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Four pillars of aging policy in the United States

Keywords: long-term services and supports, Social Security, Medicare, end-of-life, United States

Abstract

To understand aging policy in the United States, it is critical to understand the federal budget, which along with national defense is dominated by Social Security, the publicly funded pay-as-you-go universal retirement program, and health care programs largely targeting the elderly (Medicare) and the poor, including the poor elderly (Medicaid). Not only is a large portion of the U.S. federal budget spent on elders, spending under these categories is mandatory: in other words, Social Security, Medicare, and Medicaid are entitlements, guaranteed by law. Politicians therefore have limited ability to allocate funds elsewhere. Discretion is further limited by the fact that currently, the U.S. budget is operating under a deficit. These budgetary pressures have evoked a variety of policy responses, which vary according to political affiliation. No matter the ideological vantage point, however, the spiraling cost of existing commitments has prevented serious consideration of other, emerging public policy issues in aging, such as the perilous state of systems for providing long-term services and supports (LTSS). Still, one bright spot is increasing attention to end-of-life issues – most likely because this is viewed as a cost-saver. It is because of Social Security, health care, LTSS, and end-of-life care that aging policy is central to the current budgetary and political debate

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in the U.S., a position that will only grow with time with the aging of the unprecedentedly large "baby boom" cohort born between 1946 and 1964. The irony is that these programs are in fact hugely popular among recipients and potential recipients. That is not to say that Social Security and programs providing health care to the poor and the elderly do not need reforming: there is enormous waste in the system. Yet sensible proposals for reform are often stymied by political obstructionism. So, too, are attempts to plan more systematically and thoughtfully about the growing aging population in the U.S. An advantage of the U.S. federal system of government is that in some cases progress can be made at the state-level such as with LTSS and end-of-life care; the downside is that this creates enormous cross-national disparities and that it fails to utilize the tools and the power that central government alone can provide.

Introduction

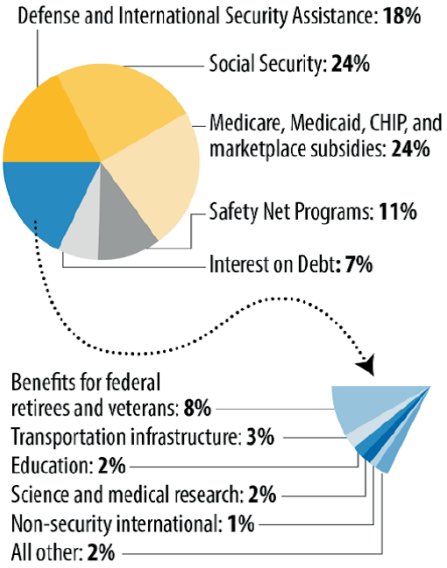
To understand aging policy in the United States, it is critical to understand the federal budget, one of its key drivers. Figure 1 shows how the budget, which will amount to $2.8 trillion (€2.5 trillion) in 2015, is allocated (Center for Budget & Policy Priorities, 2015). Nearly a quarter of spending (24%) goes toward Social Security, the publicly funded pay-as-you-go universal retirement program. A further 24% goes toward healthcare programs. Although these programs cover populations other than elders, the bulk of spending is on older people. Additionally, 8% of federal spending goes toward federal retirees and Veterans. Spending under these categories is also mandatory: in other words, these programs are entitlements, guaranteed by law. Politicians therefore have limited ability to allocate funds elsewhere. This discretion is further limited by the fact that currently, the US budget is operating under a deficit – that is, the US is spending more money than it is collecting in revenue (Congressional Budget Office, 2015).

Interest payments on this debt thus comprise a significant portion of the budget, a portion that is projected to rise over time as the population ages and the need to fund those commitments – that is, entitlement programs – increases (See Figure 2).

