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The Challenge of an Aging Population

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CHAPTER SEVEN

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The "Graying of American society" is the concept used to explain the reshaping of the population of the United States. This transformation of American society has already led to the emergence of many challenges, both at the federal and state levels. Foremost among these is how to provide for the quality of life of the elderly at a time when societal resources are stretched to the limit. Specifically, the provision of economic security, affordable health care and long-term care, adequate housing, and supportive services are necessary to maintain the well-being of an expanding elderly population.

To understand the challenges of an aging population faced by the state of Connecticut, the state must be placed within the context of the population revolution that has been going on in American society since the middle of the last century. However, the population projections for the future make the current challenges pale in comparison to those the society will face during the first fifty years of the twenty-first century. In the early 1900s, the United States was a young nation, with 50% of its population less than twenty-three years old, and a small percentage (4%) of the population over sixty-five. At that time, the median age of the American population was 22.9. The tripling of the sixty-five and older age category by the beginning of the twenty-first century brought the median age to 35.5, and elderly persons outnumbered teenagers.[1]

The predictions for the next thirty years indicate that the sixty-five and older age category will make up 22% of the population. This substantial increase reflects the entrance of the baby boomers into that age group. And by 2030, the population of the United States will be reshaped to the point where more than 50% of Americans will be over 40 years old, and the median age will be over 39.[2]

The social structures of American society are severely affected by this transformation of its population. The older the population of a society, the more resources it must commit to assure the well-being of its elderly members. During a period of slow economic growth, this presents a major challenge for the society. Allocating resources to assure the well-being of its elderly population requires a balancing act on the part of the society, for inevitably people of different age categories are affected by the unavoidable shift in the allocation of resources that must be committed to the elderly segment of the society. Table 1 demonstrates the shifts in the age distribution of the population from 1998 to 2025.[3]

Table 1
Age Distribution of U.S. Population from 1998-2025

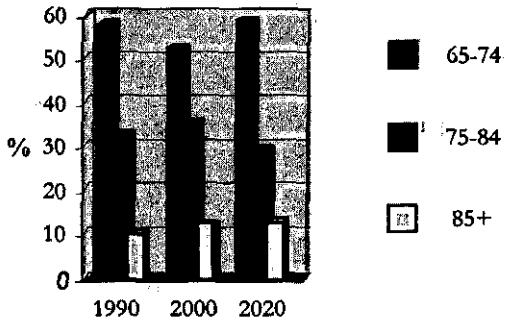
	1998	2000	2005	2015	2025
Age					
0-4	7.0	6.8	6.7	6.7	6.6
5-17	18.8	18.7	18.3	17.0	17.2
18-24	9.4	9.7	9.9	9.7	9.0
22-64	52.0	52.4	52.5	51.9	48.7
65 and over	12.7	12.4	12.6	14.7	18.5

Source: U.S. Census Bureau, National Population Projections.

According to a publication by the Office of the Administration on Aging, "A Profile of Older Americans: 2002," about one in every eight persons in the population is an older American. The sixty-five and older social category was overwhelmingly female. In 2000, there were 20.6 million older women to 14.4 million men, a ratio of 143 females to 100 males. The majority of the women seventy-five and older lived alone. The life expectancy of a female

who became sixty-five in 1998 was 84.2 years, and for a male it was 81.3 years. About one third of the non-institutionalized older persons lived alone. Since 2000, the real median income of older people has suffered a decrease of 2.6%. The number of older Americans living below poverty level in 2001 was about 1.1%, and 2.2% fell in the category of the "near poor." The Social Security Administration indicates that for 90% of retired older people, Social Security benefits are one of the primary sources of their income.[4] Because it is the group that requires more services, the eighty-five and older age category is significant not only in terms of allocation of resources, but also because it is the fastest growing age category. Graph 1 presents the age distribution of the sixty-five and older population of the United States. While the seventy-five to eighty-four category decreases by 3.4%, the eighty-five and older group increases continuously by 4%.[5]

Graph 1
Age Distribution in the U.S.
Population 65+ from 1990-2020

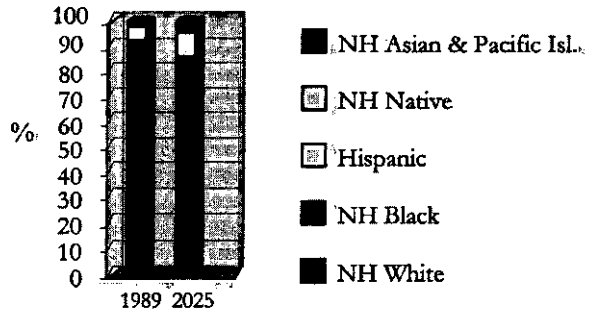


Source: U.S. Census Bureau.National Projections, 2000.

