES						

1995	262,820	x	x	128,311	134,509	95.4
2000	274,634	x	4.5	134,181	140,453	95.5
2010	297,716	x	13.3	145,584	152,132	95.7
2030	346,899	x	32.0	169,950	176,949	96.0
2050	393,931	x	49.9	193,234	200,696	96.3
55-64						
1995	21,138	8.0	x	10,045	11,093	90.6
2000	23,961	8.7	13.4	11,433	12,528	91.3
2010	35,283	11.9	66.9	16,921	18,362	92.2
2030	36,348	10.5	72.0	17,441	18,907	92.2
2050	42,368	10.8	100.4	20,403	21,965	92.9
65-74						
1995	18,758	7.1	x	8,337	10,421	80.0
2000	18,136	6.6	-3.3	8,180	9,956	82.2
2010	21,058	7.1	12.3	9,753	11,305	86.3
2030	37,407	10.8	99.4	17,878	19,529	91.5
2050	34,732	8.8	85.2	16,699	18,033	92.6
75-84						
1995	11,151	4.2	x	4,326	6,825	63.4
2000	12,316	4.5	10.4	4,938	7,378	66.9
2010	12,680	4.3	13.7	5,363	7,317	73.3
2030	23,517	6.8	110.9	10,818	12,699	85.2
2050	25,905	6.6	132.3	12,342	13,563	91.0
85+						

1995	3,624	1.4	x	1,015	2,619	38.8
2000	4,259	1.6	17.2	1,228	3,031	40.5
2010	5,670	1.9	56.0	1,771	3,899	45.4
2030	8,454	2.4	132.7	3,021	5,433	55.6
2050	18,224	4.6	401.5	7,036	11,188	62.9
65+						
1995	33,544	12.8	x	13,678	19,866	68.9
2000	34,710	12.6	3.5	14,346	20,364	70.4
2010	39,409	13.2	17.5	16,887	22,522	75.0
2030	69,379	20.0	106.8	31,718	37,661	84.2
2050	78,859	20.0	135.1	36,076	42,783	84.3

SOURCE: U.S. Bureau of the Census (1996a).

[1] Males per 100 females.

x = not applicable

Table compiled by the National Aging Information Center

The growth in the number of the oldest old (aged 85 and over) is of greater public concern. During 1995 to 2010, this population is expected to grow by 56 percent, as compared with 13 percent for the population aged 65 to 84. This means that a larger share of the elderly will be over age 85. In subsequent decades, especially between 2030 and 2050, the 85-and-over age group will grow sharply as the baby-boom cohorts age. The 85-and-over age group is expected to increase from 3.6 million in 1995 to 5.7 million in 2010 to 8.5 million in 2030, and to 18.2 million in 2050. Thus, while the expected increase from 2010 to 2030 is less than 50 percent, the increase from 2030 to 2050 is 116 percent. The cumulative growth in the 85-and-over population from 1995 to 2050 is anticipated to be more than 400 percent, and the proportion of that group in the total population is likely to increase from 1.4 percent in 1995 to 4.6 percent in 2050.

Alternative higher and lower population projections were also published by the Bureau of the Census. The basic assumptions in the Bureau of the Census projections, expressed in terms of ultimate values for fertility, mortality and immigration in 2050, are as follows:

	Year			
Component:	**1995**	**2050**		
		Low	**Middle**	**High**
Fertility (total fertility rate)	2055	1910	2245	2580
Life expectancy (at birth)	75.9	74.8	82.0	89.4
Annual net immigration (in thousands)	820	300	820	1270

The total fertility rate represents the number of children 1,000 women would have in their lifetimes, assuming that none of the women died before the end of childbearing. Life expectancy represents the average number of years of life remaining at birth to a newborn cohort. Annual net immigration is the yearly total number of immigrants to the United States minus the number of emigrants. The "lowest" population series (that is, the series showing the lowest population numbers) is based on a combination of low fertility, low life expectancy, and low net immigration. The "highest" series (that is, the series showing the highest population numbers) is based on a combination of high fertility, high life expectancy, and high net immigration.

These series present very different outlooks on the growth of the elderly population. For example, the highest series of population projections shows a 754 percent increase in the number of persons aged 85 and over between 1995 and 2050 (Table 2). The middle series shows a 402 percent increase, and the lowest series an increase of 166 percent for that group. The proportion of the oldest old in the total population is projected to be over 4.5 percent in 2050 in the middle series, but 6.0 percent in the highest series. The number of persons aged 65 and over in the highest series grows much more rapidly than in the middle series, but the proportion of elderly in the population is about the same in the two series in all future years because of the parallel growth of the elderly and the nonelderly populations.