Between 2010 and 2050 the population aged 65 years and older in the U.S. will more than double from 40.3 to 88.5 million, or from 13% to 20.2% of the total population (Federal Interagency Forum on Aging-Related Statistics, 2012). The population with the most significant health needs – the population eighty-five years and older – will nearly quadruple, going from 5.5 to 19.0 million during this time period, or from 1.9% to 4.3% of the total population. In light of population aging, the U.S. has made promises in the way of Social Security and health care to its elderly citizens that it is poorly prepared to deliver on.

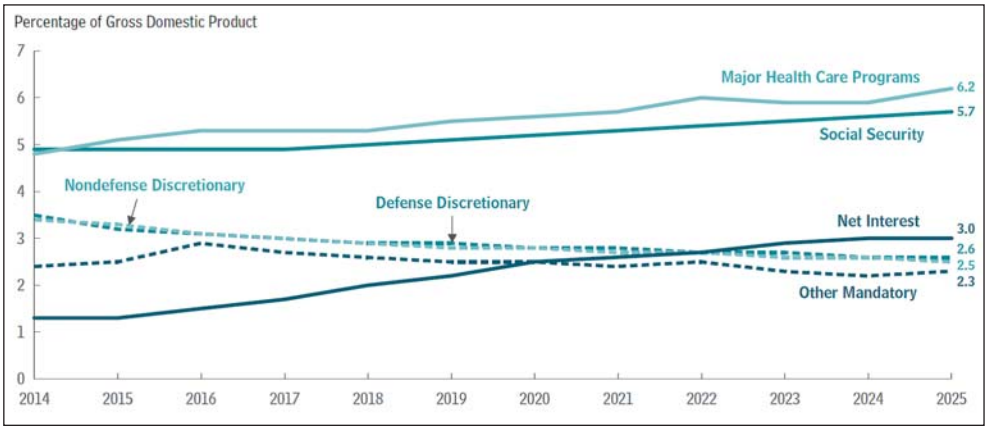
These budgetary pressures have evoked a variety of policy responses, which vary according to political affiliation. To conservatives, these pressures underline the failings of

Figure 1. The 2014 U.S. Federal Budget: Breakdown by Major Program Areas



Source: Center on Budget & Policy Priorities (May, 2014) analysis of Office of Management and Budget Data, FY 2016 Historical Tables

Figure 2. Projected Outlays for Major Budget Categories, 2014–2025



Source: Congressional Budget Office (January 2015)

"big government" and the pitfalls of shifting responsibility for old age security out of the private sphere and into the public. Liberals, on the other hand, see the social safety net as inadequate and poorly managed due to lack of investment. Both sides agree, however, that reforms are needed – although the extent to which they are needed, and the specific

reforms that are seen as necessary, differ sharply. No matter the political vantage point the spiraling cost of existing commitments has prevented serious consideration of other, emerging public policy issues in aging, such as the perilous state of systems for providing long-term services and supports. One bright spot is increasing attention to end-of-life issues – most likely because this is viewed as a cost-saver.

Social Security

More than three-quarters (77%) of Social Security funding goes toward older people (Center on Budget & Policy Priorities, 2012). (The remainder provides income for younger disabled persons and survivors, including children.) Funded out of a payroll tax, split between employees (who pay 6.2% of income) and employers (who pay the same), the program is funded as a pay-as-you-go system, although surpluses are meant to be earmarked to a Social Security Trust Fund – which, unfortunately, has been repeatedly raided to narrow the federal budget deficit and for other purposes over time. The most current estimates from the Social Security Trustees project indicate that the trust fund will be depleted by 2034 for the old age and survivors' portion of the program (Social Security Administration, 2015). However, such projections depend on a range of assumptions and forecasts – about, for example, growth in the economy and employment rates – which are hotly contested and are, to some extent, unpredictable (Blahous, 2015). So, too, are the implications of future funding deficits, which are estimated at about 1% of GDP over the longer term (Munnell, 2014). While it is clear that shortfalls are inevitable, steps for addressing them range from cutting benefits (by raising the retirement age, for example) to increasing revenues (by raising the cap on income that can be taxed). Some argue that a major overhaul of the program is needed, while others see the need for only minor tweaks.