Since the racial and ethnic distribution of the sixty-five and older population in the United States reflects the racial and ethnic distribution of the total population,[6] graph 2 gives an indication of the change in the diversity of the sixty-five and older age category. Except for the non-Hispanic white group, which will

experience a decrease in its elderly population by 2025, other ethnic and racial groups 65 and older will grow in their numbers. Although the non-Hispanic Black group is experiencing rapid growth, it is projected that Hispanic elderly will outnumber non-Hispanic Black elderly persons in 2025.[7]

Graph 2
Racial and Ethnic Distribution of
U.S. Population 65+ from 1998-2025



Source: U.S. Census Bureau National Projections, 2000.

The brief survey of the challenges of an aging population at the national level presented above provides a context for understanding how these challenges are mirrored in Connecticut. Additionally, the survey provides a background for understanding how the state, through its policies on aging, is addressing the health care, long-term care, housing, economic security, and supportive services for its older residents, and how it is planning for an increase in this age category in the future.

Table 2 presents the age distribution of the population of Connecticut from 1995 to 2025. The data indicate that until the year 2000, the sixty-five and older age category in Connecticut made up a larger percentage of the state's population in comparison to the elderly population at the national level. The same holds true for the projections for 2005 and 2015. However, in 2025 the projected increase for Connecticut is 1% lower than the increase projected for the nation.[8]

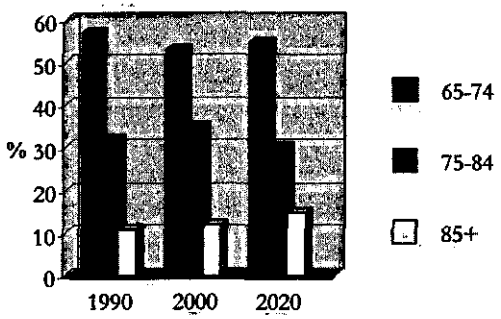
Table 2
Age Trends (% of Total Population) in Connecticut: 1995-2025

Age	1995	2000	2005	2015	2025
0-4	6.9	6.4	6.1	6.4	6.5
5-17	17.4	17.6	17.2	15.9	16.3
18-24	8.2	8.3	8.9	9.2	8.5
25-64	53.1	53.5	53.8	53.3	50.5
65 and up	14.2	14.0	13.7	15.0	17.9

Source: U.S. Census Bureau. Population Projections for States, 2000.

The fastest growing age category in Connecticut, as is the case nationally, is the eighty-five and older population. The data in graph 3 show that, while all other categories experience a 2% decrease, the eighty-five and older category in Connecticut increases continuously by 4% from 1990-2020.[9]

Graph 3
Age Distribution of Connecticut
Population 65+ from 1990-2020

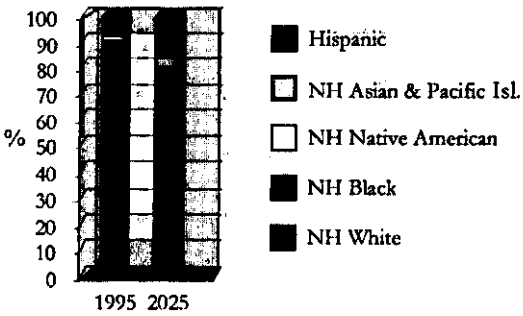


Source: U.S. Census Bureau National Projections, 2000.