To understand why the elderly population will grow more slowly between 1995 and 2010 than in earlier periods, we have to consider the trend of births 65 years or more before each of these two dates. The number of births from 1910 to 1930 was much greater than the number of births from 1925 to 1945. The Depression Era babies, among the latter cohorts, are now reaching age 65, hence the number of those 65 to 74 is actually decreasing. Because of the 1946 to 1964 baby boom, we can anticipate an extremely large increase in the number of people aged 65 and over, and especially aged 65 to 74, after 2010. The decline in death rates, especially at the older ages, is also contributing to the increase in the current number of elderly, and it is assumed that this trend will continue. Death rates of people in the older age ranges began to plunge in the late 1960's and are anticipated to continue to decline, albeit at a slower pace than in recent decades.

To understand the rapid growth of the oldest-old population between 1995 and 2010, we have to consider demographic events that occurred between 1900 and 1925 and later. The number of births increased rapidly from 1900-1910 (1910 being the year the youngest of those aged 85 and over in 1995 were born) to 1915-1925. A high immigration rate contributed greatly to the number of births in this period. However, the number of births from 1915 to 1925 (the years of the birth cohort that will be 85 years or over in 2010) greatly exceeded the number born from 1900 to 1910, as a result of the rapid growth of the population. Immigration in this and previous decades contributed substantially to the number of births in 1915 to 1925, although the volume of immigration had fallen off sharply as

compared with the volume of immigration affecting the 1900 to 1910 cohorts. However, the later cohorts benefited from lower death rates as they grew older.

Changes in the proportion of elderly in the total population have a different causal basis. The projections of a very high and increasing proportion of elderly from 2010 to 2030 are accounted for by three factors: (1) declining and low fertility in the past and the prospect of continuing low fertility up to 2030 (and beyond); (2) maturing of the baby-boom cohorts; and (3) sharp declines in mortality at the adult and older ages in the recent past and the prospect of continuing low mortality up to 2030 (and beyond). Once the baby-boom influx is over (i.e., has completely passed age 65) in 2030, the proportion of elderly in the total population stabilizes.

Table 2 - Projections of the Percentage Increase in Population, by Age: 1995 to 2010, 1995 to 2030, 1995 to 2050

(Minus sign denotes a decrease. Projections are based on the lowest, middle, and highest population series of the U.S. Bureau of the Census.)

AGE AND PERIOD	LOWEST POPULATION	MIDDLE POPULATION	HIGHEST POPULATION
ALL AGES			
1995-2010	7.1	13.3	19.7
1995-2030	10.8	32.0	54.1
1995-2050	7.5	49.9	97.4
UNDER 65			
1995-2010	6.6	12.7	19.0
1995-2030	1.3	21.0	42.1
1995-2050	-1.2	37.4	81.2
65+			
1995-2010	10.8	17.5	24.2
1995-2030	75.6	106.8	136.4
1995-2050	66.8	135.1	208.3
75+			
1995-2010	14.5	24.1	35.0
1995-2030	71.8	116.2	164.0
1995-2050	91.1	198.5	326.8
85+			
1995-2010	37.9	56.0	79.1
1995-2030	59.1	132.7	235.1
1995-2050	165.6	401.5	754.2

SOURCE: U.S. Bureau of the Census (1996a).

Table compiled by the National Aging Information Center

Race groups and Hispanics

The figures for all race groups combined tend to reflect mainly the changes in the white elderly population. Blacks, Asian and Pacific Islanders, and Hispanics will share in the main trends described, but to a more intensive degree. Between 2010 and 2030, the size of these racial/ethnic groups will increase dramatically. Similarly, dramatic increases are projected between 2030 and 2050 for the 85-and-over age group (Tables 3 and 4a). The rates of growth for Asian and Pacific Islanders (the main component of the "other races" group) and Hispanics far exceed those for whites in all periods. In addition to the role of higher fertility rates, particularly among Hispanics, and lower mortality for both Asian and Pacific Islanders and Hispanics, immigration is a major factor in the growth of these groups. For blacks, higher fertility explains the higher growth rate since net immigration is less important and mortality is higher than for whites.

As a result of these projected differences in growth rates, the racial and ethnic composition of the elderly population will change profoundly in the next 50 years. As shown in Table 4b, Hispanics are expected to constitute 17.5 percent of the elderly population in 2050, as compared with the 4.5 percent estimated for 1995. Furthermore, during this time period, the proportion of elderly within the Hispanic population will increase from approximately 6 percent to a little more than 14 percent. The proportions of blacks and "other races" in the elderly population are also expected to increase. In particular, the proportion of "other races" will more than triple in this period. Conversely, the proportion of whites in the elderly population will decrease, from 90 to 82 percent. If we calculate the percentages for the non-Hispanic white population, the shift is even greater, from 85 to 66 percent, meaning that in 2050 about one-third of the elderly population would be black, Hispanic, or in the "other races" category.