The debate over the future of Social Security is colored by the current political focus on inequality in the U.S., and the sense that the political system is working only for the wealthy, a view endorsed by 61% of Americans (DeSilver, 2013); moreover, the public largely believes that this trend towards growing inequality in income and influence is only increasing over time (Pew Research Center, 2014a). Such beliefs diverge along political lines, with Democrats (liberals) more likely to agree with this assessment than Republicans (conservatives). The facts about inequality are well-known: income and wealth are concentrated to an extent not seen for nearly a century (Kreuger, 2012). More importantly, however, income and wealth among poor and middle-income people has not risen, in real terms, while large increases in income and wealth has been seen among the wealthy (Saez and Zucman, 2014; Stone, Trisi, Sherman, & DeBot, 2015). Such inequality is cumulative over time, resulting in an aging population with fewer chances of attaining a secure retirement than their predecessors. Most Medicare beneficiaries – 83% of whom are seniors – have limited income and asset levels. For example, 92%, 53%, and 27%

of beneficiaries have incomes below $75,000 (€67,530), $25,000 (€22,510), and $15,000 (€13,506), respectively (Jacobson, Huang, Neuman, & Smith, 2014). Similarly, 59%, 46%, and 24%, respectively, have savings below $100,000 (€90,023), $50,000 (€45,011), and $10,000 (€9,003). Moreover, 50% had home equity below $66,700 (€60,051) and 25% below $12,250 (€11,029); 21% had no home equity at all.

A dearth of income and assets in retirement has increased the importance of the Social Security safety net. For a full 21% percent of households with a recipient 65 and older, Social Security represents their entire income, while for nearly 60%, it represents 50% or more of their total income (Social Security Administration, 2014). Minorities are even more dependent on Social Security than whites, with, for example, 41% of Hispanics relying solely on Social Security for retirement income (Social Security Administration, 2014). Moreover, benefits are modest: the average Social Security benefit for retired workers was $15,943 in 2014, only a bit higher than the federal poverty level of $11,670 (Ruffing & Van de Water, 2015). This benefit amounts to about 41% of the median worker's income, compared to a 58% average across OECD nations (Ruffing & Van de Water, 2015).

Thus debate over Social Security reform is constrained by the very real need for the program and considerable public support for it, with 87% of the public believing that it "has been good for the country" (Kohut, 2012). Indeed, it is known as the "third rail of American politics" – a reference to the live electric rails on American train lines that kill anyone who comes into contact with them. The last major proposal to reform the program, G.W. Bush's bid to transfer a portion of beneficiaries' Social Security contributions into individual retirement accounts, garnered intense opposition and has dim prospects for revival, particularly after the 2008 stock market crash. Realistic proposals for reform, therefore, are limited to calls to raise the full retirement age (which has already been raised from 65 to 67 for people born after 1954); means-test benefits so that wealthier people receive less than they already do under the currently progressive benefit structure; or change the mechanism by which benefit amounts are adjusted for inflation to a less generous one. However, benefit cuts of any kind are unpopular: over two-thirds of the public opposes them, including most political conservatives (Pew Research Center, 2014b). More popular are proposals to increase revenue, by raising the amount of income on which the payroll tax is levied or by increasing the payroll tax, measures which appear to have significant public support (Tucker, Reno, & Bethell, 2013). Indeed, many experts agree that such adjustments would likely address much of the Social Security funding shortfall. Unfortunately, the current political stalemate in Washington means that even moderate proposals for reform that have wide public support are unlikely to be instituted.