The data in graph 4 point out that the non-Hispanic white group sixty-five and older in Connecticut will decrease by 13% between 1995 and 2025, a slightly larger decrease than nationally. However, it is projected that all other racial and ethnic groups in

the state, just as in the nation, will experience an increase. Although at the national level the Hispanic group will outnumber the non-Hispanic Black group in 2025 by 1%, in Connecticut it will be larger by 5.2%.[10]

Graph 4
Racial and Ethnic Distribution of Connecticut
Population 65+ from 1995-2025



Source: U.S. Census Bureau National Projections, 2000.

As the data presented above indicate, the rate of growth and the characteristics of the sixty-five and older residents of Connecticut create many challenges, especially during a period of slow economic growth. These challenges have expanded significantly over the past three years due to budgetary constraints combined with rising costs in health and long-term care, housing, and supportive services. Nonetheless, the priority of maintaining and improving the quality of life for elderly persons accentuates the need to support their capacity to live in their own homes for as long as possible with dignity and maximum independence. To address this need, it is imperative that the elderly have access to an array of community services including at the very least affordable health care, housing, and transportation.

Since the enactment of the Older Americans Act in 1965, the aging population in Connecticut has seen significant growth in the allocation of resources needed for nutrition, socialization, housing, health care, prescription drugs, long-term care, protection

and advocacy, transportation, and financial assistance. During the late 1990s, when the state budget surplus totaled more than $500 million, funds were appropriated to expand such programs as Connecticut Phramaceutical Assistance Contract to the Elderly and Disabled (ConnPACE), the Connecticut Home Care Program for Elders (CHCPE), the Elderly Nutrition Program (Meals-On-Wheels and congregate meals), the Statewide Respite Program (caregivers' support), Senior Centers, Dial-a-Ride (transportation services), subsidized housing, assisted living, adult day care, and the State Long-Term Care Ombudsman Program (protection of seniors from abuse).

Despite such expansion of programs and services to the elderly, several areas of unmet need are identified in the 2002-05 Connecticut State Plan on Aging, including, among others, health promotion and disease prevention, economic security, housing, transportation, accessibility of services for target populations (older, lower income, minority group members), and of particular importance, long-term care.[11] In recent years, due to budgetary constraints, the above-listed categories were subjected to funding cutbacks. As a result, the state faces ongoing challenges in developing a satisfactory and stable level of services for the elderly that is not vulnerable to economic fluctuations.

Within the category of health promotion and disease prevention, two service areas have been defined as needing further attention in consumer and provider surveys, needs assessments, and statistical studies: elderly nutrition and prescription drug benefits. Elderly nutrition is cited as one of the factors most likely to prevent premature institutionalization, due to the fact that poor nutrition places seniors at serious risk of chronic health problems, which frequently necessitate nursing home placement.[12] By 2002, $250,000 had been cut from the Elderly Services budget line for nutrition programs, including Meals-On-Wheels and congregate meals.[13] With the introduction of Committee Bill 729 in 2003, funding was restored to the previous level, but the possibility exists that in the future there may be "a reduction in funding for home-delivered meals, resulting in the implementation of waiting lists."[14]

The second area cited—the rapidly escalating cost of prescription drugs—has caused growing concern on the part of

Connecticut legislators since the introduction of the state-funded Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (ConnPACE) in 1987. Although ConnPACE provides assistance for lower-income persons 65 years of age or older or those who receive Social Security disability benefits, in 2001 165,000 Connecticut seniors still lacked prescription drug coverage, due to the fact that the income limits had not been modified for many years.[15] In 2002 changes in the law expanded the capability of seniors to receive prescription drug assistance through a state application to the federal government for a waiver to use Medicaid dollars to help support the ConnPACE Program. However, with the ensuing budget crisis that occurred in 2002, Governor Rowland proposed several cost containment limitations to the ConnPACE program that would include asset testing for assistance, imposition of asset recovery provisions on estates following the death of ConnPACE recipients, prior authorization for costly drugs, allowance of generic drugs only, and increases in the application and co-pay fees.

With a budget surplus in 2004, the state legislature appropriated $1.25 million to eliminate the ConnPACE asset test and estate recovery requirements, and appropriated $14.5 million to repeal the Medicaid co-payments that were enacted in 2003.[16] Additional legislation was passed that maximizes the use of federal benefits for recipients of the ConnPACE program through a requirement that program participants with incomes below 135% of the federal poverty level obtain a Medicare Discount Drug Card to be used in conjunction with ConnPACE. Through combined benefits, the participant will pay the lower of the two co-pays up to the $16.25 limit imposed by the ConnPace program.[17] Despite these recent enhancements to the prescription drug benefits, advocates for the elderly in Connecticut are concerned that future budget crises may produce further reductions in eligibility limits and additional out-of-pocket expenses for low-income seniors on fixed incomes.