Gender balance

Most elderly, and especially the older aged, are women. Overall, the elderly population in 1995 included 45 percent more women than men, and the older the age group, the lower the proportion of men in the group (Table 1). For example, there are 158 percent more women than men aged 85 years and over in 1995. The projected population imbalance between the sexes is less than it would otherwise be over the next several decades because of an assumption of converging mortality rates. Even so, it is projected that in 2050 women aged 85 and over will outnumber men aged 85 and over by more than 4 million, or nearly 60 percent, and women will make up 61 percent of the population ages 85 and over. As long as the mortality of men, in general, exceeds that of women, women will outnumber men among the elderly, especially among the oldest-old age group.

Table 3 - Projections of the Total and Elderly Populations, by Age, Race, and Hispanic Origin: 1995 to 2050

(Numbers in thousands. Middle series of U.S. Bureau of the Census.)

AGE AND YEAR	WHITE	BLACK	OTHER RACES[1]	HISPANIC ORIGIN[2]
ALL AGES				
1995	218,078	33,144	11,598	26,936
2000	225,533	35,454	13,647	31,365

2010	239,588	40,110	18,019	41,139
2030	269,046	50,001	27,852	65,571
2050	294,614	60,592	38,723	96,508
65+				
1995	30,057	2,718	769	1,505
2000	30,842	2,883	984	1,871
2010	34,416	3,430	1,561	2,847
2030	58,767	6,919	3,692	7,782
2050	64,427	8,613	5,819	13,770
75+				
1995	13,417	1,104	264	557
2000	14,998	1,208	370	751
2010	16,316	1,397	638	1,242
2030	27,650	2,663	1,659	3,361
2050	36,890	4,162	3,074	7,760
85+				
1995	3,307	275	52	131
[illegible]	3,865	317	77	183
2010	5,108	396	166	346
2030	7,327	638	489	988
2050	15,443	1,562	1,218	3,244

SOURCE: U.S. Bureau of the Census (1996a).

[1]Other races category includes Asian and Pacific Islanders and American Indians, Eskimos, and Aleuts.

[2]Hispanics may be of any race.

Table compiled by the National Aging Information Center

Table 4a - Projections of the Percentage Increase in Population, by Age, Race, and Hispanic Origin: 1995 to 2050

(Middle series of U.S. Bureau of the Census.)

AGE AND PERIOD	WHITE	BLACK	OTHER RACES[1]	HISPANIC ORIGIN[2]
ALL AGES				
1995-2010	9.9	21.0	55.4	52.7
1995-2030	24.4	50.9	140.1	143.4
1995-2050	35.1	82.8	233.9	258.3
65+				
1995-2010	14.5	26.2	103.0	89.2
1995-2030	95.5	154.6	380.1	417.1
1995-2050	114.3	216.9	656.7	815.0
75+				
1995-2010	21.6	26.5	141.7	122.6
1995-2030	106.1	141.3	528.4	503.2
1995-2050	174.9	276.9	1064.4	1292.6
85+				
1995-2010	54.4	44.0	219.2	163.4
1995-2030	121.5	132.0	840.4	654.2
1995-2050	366.8	468.0	2242.3	2377.1

SOURCE: U.S. Bureau of the Census (1996a).

[1]Other races category includes Asian and Pacific Islanders and American Indians, Eskimos, and Aleuts.

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[2]Hispanics may be of any race.

Table compiled by the National Aging Information Center

Table 4b - Projections of the Percentage of Persons 65 Years and Over in the Total Population, by Age, for Race Groups and Hispanic Origin: 1995 to 2050

(Middle series of the U.S. Bureau of the Census.)

	PERCENT OF ALL AGES[1]				PERCENT BY RACE[2]			
AGE AND YEAR	White	Black	Other Races	Hispanic Origin[3]	White	Black	Other Races	Hispanic Origin
65+								
1995	13.8	8.2	6.6	5.6	89.6	8.1	2.3	4.5
2000	13.7	8.1	7.2	6.0	88.9	8.3	2.8	5.4
2010	14.4	8.6	8.7	6.9	87.3	8.7	4.0	7.2
2050	21.9	14.2	15.0	14.3	81.7	10.9	7.4	17.5
75+								
1995	6.2	3.3	2.3	2.1	90.7	7.5	1.8	3.8
2000	6.7	3.4	2.7	2.4	90.4	7.3	2.3	4.5
2010	6.8	3.5	3.5	3.0	88.9	7.6	3.5	6.8
2050	12.5	6.9	7.9	8.0	83.6	9.4	7.0	17.6
85+								
1995	1.5	0.8	0.4	.5	91.0	7.6	1.4	3.6
2000	1.7	0.9	0.6	.6	90.7	7.4	1.8	4.3
2010	2.1	1.0	0.9	.8	90.1	7.0	2.9	6.1
2050	5.2	2.6	3.1	3.4	84.7	8.6	6.7	17.8

SOURCE: U.S. Bureau of the Census (1996a).