Medicare

Medicare is arguably one of the biggest threats to the federal budget, more so than Social Security. The future costs of the program are unpredictable both on the demand side –

because it is challenging to predict the future health needs of the older population – and on the supply side, where the costs of labor and future technology as well as the evolution of the insurance and health care industries are highly unpredictable. Thus, it is difficult to project future liabilities in the same way that we can predict Social Security costs. However, there is little doubt that future Medicare costs will be high, both in light of the sheer number of elders being served and the persistence of cost increases that outpace inflation. Historically (1969-2013), average annual costs per Medicare enroll increased by 7.5%, compared to 9.1% in the private sector (The Henry J. Kaiser Family Foundation, 2015b). Over the same time, inflation went up 6.3% per annum, on average (Bureau of Labor Statistics, 2015). Per capita Medicare program increases are expected to moderate to an average of 4.1% from 2014-2024, down from 7.0% during 2000-2010 (The Henry J. Kaiser Family Foundation, 2015b). However, these expected increases still outpace the expected average annual projected inflation rate of 3.4% over the same period, creating continuing pressure on the federal budget.

In addition to its increasing costs, the program also suffers from an outdated structure. The Medicare program grew incrementally, initially having two parts: Part A, which mainly covered hospital expenses, and Part B, which covered outpatient expenses. The two parts were financed differently, with Part B charging premiums. Over time, the program has added a Part C – private insurance plans that cover Part A and B services – and a Part D, which covers prescription drugs. In addition, many participants (called "beneficiaries") supplement their Part A, B, and D coverage with plans that cover gaps in coverage. This is all very confusing for beneficiaries, who need to make the choice of whether to stick with traditional Medicare Part A and B coverage or join a Part C plan. If they do so, they must then choose among plans. In addition to its confusing structure, the program has been slow to update how services are delivered and what benefits are covered. For example, it has only slowly begun to cover mental health as comprehensively as it covers physical health (Ostrow & Manderscheid, 2010), and the lack of dental coverage is becoming increasingly indefensible as evidence on the link between dental and physical health becomes stronger (Ornstein, et al. 2015). Reforms are needed.

Yet Medicare reform is far more complex than Social Security reform. Unlike Social Security, which is a cash benefit program, Medicare pays for services using third parties and consequently involves an enormous array of stakeholders – health care providers, insurance companies, pharmaceutical companies, and beneficiaries. Any change to the Medicare program thus creates ripple effects and unintended consequences; and because Medicare is such a big player in the healthcare market (comprising 20% of all health expenditures nationally) (Centers for Medicare & Medicaid Services, 2015), these ripples extend beyond Medicare to the healthcare market as a whole. Unsurprisingly, any change to the program creates political opposition. Because of the enormous dollars involved – $597 billion (€537.9 billion) in 2014 (The Henry J. Kaiser Family Foundation, 2015b)

– stakeholders have organized sophisticated lobbying resources, which often play a key role in setting regulation and influencing legislation.

Few tools for addressing cost were built into the Medicare program at its inception: the program was originally devised to simply pay medical bills – what is known as "fee-for-service" medicine. The trade association representing doctors, the American Medical Association, actively opposed "government-run healthcare," and secured provisions that protected doctor's independence, allowing them to determine the "reasonable and necessary" costs of services (Marmor, 2000). Thus, if a service was included in the program's benefit package and it was delivered via a Medicare-certified provider, it would be covered at the market rate. This proved a recipe for the inefficient delivery of care and spiraling costs: when providers are largely paid according to volume, they are naturally inclined to provide larger amounts of well-reimbursed services. These incentivizes are particularly problematic in light of the growth of for-profit health care – in 2013, for example, about 21% of all hospitals were for-profit (The Henry J. Kaiser Family Foundation, 2015a), up from18% in 2006 (Selvam, 2012). Consequently, considerable policy attention has been aimed at changing the financial incentives built into the program.

This concern has helped drive the growth of managed care in the Medicare program as well as other forms of "prospective payment," whereby reimbursement is based on the appropriate costs of services, determined beforehand, rather than retrospectively, as under traditional fee-for-service payment. Forms of prospective payment range from DRGs (diagnostic-related groups), which pay a flat rate for a hospital stay that is adjusted to reflect the patient's diagnosis and risk level, to capitation, in which a managed care organization is paid a per-person monthly rate to cover a defined package of benefits – under Medicare, this is typically the full Medicare benefit package. Governments favor prospective payment because healthcare costs become more predictable. It also shifts risk and helps control cost, because providers or insurers are challenged to deliver on their commitments within a given budget. Advocates also emphasize the ability of managed care plans to be more flexible in delivering services: they are not limited by the defined package of benefits covered under Medicare, allowing them more room for experimentation and to provide enhanced benefits. Lastly, managed care plans have greater flexibility in negotiating with providers, particularly with respect to price, where they are not bound by the limitations of the traditional fee-for-service Medicare program.