Uneasiness over the future of Social Security, Medicare, and pension income have produced a general sense of economic insecurity in later life. In 2000, almost 4% of the state's elderly population was below the poverty level and experienced difficulty

in meeting such specialized needs as paying for the high cost of medical care and prescription drugs, housing, nutritional meals, transportation, and personal care services.[18] While the segment of the aging population with the lowest income has access to an array of federal and state-funded programs and services, those whose income is slightly above Medicaid guidelines are ineligible for assistance. Over the past two years, in response to budget deficits, the state of Connecticut has enacted legislation that lowers state costs for services and raises out-of-pocket expenditures for consumers. For example, as of October 1, 2003, increases in co-payments for prescription drugs have been imposed on Medicaid recipients. Furthermore, recent legislation has attempted to require the elderly to assume a greater share of the expenses for their long-term care. Examples include the state's Partnership Program, which promotes long-term care insurance policies; proposed changes in the penalty period for transfer of resources; transferee liability; and "Income-First," which redefines how a couple's assets are divided when one spouse requires nursing home care. In response to such measures, advocates of the elderly support expansion of eligibility limits for services, along with protection of the consumer who is ineligible for Medicaid support.[19] The vast majority of elderly experience substantial cuts to their incomes following retirement. As the costs of services increase, aging persons, and especially those on fixed incomes, become less self-reliant and increasingly dependent on the state to provide for their basic needs.

Subsidized housing and transportation services for the elderly are two elements of independent living that promote security, self-sufficiency, and the capacity to remain in one's home and community. In its 2001-05 Area Plan on Aging, the South Central Connecticut Agency on Aging cited "Connecticut's failure to provide adequately for the transportation and housing subsidy needs of its older adults" as a barrier that decreases accessibility to the state's elderly services network.[20] Further, "In its 2001 Long-Term Care Plan, the Long-Term Care Planning Committee recognized that expanded transportation services and accessible housing are integral supports that allow older adults . . . to live successfully in the community."[21]

Most elderly persons choose to live in their own homes with supportive services that allow them to remain independent. However, the exorbitant cost of home care can deplete an individual's resources within a relatively short period of time. For such individuals, the only alternative may be Medicaid-supported nursing home care. The 1999 U.S. Supreme Court Olmstead decision, which affirmed the right of people with chronic illnesses or disabilities to avoid institutionalization and remain in the community with appropriate support services, highlights the demand for more affordable, accessible housing and assisted living options.[22] Moreover, significant increases in the cost of nursing home care have created a need to examine other viable alternatives for frail elderly who require services. In response to the Olmstead decision and the growing need for housing options, Connecticut has initiated several pilot projects that provide subsidized assisted living to elderly and disabled persons. Unfortunately, however, eligibility requirements still limit access to assisted living to those who can self-pay and low-income individuals eligible for Medicaid. Major housing priorities for the State of Connecticut over the next few years will include: expansion of access to assisted living by low- and moderate-income elderly, raising income limits for housing assistance, expansion of Reverse Annuity Mortgage (RAM) loans, and the provision of alternative housing options, along with increased subsidies for elderly housing.

Those most in need of transportation services tend to be older, lower income, minority group members who live alone and require assistance with personal care and routine activities. According to the 2003 Legislative Summary by the Connecticut Elder Action Network (CEAN), the state has not met the need for elderly transportation services due to insufficient funding, lack of state oversight for dial-a-ride programs, and because no coordinated system of regional transportation services exists for older persons.[23] The Elderly Services Division of the Connecticut Department of Social Services stated as one of its objectives in the 2002-05 Connecticut State Plan on Aging that it would expand its advocacy efforts to establish coordinated transportation services for the elderly and disabled and would explore the feasibility of innovative transportation programs.[24] No new legislation on

transportation services was introduced in the 2003 session of the legislature. In 2004, House Bill #5006 proposed that $500,000 be allocated to the Department of Transportation to assist municipalities in funding the Dial-a-Ride program; however, no action was taken on this bill prior to the close of the legislative session.[25]