[1]Represents the percent of the age group in the total population of all ages for the particular race/Hispanic group.

[2]Represents the percent of the race/Hispanic group in the total population of all races for the particular age group.

[3]Hispanics may be of any race.

Table compiled by the National Aging Information Center

Age structure

By itself, the size of the population in the various age segments will not determine the demand for services or the extent of participation in public programs. However, the age structure of future populations will affect the social and economic condition of the Nation, in particular as regards support for the economically dependent classes in our population.

The extent of labor force participation at the various ages, including the older ages, and the ages of retirement also will be influential, as will related economic factors such as the levels of productivity, unemployment, and cost of living. We consider the effect of labor force changes in the next section.

In this subsection, we describe the changes in age structure, i.e., the relative numbers of the age segments. Here, we discuss three dependency ratios: (1) the elderly dependency ratio, (2) child dependency ratio, and (3) total dependency ratio. By elderly dependency ratio we mean the number of persons 65 and older for every 100 persons 18 to 64. The child dependency ratio is expressed as the number of persons under 18 for every 100 persons 18 to 64. The total dependency ratio is expressed as the number of persons under 18 plus 65 and older per 100 persons 18 to 64.

The Bureau of the Census population projections initially show only small increases in the elderly dependency ratio from 20.9 in 1995 to 21.2 in 2010. Then, steep increases are projected during 2010 to 2030, with stability occurring at the level of 36 from 2030 to 2050 (Table 5). These changes in the ratios result from the entry of the baby-boom cohorts into the older age groups during 2010 to 2030, and the aging of the cohorts that follow the "baby boomers" (also known as the "baby bust" cohorts). Over the same decades, the child dependency ratio shows a modest U-shaped trend, meaning that the numbers decline from 43 persons under 18 per 100 persons ages 18 to 64 in 1995 to 39 in 2010, and then increase to 43 in 2030. The total dependency ratio will be lower in 2010 than in 1995. Between 2020 and 2030, however, the total dependency ratio will rise sharply, stabilizing at nearly 80 over the years 2030 to 2050. In fact, in the period 2010 to 2030, both the total dependency ratio and its component ratios will rise. Then, the ratios remain nearly unchanged from 2030 to 2050 as the age structure of the population stabilizes.

Table 5 - Projected Total, Child, and Elderly Dependency Ratios: 1995 to 2050

(Ratios expressed per 100 population. Middle series of U.S. Bureau of the Census.)

YEAR	TOTAL[1]	CHILDREN[2]	ELDERLY[3]
1995	63.7	42.8	20.9
2000	62.4	41.8	20.5
2010	60.2	39.0	21.2
2020	68.2	40.4	27.7
2030	78.7	43.0	35.7
2040	79.7	43.1	36.5
2050	79.9	43.9	36.0

SOURCE: U.S. Bureau of the Census (1996a).

[1]Ratio expressed as the number of persons under 18 plus the number of persons 65 years and over per 100 persons 18 to 64.

[2]Ratio expressed as the number of persons under 18 per 100 persons 18 to 64.

[3]Ratio expressed as the number of persons 65 years and over per 100 persons 18 to 64.

Table compiled by the National Aging Information Center

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Hypertext conversion by Saadia Greenberg, January, 1997

Congressional Quarterly Weekly Report, Sep 13, 1997 v55 n36 p2146(4)

Critics: law could be unhealthy for elderly - and for medicare. (includes related article on medicare options) *Mary Agnes Carey.*

Abstract: With the signing of the balanced-budget agreement on Aug. 5, 1997, Pres. Bill Clinton enacted new legislation that would let individuals covered by Medicare choose from a wider range of health care plans. In addition to the common fee-for-service plan, senior citizens will be able to join a managed care organization or set up a medical saving account. Seniors can also choose a private fee-for-service plan or contract privately with a doctor. Critics of the plan are concerned that managed care will not provide the care necessary for sick elderly because of cost control efforts.

Article A19844110

Journal of Aging Studies, Fall 1997 v11 n3 p171(5)

Health care reform: implications for seniors. *Neena L. Chappell.*

Abstract: Changes in the old health care policies will be evident in the 1990s as an offshoot to the growing concern on health care costs. This will involve less government involvement but will reflect a strong interventionist state policy. Most likely to be affected are the senior population. They will be instrumental in dismantling universal Medicare since they are likely to support private health care to get away from the hassles of waiting lists and other disadvantages of a cutback universal system. A medicalization of community care is emerging rather than social care expansion.

Article A20007433