Thus, Medicare managed care, which began as a provision for "prepaid health plans" in the original Medicare legislation but only took off in the 1990s, has grown to become a significant part of the Medicare program, enrolling 31% of Medicare beneficiaries (Jacobson, Damico, Neuman, & Gold, 2015). However, the evidence on whether managed care saves government money is limited. Under the 1982 Tax Equity and Fiscal Responsibility Act legislation, payment for managed care plans was pegged at 95% of the cost of traditional Medicare services – thus, by definition, managed care was cheaper. Over time, however, this requirement was lifted and, to incentivize managed care plans

to participate in Medicare, rates began to rise, relative to traditional Medicare. At its peak, it was estimated that managed care plans were paid 14% more than was spent on comparable individuals receiving traditional Medicare services (Biles, Casillas, Arnold, & Guterman, 2012). From the beneficiary's perspective, managed care plans offer a more streamlined service, with enhanced benefits and fewer bills to manage than the traditional fee-for-service program; the complexity of the traditional program, which requires beneficiaries to pay as many as three premiums for different parts of their coverage (Part B, Part D, and, in some cases, for supplemental insurance, can be overwhelming. Consequently, managed care has built up a considerable constituency within the older population, who oppose efforts to rein in costs – which they view as "cuts." Proposals to bring managed care reimbursement in line with traditional Medicare were part of the 2010 Patient Protection and Affordable Care Act sponsored by the Obama administration, but have been politically difficult to implement.

Nonetheless, managed care plays a large role in conservative proposals for reform, which take managed care's efficiency as a given. These reform proposals envisage a Medicare program where insurers compete for market share. However, such proposals hinge on beneficiaries being given a fixed amount – a voucher (also known as "premium support") – that can be used to purchase insurance coverage. Such an arrangement has clear benefits in limiting government liability and in making government expenditures more predictable and manageable over time. From a beneficiary standpoint, however, there is concern that the voucher amount would be insufficient to cover premiums, leading to a situation where wealthy people would be able to purchase generous coverage, while less well-off people would only be able to purchase cheaper, less generous coverage and incur high out-of-pocket costs. This latter possibility is a significant politically drawback because beneficiaries already feel that their out-of-pocket costs are high: despite benefit expansions over the years. Even with the relatively recent addition of prescription drug coverage, beneficiaries out-of-pocket costs average nearly $5,000 per year and rise with age (Cubanski, Swoope, Damico, & Neuman, 2014)

Public support for such reforms, however, does exist. In 2011, a poll found that 46% of the public would support changing Medicare "to a system in which people choose their insurance from a list of private health plans that may offer different benefits at different premium amounts and the government pays a fixed amount (sometimes called a voucher) towards that cost" (The Henry J. Kaiser Family Foundation, 2011) – although 50% were opposed to any changes to the program. However, survey responses varied considerably based on how the question was framed, indicating the public's low level of understanding of the issue and their potential susceptibility to political persuasion. Broad support for the Medicare program overall is strong, at around 69% (PollingReport.com, 2015).

In summary, Medicare reform is enormously complex, not least because it intrinsically linked with the problems of the larger U.S. healthcare system. However, because

it is so complex, and so many stakeholders are involved, it is also difficult to change due to considerable lobbying by the various interest groups affected. In 2014, for example, the largest spending group, pharmaceutical companies, spent $230 million lobbying nationally (OpenSecrets, 2015). Medicare's complexity also deters informed public involvement, resulting in behind-the-door policy making, often within the bureaucracy, and opportunities for grandstanding on the political front, with little substantive public discussion.