Although lower income, minority seniors comprise the group of elderly who are most in need of supportive services, they are also more likely to experience economic, cultural, linguistic, and informational barriers to services. Moreover, African-American and Hispanic elderly tend to under-utilize the health care system and therefore are more vulnerable to chronic illness and eventual nursing home placement.[26] Due to the significant growth in Connecticut's minority population over the past ten years, a commitment to serving older, low-income members of minority groups has received increased attention in the legislature and in the State and Area Plans for services to the elderly. Other target populations that have been prioritized in the 2002-05 Connecticut State Plan on Aging include older women, isolated elderly, and residents of rural communities.[27]

Historically, long-term care was interpreted to mean nursing home placement, and the state legislature traditionally supported funding for nursing home care as the primary response to an aging and infirm population in their later years. Medicaid reimbursement has also favored institutional care over home and community-based care. During the 1990s, Connecticut allocated the vast majority of the state's Medicaid long-term care spending for institutional care. The past decade, however, has witnessed a growing movement toward assisting elderly persons in their capacity to remain independent and continue to live in their homes and communities. The 2004 Long-Term Care Plan for Connecticut states that "Individuals should receive care in the least restrictive setting with institutional care provided as a last resort."[28] And, as noted in the 2001-05 Area Plan for Aging, "Today, the expansion of the long-term care system into a continuum of interrelated home and community-based services has become a high order priority at both the state and local levels in Connecticut."[29]

At a cost of almost $60,000 per year for nursing home care in Connecticut, and with the growing numbers of older elderly persons (eighty-five years and older) who require care, the state is being forced to adopt measures to ensure a balance in the proportion of funding allocated to institutional and home-based care. Although there has been a slight shift in recent years, during 2003 70% of Medicaid long-term care funding was still allocated to institutional care, while only 30% was spent on community-based services[30] Moreover, 52% of elderly persons received Medicaid funding for institutional care, while only 48% received assistance for community-based care.[31] To increase the percentage of Medicaid spending for community-based care, the state has enacted legislation in recent years that expands home and community-based services through CHCPE. Other measures recently adopted by the state legislature have eliminated the income eligibility caps for CHCPE, and offer additional assisted living and elderly housing options. Nonetheless, substantial increases in spending for home care will need to be undertaken to meet the objectives of the 2004 Long-Term Care Plan for providing community-based care to 75% of the elderly population by 2025.[32] As noted in the Connecticut Elder Action Network (CEAN) 2004 Legislative Summary, "Despite significant commitment on the part of the State to the concept and practice of home and community-based care, however, the level of public resources devoted to institutional care still remains disproportionate to that expended for home care supports."[33]

Thus, as the baby boomers approach retirement age and the growth in the elderly population begins to expand rapidly during the first quarter of the twenty-first century, Connecticut will face daunting challenges in providing vital resources and services to its elderly population. Specifically, Connecticut needs to provide economic security, affordable health care and long-term care, adequate housing, and supportive services necessary to maintain the well-being of its expanding elderly population. Moreover, the relatively recent shift in thinking about how to care for the aging population necessitates taking a fresh look at the proportion of Medicaid dollars allocated to institutional versus home and community-based care. Finally, the commitment to individual

choice, to independent living for as long as possible, and to community-based care will depend on the willingness and capacity of the legislature to seek innovative methods of funding services for the elderly of Connecticut.

Notes

1. Federal Interagency Forum on Aging-Related Statistics. Last updated December 16, 2003. www.agingstats.gov.

2. Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 2025 to 2045. U.S. Census Bureau, 2000. www.census.gov/population/projections/nation/summary.

3. U.S. Census Bureau, 2000, Projections of the Total Resident Population by 5-Year Age Groups, and Sex with Special Age Categories: Middle Series, 1998 to 2025. www.census.gov/population/projections/nation/summary.

4. Administration On Aging, "A Profile of Older Americans: 2002." Last updated October 2, 2003. www.aoa.gov/prof/Statistics/profile/highlights.asp.