Long-Term Services and Supports

The US faces many challenges with respect to long-term care (known as long-term services and supports, or LTSS, in the US.). As in many nations, the system for helping people with needs for physical or cognitive supports operates separately from the medical system, both in terms of its financing and its delivery. This separation has many consequences, the most significant of which is limited financing; however, the system also suffers from being poorly integrated with the medical system and lacking the infrastructure to ensure access and quality.

Probably the most critical issue is financing. The US has no public LTSS program available to all citizens. This is a problem because LTSS is beyond the financial means of most Americans: in 2014, the median annual cost of long-term care was $42,000 (€37,852) for assisted living and $77,380 (€69,781) for a semi-private room in a nursing home (and nearly $88,000 (€79.358) for a private room) (Genworth Financial Inc., 2014). The median annual cost of community-based care was estimated at $43,000 (€38,776) to $45,000 (€40,580) annually (for 44 hours of homemaker and home health service per week). And yet, public financing for these services is only available under Medicaid, the state-run public health insurance program for the poor, which requires potential recipients to impoverish themselves, forfeit their savings, or accrue medical expenses in excess of their income, before they can become eligible. A few states operate state-only funded programs; however, these provide limited services and are typically targeted at low-income individuals as well. Consequently, the bulk of LTSS is provided by unpaid family members, although a small population has private insurance for LTSS – about 7% of the population aged 65 years and older (Melnyk, 2005) – and many others pay out-of-pocket towards the substantial costs of care. Thus the need to pay for or provide LTSS results a significant financial risk – particularly for low-income families already under considerable stress.

In 2014, 22.0% of the nation's $220 billion (€198 billion) LTSS bill was paid out-of-pocket and 12% through insurance and other private sources; nearly two thirds (61.0%) was paid for by Medicaid and other public programs (5.0%) (National Health Policy Forum, 2014). It has been estimated that the total estimated value of unpaid family caregiving is $450 billion (€405) annually (Feinberg, et al., 2011). More than 11 million Ameri-

cans need LTSS, including 9.6 million (86%) who live in the community and 1.5 million (14%) who reside in a nursing home (Feder & Komisar, 2012). Most – 56% – are aged 65 years and older; a large minority – 44% – are under aged 65 years. Most community residents with LTSS needs – 78% – rely exclusively on unpaid, informal care; just a fraction – 8% – only receives paid care (Kaye, Harrington, & LaPlante, 2010).

Repeated attempts to establish a system for financing LTSS have failed, primarily due its potential high costs. Early Medicare proposals included a LTSS benefit but were later dropped due to cost; LTSS would also have been covered under the 1988 Medicare Catastrophic Care Act – which met considerable opposition from financially better off elders who were asked to subsidize their less well-off counterparts and was repealed a year later; and LTSS was included as part of the 2010 Affordable Care Act as the Community Living Assistance Services and Supports (CLASS) Act, which, again, was repealed just a few years after it was passed (Miller, 2011; Miller & Nadash, 2015). The CLASS Act represented a fatally flawed effort to cater to the American aversion to mandates: it tried to establish a voluntary public insurance program covering LTSS. However, with no restrictions based on disability or health status (although people currently claiming benefits could not apply), such a program could not be determined to be actuarially sound, as required by law. There was no way to avoid an insurance death spiral, whereby those opting for insurance are more likely to be high-risk, driving up premiums and deterring lower-risk individuals from participating. The clear lesson is that risk pooling (in other words, mandated participation across all levels of risk) is necessary for an actuarially sound program – and yet, any such mandate is highly unlikely in the current political environment.

Given the slim prospects for movement on the financing side of LTSS, the focus has shifted to other issues. Indeed, following the failure of CLASS, the Obama administration set up a commission to address LTSS more generally. Although the ensuing report punted on the question of financing, there was general agreement about other areas where progress could be made, including the need to focus delivery on community-based, rather than institutional care options, improve the workforce, and promote high-quality, integrated, person-centered care – all of these are non-controversial approaches that are, to varying degrees, already embedded in policy (Commission on Long-Term Care, 2013). For example, the 2010 Affordable Care Act contained several measures encouraging states to invest more heavily in home and community-based care (Harrington, Ng, Paplante, & Kaye, 2012). Even before these initiatives, the movement toward community-based options had been substantial with, for example, the number of Medicaid participants receiving home and community-based services increasing from 2.1 to 3.2 million between 2001 and 2011 (Ng, Harrington, Muscumeci, & Reaves, 2014). The healthcare reform law also directed substantial funds toward experiments in integrating care across the medical and LTSS divide (Miller & Nadash 2014). More recently, the once-a-decade White House Conference on Aging (in July 2015) prompted the Obama

administration to propose an overhaul of regulations to better ensure and improve quality in nursing homes, addressing widely-acknowledged persistent quality problems in the nursing home sector (The White House, 2015). Other efforts to improve quality in LTSS include increasing efforts to publicize the quality of LTSS providers: for example, the federal government now reports on nursing home and home health agency quality via websites that assess facilities using a five-star ranking system, and which also provide more detailed data about providers (Mor, 2005). Government is also experimenting with "pay-for-performance," whereby providers get financial rewards for improving quality (Miller, Doherty, & Nadash 2013). All of these efforts require good data that can be used to assess provider performance, a tricky prospect to pull off.

In summary, LTSS in the US presents significant ongoing issues. The federal government has been limited in its ability to tackle prevailing challenges on a national level, so decision-making has largely been delegated to the state level, where limited finances due to the lingering effects of the Great Recession have prevented bold action. In the absence of pressure from the public, it is difficult to see how this deadlock on real planning around the need for LTSS will be broken.

End-of-Life Care

One of the more positive developments in aging policy has been increasing discussion of end-of-life issues in the U.S. These discussions have taken a variety of forms, from attempts to pass "death with dignity" laws to the increasing recognition of palliative care within the medical system. All of these efforts represent significant movement in the public's ability and willingness to make policy to address the contentious issues raised by the end-of-life. However, the conversation is also colored by fears about the motivations behind change – that policy change is spurred by the need to control spending and by the low value placed on older and disabled lives, rather than by a desire to improve the dying process.

Attracting the most attention is the discussion around "death with dignity", also known as assisted suicide or physician-assisted suicide – all terms for measures that enable people to end their own life with the assistance of a health care provider. Regulation is set at the state level: the earliest state to move on this was Oregon, which voted to legalize assisted suicide in 1997. To date, only four other states have allowed such practices (two via judicial, rather than legislative means) (FindLaw, 2015), but the number of "death with dignity" bills proposed across states has increased considerably, with 25 states considering such legislation in 2015 (Death with Dignity National Center, 2015). Public opinion also appears to be swinging in the direction of supporting assisted suicide, with polls reporting that 68% favor it, up from 52% in 1997 (Dugan, 2015). Substantial opposition to such laws remains, however. Religion is an important factor: in liberal Massachusetts, for example, which recently defeated a bill, Catholics comprise

44.9% of the population (Catholic News Agency 2012). Organized medicine is also opposed: the American Medical Association (1999-2015), the leading membership organization for physicians in the US, has issued policy statements in opposition. Lastly, disability groups have been effective in questioning the bias embedded in how the quality of disabled lives is judged (Coleman, 2015). Although this issue has not taken on the partisan character of many aging issues, opponents of such bills lean right, while supporters lean left (Dugan, 2015). Thus, on occasion, the issue has become a flashpoint in the US's right to life debate, as in the high-profile case of Terri Schiavo, where then Governor Jeb Bush of Florida intervened to prevent a woman from being taken off life support.