5. U.S. Census Bureau, 2000, Projections of the Total Resident population by 5-Year Groups and Sex with Special Age Categories: Middle Series, 2000, 2020. www.census.gov/population/projections/nation/summary; General Population Characteristics, United States, U.S. Census Bureau 1990 (CP-1-1), www.census.gov

6. U.S. Census Bureau, Total Population by Age, Race and Hispanic or Latino Origin for the United States: 2000, www.census.gov/population/cen2000/phc-t9/tab01.xls.

7. Total Population by Age.

8. Projections of State Populations, By Age and Sex 1995 to 2025 www.census.gov/population/state.

9. Projections of State Populations. "Connecticut State Plan on Aging," Department of Social Services-Elderly Services Division, October 1, 2002 to September 30, 2005, p. 10.

10. Projections of State Populations, By Sex, Race, and Hispanic Origin 1995 to 2025 www.census.gov/population/state.

11. "Connecticut State Plan on Aging," Department of Social Services-Elderly Services Division, October 1, 2002 to September 30, 2005, pp. 14-25.

12. "Elderly Services: Preserving Dignity and Saving Tax Payer's Dollars" www.cafca.org/legislative/2003Elderly.pdf.

13. "Report on Bills Favorably Reported by Committee," Select Committee on Aging www.cga.state.ct.us/2003/jfr/s/2003SB-00729-ROOAGE-JFR.htm.

14. Beverly Kidder, "CT Legislative Agenda/Seniors," personal e-mail, January 14, 2004.

15. "Connecticut's Prescription Drug Assistance Program Expanded," www.aarp.org/ct/Articles/a2002-06-26-ct-feature-prescription drug.html.

16. "OLR Major Acts," Regular Session and May 2004 Special Session, Office of Legislative Research, May 7, 2004. www.cga.state.ct.us/2004/rpt/2004-R-0411.htm.

17. "OLR Major Acts."

18. "Connecticut State Plan on Aging," Department of Social Services—Elderly Services Division, October 1, 2002 to September 30, 2005, pp. 10, 12.

19. "2003 Legislative Summary," Connecticut Elder Action Network, October, 2003, pp. 5- 6. www.agencyonaging-scc.org/Advocacy/CEAN-summary.htm.

20. "Area Plan on Aging for the South Central Connecticut Planning and Service Area," South Central Connecticut Agency on Aging, October, 1, 2001 through September 30, 2005, p. 100.

21. "Area Plan on Aging."

22. Judith Lohman, "Major Issues for 2003," Office of Legislative Research, November 21, 2002. www.cga.state.ct.us/2002/olrdata/lm/rpt/2002-R-0927.htm.

23. "2003 Legislative Summary," Connecticut Elder Action Network (CEAN), October, 2003, p. 9. www.agencyonaging-scc.org/Advocacy/CEAN-summary.htm.

24. "Connecticut State Plan on Aging," Department of Social Services-Elderly Services Division, October 1, 2002 to September 30, 2005, p. 6.

25. "2004 Legislative Summary," Connecticut Elder Action Network (CEAN), June 2004, p. 9, www.agencyonaging-scc.org/Advocacy/CEAN-summary.htm.

26. "Area Plan on Aging for the South Central Connecticut Planning and Service Area," South Central Connecticut Agency on Aging, October, 1, 2001 through September 30, 2005, p. 87.

27. "Connecticut State Plan on Aging," Department of Social Services-Elderly Services Division, October 1, 2002 to September 30, 2005, p. 24.

28. "Balancing the System: Working Towards Real Choice for Long-Term Care in Connecticut," Report to General Assembly, Long-Term Planning Committee of the State of Connecticut, January 2004, p. 10.

29. "Area Plan on Aging for the South Central Connecticut Planning and Service Area," South Central Connecticut Agency on Aging, October, 1, 2001 through September 30, 2005, p. 77.

30. "Balancing the System: Working Towards Real Choice for Long-Term Care in Connecticut," Report to General Assembly, Long-Term Planning Committee of the State of Connecticut, January 2004, p. 2.

31. "Balancing the System," p. 3.

32. "Balancing the System," p. 4.

33. "2004 Legislative Summary," Connecticut Elder Action Network, June 2004, p. 13.