Another important part of the effort to improve end-of-life care is the integration of palliative care into mainstream medicine. Palliative care is an approach that focuses on reducing suffering; it may supplement, rather than replace, traditional curative treatment, and it is not solely provided at the end-of-life. Models vary but typically involve hospital-based multidisciplinary teams, which work with patients to provide symptom relief, identify patient goals, help patients make complex medical decisions, and provide practical, spiritual, and psychosocial support. Since the National Hospice Study established in the early 1980s that palliative care was effective in reducing costs and relieving suffering (Greer, Mor, Morris, Sherwood, Kidder, & Birnbaum, 1986), it has become increasingly part of health care. The 2014 consensus report from the Institute of Medicine (IOM, 2014), *Dying in America,* endorsed the approach as the standard of care. However, there is a long way to go before palliative care becomes widely available. On average, physicians receive only limited training about palliative care (17 hours in total) and only an estimated 6,500 physicians are board-certified in palliation, roughly a third of what is needed, according to the IOM.

Reformers also focus on the extent to which the Medicare program structurally supports end-of-life care and decision-making. Medicare's hospice benefit, which has been part of the program since 1982 and aims to provide comfort care at the end-of-life, has significant problems. Although it is well used (with an estimated 32% percent of all Medicare recipients who died using hospice), patients often enter it too late and fail to get the maximum benefit; 28.4% used the benefit for three days or less (Teno, et al. 2013). Moreover, hospice providers are often poorly integrated with the service delivery system and seem to be particularly vulnerable to fraud (Carter, 2011; Davis, Strasser, & Cherny, 2015).

More recently, in 2015 the Obama administration revived plans to reimburse doctors for conversations with Medicare patients about their preferences about end-of-life options if they became too sick to speak for themselves. This is the same Medicare benefit originally proposed for inclusion but ultimately dropped from the 2010 health care reform legislation, which was famously depicted as "death panels" by the Republican vice-presidential nominee, Sarah Palin – so successfully that poll found that 41% of the

population believed this blatantly false description of the policy being proposed (CNN Opinion Research Corporation, 2009).

The evolution of legal tools (set at the state-level) to ensure that patient wishes are honored has accelerated over the last few years: advance directives, for example, are well-established. These include do-not-resuscitate orders, which specify the circumstances under which resuscitation takes place; living wills, which document broad preferences regarding end-of-life care; and health care proxies and durable powers of attorney, which delegate medical decision making to specified individuals. However, these instruments are underutilized: health care providers may not know they exist or fail to follow them. More recently, states have experimented with a different mechanism, generally known as POLST (physician order for life-sustaining treatment). All but five states have or are developing a POLST program (National POLST Paradigm, 2012-2015). Its distinguishing characteristic is that it is a standing medical order designed to follow the patient from treatment setting to treatment setting; unlike advance directives, POLST orders are only created when an individual likely has a year or less to live. In Oregon, the state that has implemented them most widely, these mechanisms have been found to be effective in honoring patient preferences by reducing costly hospitalizations at the end-of-life (Fromme, Zive, Schmidt, Cook, & Tolle, 2014). Furthermore, unlike advance directives, physician compliance with POLST is high.

Conclusion

Aging policy is central to the current political debate in the U.S. This stems from the aging of the "baby boom" generation born between 1946 and 1964 and the prominence of well-established programs that serve older people: Social Security, Medicare, and Medicaid. As significant portions of the federal budget, these three programs loom large in the broader debate over whether and how the federal government can meet its fiscal obligations in light of population aging. The irony is that these programs are in fact hugely popular among recipients and potential recipients. That is not to say that Social Security and programs providing health care to the poor and the elderly do not need reforming: even Donald Berwick, a former administrator of the Medicare and Medicaid programs and a well-known, prominent liberal, argues that there is enormous waste in the system (Berwick & Hackbarth, 2012). Yet, sensible proposals for reform are often stymied by political obstructionism. So, too, are attempts to plan more systematically and thoughtfully about the growing aging population in the US. An advantage of the US federal system of government is that in some cases progress can be made at the state-level such as with LTSS and end-of-life care; the downside is that this creates enormous cross-national disparities and that it fails to utilize the tools and the power that central government alone can provide.

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